

THE STATE OF SOUTH CAROLINA
IN THE SUPREME COURT

RECEIVED

MAY 30 2018

Appeal from Charleston County
Court of Common Pleas

S.C. SUPREME COURT

R. Markley Dennis, Jr., Circuit Court Judge

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

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

Clair Craver Johnson, Respondent,
v.

John Roberts, M.D., Petitioner.

And

Clair Craver Johnson, Respondent,
v.

Medical University of South Carolina, Petitioner.

JOINT APPENDIX VOLUME 1 OF 2

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

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

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

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

RECEIVED

MAR 14 2016

SC Court of Appeals

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

Appellate Case No.: 2015-001463

Clair Craver Johnson Appellant

v.

John Roberts, M.D. Respondent

And

Clair Craver Johnson Appellant

v.

Medical University of South Carolina Respondent

RECORD ON APPEAL
Volume I of II

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STATE OF SOUTH CAROLINA
 COUNTY OF CHARLESTON
 CLAIR C. JOHNSON

IN THE COURT OF COMMON PLEAS
 FOR THE NINTH JUDICIAL CIRCUIT
 CASE NO. 2010-CP-10-5135

Plaintiffs,

vs.

MEDICAL UNIVERSITY OF
 SOUTH CAROLINA, MILTON FOUST, MD
 AND JOHN FRED JOHNSON, MD
 Defendant.

NOTICE OF INTENT TO FILE SUIT
 S.C. Code Sec. 15-79-125 and 15-36-100

FILED
 2010 JUN 25 AM 11:14
 JULIE J. ARMSTRONG
 CLERK OF COURT

1. ADVERSE PARTIES:

a. MUSC - through its agents and employees.

2. SHORT AND PLAIN STATEMENT OF THE FACTS SHOWING THAT THE PARTY
 FILING THIS NOTICE IS ENTITLED TO RELIEF.

STATEMENT

1, Clair Johnson, due to having ECT- electroconvulsive therapy for an
 extended period of time between 2003 and 2008 am now left with cognitive
 impairment and excessive memory loss. This condition is greatly affecting
 my ability to have a normal life.

Clair C. Johnson
 6-25-10

State of South Carolina)
County of Charleston)

In the Court of Common Pleas
For the Ninth Judicial Circuit
Case No. 2010-cp-10- 5135

Clair Johnson,)
Plaintiff,)
Vs.)
Medical University of)
South Carolina and MILTON)
FOUST, MD and John FRED)
Johnson, MD)
Defendants.

Affidavit of Clair Johnson Pursuant to
S.C. Code Sec. 15-79-125 and 15-36-100

The undersigned, first being duly sworn, deposes and states the following:

1. I am Clair Johnson over the age of 18 and the plaintiff in this matter.
2. I have filed a Notice of Intention to file suit against the above-named Defendants.
3. Pursuant to the statutes above named I am informed and have a good faith belief that the statute of limitation on my cause of action in this matter (absent a discovery exception) will expire within the next 10 days from the date my Notice of Intent to File Suit is filed.
4. Because of these time constraints I do not have time to obtain an affidavit of an expert to file in this matter.
5. Therefore I seek an extension of time to file such an expert affidavit as provided by S.C. Code Sec. 15-79-125 and 15-36-100.

Further the affiant sayeth not.

Clair C. Johnson
Clair Johnson

Sworn to and subscribed before me
this 25th day of June, 2010.

Paul Kornahrens
Notary for the State of South Carolina
My Commission Expires: March 6, 2016

JUN 24, 2010 02:59p

PAUL KORNAHRENS
Notary Public - State of South Carolina
My Commission Expires March 6, 2016

18037792822

page 1

*Additional plaintiff may be added per court rule 1-
8-10-10

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIRE C. JOHNSON

11

Plaintiffs,

vs.

MEDICAL UNIVERSITY OF
SOUTH CAROLINA, MILTON FOUST, MD
AND JOHN FRED JOHNSON, MD
Defendant.

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT
CASE NO. 2010-CP-10-5135

PLAINTIFFS' ANSWERS TO
STANDARD INTERROGATORIES

FILED
2010 JUN 25 AM 11:15
JULIE J. ARISTIDE
CLERK OF COURT

TO WHOM IT MAY CONCERN:

The following information is provided in compliance with the provisions of S.C. Code of Laws, as amended, which requires that the Notice of Intent to File Suit include "any standard interrogatories or similar disclosures required by the South Carolina Rules of Civil Procedure."

1. Give the names and addresses of persons known to the parties or counsel to be witnesses concerning the facts of the case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.

ANSWER:

a. CLAIR JOHNSON
2 TURTLE COVE LANE
IRMO, S.C. 29063

b. MILTON FOUST, MD
MUSC - INSTITUTE OF PSYCHIATRY
CHARLESTON, S.C.

c. Agents and Employees of the Medical University of South Carolina Hospital,
hereinafter identified.

d. John Fred Johnson, MD
Southeastern Spine Institute
1106 Chuck Dawkey Blvd., Ste. 200
Mt. Pleasant, SC 29464

e. John M. Roberts, MD
222 W. Coleman Blvd.
Mt. Pleasant, SC 29464

JUN 23, 2010 09:00

2. Set forth a list of photographs, plats, sketches or other prepared documents in the possession of the party that relate to the claim or defense in the case.

ANSWER:

Plaintiffs are in possession of various records from the Medical University of South Carolina Hospital from 2003 to 2008. Plaintiff also has records from
1. Dr. John Roberts - MT. PLEASANT, S.C. 29464
2. Dr. Johnny Smith - 7037 ST. Andrews Rd. Columbia, S.C. 29212

3. In cases involving personal injury set forth the names and addresses of all physicians who have treated the party and all hospitals to which the party has been committed in connection with said injuries and also set forth a statement of all medical costs involved.

ANSWER:

Plaintiff's claims were based on her care at MUSC. She was under the care of Dr. Milton Faust

This Answer will be supplemented as more information becomes available.

4. Set forth the names and addresses of all insurance companies which have liability insurance coverage relating to the claim and set forth the number or numbers of the policies involved and the amount or amounts of liability coverage provided in each policy.

ANSWER:

Plaintiff has no liability insurance which would relate to this claim. He assumes that MUSC is covered by the South Carolina Insurance Reserve Fund, or some similar policy.

5. Set forth an itemized statement of all damages, exclusive of pain and suffering, claimed to have been sustained by the party.

ANSWER:

PLAINTIFF HAS BEEN LEFT WITH COGNITIVE IMPAIRMENT AND EXCESSIVE MEMORY LOSS. THIS CONDITION IS GREATLY AFFECTING HER ABILITY TO HAVE A NORMAL LIFE.

THE SPECIFIC ECONOMIC DAMAGES WILL CONSIST OF THOSE MEDICAL EXPENSES INCURRED IN THE EVALUATION AND TREATMENT OF HER CONDITION. THEY HAVE NOT YET BEEN CALCULATED. Additional damages to be sought per counsel. 8-10-10

6. List the names and addresses of any expert witnesses whom the party proposes to use

as a witness at the trial of the case.

ANSWER:

BECAUSE OF TIME CONSTRAINTS I AM IN THE PROCESS OF SECURING EXPERT WITNESSES.

Additionally, it is anticipated that those medical witnesses who provided care for the Plaintiff while he was a patient at MUSC will be qualified to render opinions within the fields of their expertise.

7. For each person known to the parties or counsel to be a witness concerning the facts of the case, set forth either a summary sufficient to inform the other party of the important facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witnesses.

ANSWER:

PLAINTIFF WILL TESTIFY TO THE FACTS OUTLINED IN THE NOTICE OF INTENT.

Medical personnel will presumably testify in accordance with the records which they
authored.

DATE 6-25-10

Clair C. Johnson
CLAIRE JOHNSON
2 TURTLE COVE LANE
IRMI S. P. 29063
803 781-8078

AUG 23, 2010 09:06P

10037744822

Page 12

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STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT
CASE NO.: 2010-CP-10-5135

Clair C. Johnson,

Plaintiff,

vs.

Medical University of South
Carolina, Milton Faust, M.D. and
John Fred Johnson, M.D.

Defendants.

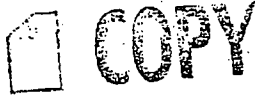
**RULE 41 (a) SCRCP STIPULATION
OF DISMISSAL WITHOUT PREJUDICE**

FILED
2010 AUG 25 PM 4:15
JULIE J. ARMSTRONG
CLERK OF COURT

The undersigned plaintiff filed the referenced Notice of Intent to Sue on June 23, 2010 and service followed. No appearances have been received from the parties served and plaintiff, pursuant to Rule 41 (a) SCRCP hereby dismisses, without prejudice, this Notice of Intent to Sue.

August 20, 2010

Clair Craver Johnson
Clair Craver Johnson
2 Turtle Cove Lane
Irmo, SC 29063-9252

 COPY

STATE OF SOUTH CAROLINA)

COUNTY OF CHARLESTON)

Clair Craver Johnson,)

Plaintiff,)

vs.)

John Roberts, M.D.,)

Defendant.)

IN THE COURT OF COMMON PLEAS
THE NINTH JUDICIAL CIRCUIT

CIVIL ACTION NO.: 2012-CP-10-2867

**AMENDED COMPLAINT
(JURY TRIAL DEMANDED)**

The plaintiff, complaining of the defendant, John Roberts, M.D., alleges:

1. Plaintiff is a resident of the County of Richland, State of South Carolina.
2. Defendant, John Roberts, M.D., is a psychiatrist licensed to practice medicine in the State of South Carolina who, upon information and belief, is a citizen and resident of the County of Charleston, State of South Carolina and who formed a patient physician relationship with the plaintiff and on or about 2003 began treating plaintiff with electroconvulsive shock therapy (ECT) despite plaintiff's refusal to give her consent to this treatment.
3. The defendant sought informed consent from the plaintiff's then estranged and now ex-husband in spite of potential conflicts of interest.
4. This involuntary treatment extended for two years until 2008.
5. During, after and as direct and proximate result of this extensive and involuntary ECT treatment, the plaintiff lacked the mental capacity to understand and appreciate the detrimental effect the ECT had upon her until 2010 when the plaintiff retained counsel, gathered her medical records and a medical expert was retained to analyze these records.
6. On or about August 10, 2011 plaintiff's medical expert, Harold J. Burstzajn, M.D. reported to the plaintiff that in his opinion that the defendant, John Roberts, M.D., in

treating the plaintiff failed to exercise the care that medical professionals under like circumstances would have exercised as more fully appears in the copy of plaintiff's expert's affidavit attached hereto as Exhibit A, which affidavit is incorporated hereby by reference and plaintiff alleges that John Roberts, M.D.'s negligence and gross negligence directly and proximately resulted in excruciating, intractable pain and suffering, loss of memory, and exacerbation of pre-existing mental impairments which the plaintiff could have avoided had an adequate assessment of available alternative medical options been made by the defendant Roberts.

7. Plaintiff, while in the care of the defendant Roberts, was involuntarily, repeatedly and improperly given ECT treatment at the request of the defendant Roberts for a period of two years or more exposing her to intractable pain, memory loss, and Post-traumatic Stress Disorder, which exacerbated plaintiff's existing mental impairment so as to prevent plaintiff from discovering the negligent and grossly negligent and reckless acts and omissions of the defendant Roberts until two (2) years after the conclusion of said treatment due to the degree of mental incompetency said treatment rendered the plaintiff.

8. The defendant owed the plaintiff the following duties of care in connection with her 2003 to 2008 course of treatment and breached one or more of these duties:

- A. The duty to exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances to accomplish the purpose for which they were employed;

B) The duty to receive informed consent by the patient for such treatment or recognize professional standards such as guardianship when faced with a potential conflict of interest;

C) The duty to provide timely and appropriate treatment when confronted with mental impairments that require such treatment;

D) The duty to exercise a greater degree of care and to respond appropriately when a risk of substantial danger and foreseeable long term affects is present;

E) The duty to perform thorough and careful mental assessments, such as the mental condition of the patient and attending circumstances vulnerability due to cognitive impairment, with such diligence and methods for treatment the mental impairment as are usually approved and practiced by psychiatrists of ordinary or average learning, judgment and skill; and

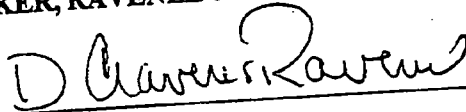
F) The duty to administer mental tests or examinations in aid of diagnosis when the recognized professional standards of skill and care, existing state of medical knowledge, and the like, required the making of tests or examinations which are generally accepted by the profession.

9. As a direct and proximate result of the negligence, gross negligence and recklessness of the defendant Roberts the plaintiff, Clair Craver Johnson, has suffered loss of memory and exacerbated mental impairment.

10. Plaintiff is entitled to recover actual and punitive damages for the unnecessary, avoidable pain and suffering, long-term memory loss, and exacerbated mental impairment which were inflicted upon plaintiff involuntarily by the defendant Roberts negligence, gross negligence and recklessness and for costs of medical treatment proximately caused by plaintiff Roberts treatment the plaintiff's condition for which she sought treatment.

Plaintiff demands a trial by jury and judgment for actual and punitive damages against the defendant on her cause of action for medical malpractice and for the pecuniary loss caused by the defendant Roberts negligent, grossly negligent and reckless treatment and the mental shock and suffering caused by the extended involuntary and excessive two year ECT treatment, psychological and mental impairments exacerbated by the excessive ECT treatments which have rendered the plaintiff incapable of a normal life and for such other and further relief as the Court deems just and proper.

BAKER, RAVENEL & BENDER, LLP



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Attorney for Plaintiff

May 15, 2012

STATE OF MASSACHUSETTS)
)
COUNTY OF MIDDLESEX)

AFFIDAVIT

1. I, Harold J. Burstzajn, M.D., am a physician currently licensed by the states of Massachusetts and New Hampshire. I am board-certified in psychiatry by the American Board of Psychiatry and Neurology. I serve as an Associate Clinical Professor of Psychiatry, Co-Founder of the Program in Psychiatry and the Law, and Principal Mentor for students at Harvard Medical School. A copy of my current curriculum vitae is attached hereto as Exhibit A.

2. This affidavit is provided pursuant to S. C. Code Ann. §§15-36-100 and 15-79-125.

3. Based upon my medical education, knowledge, training and experience, I am familiar with the generally accepted principles and standards of care in the diagnosis and treatment of Bipolar Disorder with psychotic features and a history of head trauma, for which Clair Craver Johnson was being treated.

4. I have, to date, reviewed records of Clair Craver Johnson's education, certain observations by the parents of Clair Craver Johnson over a significant period of time, court records, hospital and physicians' and psychologists' records, all documenting Clair Craver Johnson's emotional condition and the treatment of Clair Craver Johnson by the Medical University of South Carolina hospital and by John Roberts, M.D. and Milton Faust, M.D.

5. I interviewed Clair Craver Johnson in my office for 4 ¼ hours after reviewing the referenced materials.

6. After reviewing the described records and meeting with Clair Craver Johnson, and relying upon my education, knowledge, training and experience, I am of the opinion that based upon a reasonable degree of medical certainty, more likely than not, the treatment provided by



0014

the Medical College of South Carolina hospital, John Roberts, M.D., and Milton Faust, M.D., did not meet the standard of care imposed upon hospitals and physicians under like circumstances. I am of the opinion that the Medical University of South Carolina failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with electroconvulsive therapy (ECT) (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; that Dr. Roberts failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, by failing to conduct an adequate psychopharmacological assessment of alternate medication choices, by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; and that Dr. Faust failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, and by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence.

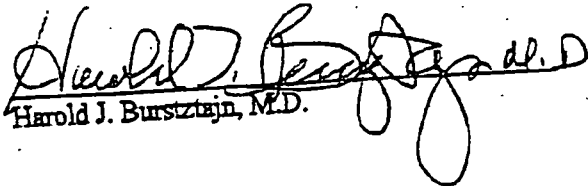
7. I am likewise of the opinion that based upon a reasonable degree of medical certainty, more likely than not, as a direct and proximate result of the negligent acts or omissions on the part of the Medical University of South Carolina, John Roberts, M.D., and Milton Faust, M.D., Clair Craver Johnson sustained the following injuries: prolonged and, to a degree, permanent exacerbation of cognitive impairments, including memory loss; impaired capacity to participate in her divorce proceedings; impairments in the post-traumatic spectrum resulting from the physically and emotionally traumatic experience of extended involuntary treatment with ECT, which produced feelings of helplessness, terror, and personal violation; a prolonged period of confusion and demoralization, resulting in a loss of access to a significant segment of her life experience and a loss of continuity of autobiographical memory; diminished trust in mental-health care providers; diminished hope for the future; and loss of the potential benefits of appropriate treatment with psychotherapy, medications, and a meaningful informed-consent process. Had Clair Craver Johnson been properly diagnosed and treated, I am of the opinion that to a reasonable degree of medical certainty, Ms. Johnson more likely than not would not have sustained the injuries described above and her emotional issues would have been managed so as to allow her to function as a productive individual.

8. Further, I am of the opinion that to a reasonable degree of medical certainty, more likely than not, Clair Craver Johnson did not regain the mental capacity to understand and appreciate the harm she suffered as a consequence of the negligent acts or omissions specified above, particularly the extended involuntary treatment with ECT, until she sought help in reviewing her medical records in June 2010, two years after ECT was concluded. Her capacity to comprehend what was going on in her life, already diminished by mental illness, was further diminished by the physical and emotional trauma and cognitive impairments associated with an

extended period of ECT, which foreseeably resulted in prolonged confusion and demoralization. She recovered the ability to process her experiences during those years only by reestablishing ties with a supportive community that helped her recreate her autobiographical memory.

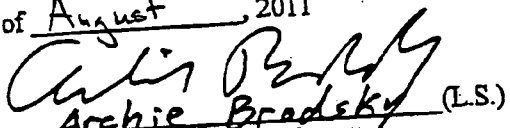
9. This affidavit does not include all of my opinions and I reserve the right to modify and/or formulate additional new opinions should additional, pertinent records be submitted for my review.

Further affiant sayeth not.


Harold J. Burstztein, M.D.

Sworn to before me this 10th day

of August, 2011


Archie Bradsky (L.S.)
Notary Public for Massachusetts

My Commission expires: June 22, 2012

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	NINTH JUDICIAL CIRCUIT
	)	
CLAIR CRAVER JOHNSON ,	)	CASE NO.
	)	
PLAINTIFF,	)	DEFENDANT JOHN ROBERTS, M.D.'S
	)	ANSWER TO THE AMENDED
vs.	)	COMPLAINT
	)	
JOHN ROBERTS, M.D.	)	
	)	
DEFENDANTS.	)	
	)	

TO: D. CRAVENS RAVENEL, ESQUIRE, ATTORNEY FOR PLAINTIFF:

The Defendant, John Roberts, M.D., referred to herein as "Defendant", hereby responds to the allegations set forth in Plaintiff's Amended Complaint as follows:

1. Any allegation set forth in the Plaintiff's Amended Complaint not specifically admitted, denied or otherwise modified is expressly denied.
2. Defendant admits to the allegations contained in Paragraph 1 of the Amended Complaint upon information and belief.
3. The Defendant denies the allegations contained in Paragraph 2 of the Amended Complaint as stated. Without waiving said denial, Defendant admits that he is a psychiatrist licensed to practice in the state of South Carolina and is a resident of Charleston County. Defendant further admits that he formed a physician-patient relationship with the Plaintiff, which is more particularly identified in the medical records. Any allegation inconsistent with this response is denied.
4. The Defendant denies the allegations contained in Paragraph 3 of the Amended Complaint as stated.

5. As to the allegations contained in Paragraphs 4 and 5 of the Amended Complaint, the Defendant denies that he was involved any involuntary treatment as alleged. The Defendant is without sufficient knowledge or information to respond to the remaining allegations regarding the Plaintiff's efforts to retain counsel and therefore demand strict proof thereof. Any allegation inconsistent with this response is denied.

6. In answering the allegations contained in Paragraph 6 of the Amended Complaint, Plaintiff's expert's affidavit speaks for itself and does not warrant a response regarding the allegations contained therein. The Defendant denies all allegations of wrongdoing as set forth in the affidavit and Amended Complaint and demands strict proof thereof.

7. The Defendant denies the allegations in Paragraphs 7, 8, 9 and 10 of the Amended Complaint, including all subparts and demands strict proof thereof.

8. The Defendant denies the prayer for relief.

**FURTHER ANSWERING AND FOR A
FURTHER AND AFFIRMATIVE DEFENSE**

9. The Plaintiff's Amended Complaint fails to state facts sufficient to support a cause of action under Rule 12(b)(6) of the South Carolina Rules of Civil Procedure.

**FURTHER ANSWERING AND FOR A
FURTHER AND AFFIRMATIVE DEFENSE**

10. The Defendant would affirmatively state that at all times he complied with the applicable standard of care.

**FURTHER ANSWERING AND FOR A
FURTHER AND AFFIRMATIVE DEFENSE**

11. The alleged negligence of Defendant was not the direct or proximate cause of any injury alleged by Plaintiff in the Amended Complaint and therefore, Defendant is not liable for the damages alleged.

**FURTHER ANSWERING AND FOR A
FURTHER AFFIRMATIVE DEFENSE**

12. There was no negligence, recklessness, gross negligence or wantonness on the part of the Defendant which proximately caused or contributed to Plaintiff's injuries.

**FURTHER ANSWERING AND FOR A
FURTHER AND AFFIRMATIVE DEFENSE**

13. The imposition of punitive damages on the basis of the acts or omissions of the Defendant with respect to the Plaintiff would represent the deprivation of liberty and property without due process of law, the imposition of cruel and unusual punishment and excessive fines and denies the equal protection of laws in violation of the Fifth, Sixth, and Fourteenth Amendments to the Constitution of the United States and cognizant provision of Constitution of the State of South Carolina.

**FURTHER ANSWERING AND FOR A
FURTHER AND AFFIRMATIVE DEFENSE**

14. The Defendant asserts Plaintiff's non-economic damages are capped in accordance with S.C. Code Ann. §15-32-220(a) and (b).

**FURTHER ANSWERING AND FOR A
FURTHER AND AFFIRMATIVE DEFENSE**

15. The Defendant would affirmatively assert that he would be entitled to any and all benefits, joint and several liability protections, emergency situations limitations on liability, any ~~and all monetary limitations or caps of liability and/or damages under the Economic~~ Development, Citizen and Small Business Protection Act and the South Carolina Medical Malpractice Reform Bill including, but not limited to §15-38-15; §15-32-200; §15-32-210; §15-32-220; §15-32-230; §15-32-240; §15-36-100; §15-32-222; and §15-79-125 and any other applicable provisions under the acts.

**FURTHER ANSWERING AND FOR A
FURTHER AND AFFIRMATIVE DEFENSE**

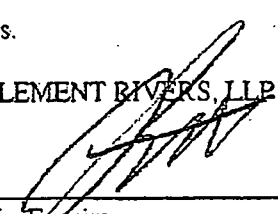
16. The Defendant reserves the right to amend additional affirmative defenses should discovery warrant such supplemental pleadings. Furthermore, the Defendant hereby specifically incorporate into his affirmative defenses any and all affirmative defenses raised by Defendant MUSC in the companion case brought by Plaintiff and consolidated with this case, to the extent they are applicable to the Defendant.

**FURTHER ANSWERING AND FOR A
FURTHER AND AFFIRMATIVE DEFENSE**

17. Upon information and belief the allegations are barred under the statute of limitations, the statute of repose and/or the disability tolling statute (§15-3-40 et al).

WHEREFORE, having fully answered the allegations contained in the Amended Complaint herein the Defendant prays that same be dismissed and he be awarded the cost of defending this action including reasonable attorney's fees.

YOUNG CLEMENT RIVERS, LLP.

By: 

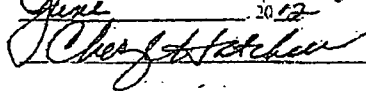
D. Jay Davis, Esquire
James E. Scott, IV, Esquire
P.O. Box 993, Charleston, SC 29402
(843) 720-5402; jscott@ycrlaw.com
Attorneys for the Defendant
John Roberts, M.D.

Charleston, South Carolina

Dated: 6/11/12

CERTIFICATE OF MAILING

I hereby certify that a copy of the foregoing pleading was mailed to all counsel of record in this proceeding this 11th day of June, 2012


Cheryl A. Fletcher

STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

COUNTY OF CHARLESTON

CASE NUMBER: 2011-CP-10-8918

Clair Craver Johnson,

Plaintiff,

COMPLAINT
(MEDICAL MALPRACTICE ACTION)

vs.

Medical University of South
Carolina,

Defendant.

FILED
2011 NOV -8 PM 12:53
J. ARNOLD
CLERK OF COURT

The Plaintiff, complaining of the Defendant, Medical University of South Carolina in Charleston, South Carolina, alleges:

1. Plaintiff is a resident of the County of Richland, State of South Carolina.
2. Upon information and belief, pursuant to the provisions of S.C. Code Ann. § 15-78-10 et seq (S.C. Tort Claims Act), Medical University of South Carolina in Charleston, South Carolina, a governmental entity, is subject to liability for medical malpractice, employed healthcare providers who negligently treated the Plaintiff with electroconvulsive therapy (hereinafter ECT) which was given without proper informed consent and with inadequate consideration for the foreseeable effects of such severe and extended treatment given the Plaintiff's history of mental impairments.
3. The ECT treatment by the defendant's employees took place between 2003 to 2008.
4. On or about 2003, psychiatrists in Charleston, South Carolina began treating the Plaintiff with ECT despite Plaintiff's refusal to give consent.

5. The treating physician's sought informed consent from the Plaintiff's then estranged and now ex-husband in spite of potential conflicts of interest.

6. This involuntary treatment extended for two years until 2008...

7. During, after and a direct and proximate result of this extensive and involuntary ECT treatment, the Plaintiff lacked the mental capacity to understand and appreciate the detrimental effect the ECT had upon her until 2010 when Clair Craver Johnson retained counsel, records of her ECT treatment were gathered, and a medical expert was retained to analyze those records.

8. Plaintiff's medical expert, Harold J. Burstzajn, M.D., reported on or about August 10, 2011, that in his opinion physicians and other healthcare providers at the Medical University of South Carolina, Charleston, South Carolina, failed to exercise the care that medical professionals under like circumstances would have exercised as more fully appears in the copy of the expert's affidavit attached hereto as Exhibit A and which is incorporated herein by reference thereto and plaintiff alleges that the healthcare provider at the Medical University of South Carolina, Charleston, South Carolina's, negligence and gross negligence as employees of Medical University of South Carolina, Charleston, South Carolina, directly and proximately resulted in excruciating, intractable pain and suffering, loss of memory, and exacerbation of preexisting mental impairments which the Plaintiff could have avoided had an adequate assessment of alternative medical options been made by Medical University of South Carolina, Charleston, South Carolina.

9. Plaintiff, while in the care of the Medical University of South Carolina, Charleston, South Carolina, was involuntarily, repeatedly and improperly given ECT treatment by the Medical University of South Carolina, Charleston, South Carolina, for two years,

exposing her to intractable pain, memory loss, and Post-traumatic Stress Disorder, which Plaintiff's exacerbated mental impairment so as to prevent Plaintiff from discovering the negligent acts or omissions of the Medical University of South Carolina, Charleston, South Carolina, until two years after the conclusion of said treatment due to the degree of mental incompetency said treatment rendered the Plaintiff.

10. The Defendant owed the Plaintiff the following duties of care in connection with her 2003 to 2008 treatment and breached one or more of these duties:

- A) The duty to exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances to accomplish the purpose for which they were employed;
- B) The duty to receive informed consent by the patient for such treatment or recognize professional standards such as guardianship when faced with a potential conflict of interest;
- C) The duty to provide timely and appropriate treatment when confronted with mental impairments that require such treatment;
- D) The duty to exercise a greater degree of care and to respond appropriately when a risk of substantial danger and foreseeable long term effects is present;
- E) The duty to perform thorough and careful mental assessments, such as the mental condition of the patient and attending circumstances vulnerability due to cognitive impairment, with such

diligence and methods for treatment the mental impairment as are usually approved and practiced by psychiatrists of ordinary or average learning, judgment and skill; and

- F) The duty to administer mental tests or examinations in aid of diagnosis when the recognized professional standards of skill and care, existing state of medical knowledge, and the like, required the making of tests or examinations which are generally accepted by the profession.

11. As a direct and proximate result of the negligence and gross negligence of the employees of Medical University of South Carolina, Charleston, South Carolina, Clair Conner Johnson, has suffered loss of memory and exacerbated mental impairments under circumstances above in violation of S.C. Code Ann. § 15-79-110 *et seq*.

12. Plaintiff is entitled to recover actual damages for the unnecessary, avoidable pain and suffering, long term memory loss, and exacerbated mental impairment which were inflicted upon her involuntarily by the defendant's employees negligence and gross negligence and for costs of medical treatment proximately caused by the defendant's employees' treatment of her condition.

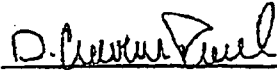
Plaintiff demands:

1. A trial by jury on Plaintiff's causes of action for Medical Malpractice.
2. Judgment under the S.C. Tort Claim Act for actual damages including damages under S.C. Code Ann. § 15-79-110 *et seq* for (1) pecuniary loss caused by the negligent treatment rendered by the employees of the Defendant; (2) mental shock and suffering caused by the extended and involuntary two year ECT treatment; (3)

psychological and mental impairments further exacerbated by the ECT treatments

which have rendered the Plaintiff incapable of a normal life.

3. And for such other and further relief as the Court deems just and proper.



D. Craven Ravenel
BAKER, RAVENEL & BENDER, L.L.P.
3710 Landmark Drive, Suite 400
Post Office Box 8057
Columbia, South Carolina 29202
Telephone (803) 799-9091
Facsimile (803) 779-3423
cravenel@brblegal.com
File No.: 10517
ATTORNEYS FOR PLAINTIFF

Columbia, SC
May 2, 2011

STATE OF MASSACHUSETTS)

COUNTY OF MIDDLESEX)

AFFIDAVIT

1. I, Harold J. Burstein, M.D., am a physician currently licensed by the states of Massachusetts and New Hampshire. I am board-certified in psychiatry by the American Board of Psychiatry and Neurology. I serve as an Associate Clinical Professor of Psychiatry, Co-Founder of the Program in Psychiatry and the Law, and Principal Mentor for students at Harvard Medical School. A copy of my current curriculum vitae is attached hereto as Exhibit A.

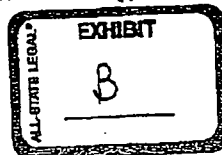
2. This affidavit is provided pursuant to S. C. Code Ann. §§15-36-100 and 15-79-125.

3. Based upon my medical education, knowledge, training and experience, I am familiar with the generally accepted principles and standards of care in the diagnosis and treatment of Bipolar Disorder with psychotic features and a history of head trauma, for which Clair Craver Johnson was being treated.

4. I have, to date, reviewed records of Clair Craver Johnson's education, certain observations by the parents of Clair Craver Johnson over a significant period of time, court records, hospital and physicians' and psychologists' records, all documenting Clair Craver Johnson's emotional condition and the treatment of Clair Craver Johnson by the Medical University of South Carolina hospital and by John Roberts, M.D. and Milton Fanst, M.D.

5. I interviewed Clair Craver Johnson in my office for 4 ½ hours after reviewing the referenced materials.

6. After reviewing the described records and meeting with Clair Craver Johnson, and relying upon my education, knowledge, training and experience, I am of the opinion that based upon a reasonable degree of medical certainty, more likely than not, the treatment provided by



the Medical College of South Carolina hospital, John Roberts, M.D., and Milton Faust, M.D., did not meet the standard of care imposed upon hospitals and physicians under like circumstances. I am of the opinion that the Medical University of South Carolina failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with electroconvulsive therapy (ECT) (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; that Dr. Roberts failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, by failing to conduct an adequate psychopharmacological assessment of alternate medication choices, by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; and that Dr. Faust failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, and by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence.

7. I am likewise of the opinion that based upon a reasonable degree of medical certainty, more likely than not, as a direct and proximate result of the negligent acts or omissions on the part of the Medical University of South Carolina, John Roberts, M.D., and Milton Faust, M.D., Clair Craver Johnson sustained the following injuries: prolonged and, to a degree, permanent exacerbation of cognitive impairments, including memory loss; impaired capacity to participate in her divorce proceedings; impairments in the post-traumatic spectrum resulting from the physically and emotionally traumatic experience of extended involuntary treatment with ECT, which produced feelings of helplessness, terror, and personal violation; a prolonged period of confusion and demoralization, resulting in a loss of access to a significant segment of her life experience and a loss of continuity of autobiographical memory; diminished trust in mental-health care providers; diminished hope for the future; and loss of the potential benefits of appropriate treatment with psychotherapy, medications, and a meaningful informed-consent process. Had Clair Craver Johnson been properly diagnosed and treated, I am of the opinion that to a reasonable degree of medical certainty, Ms. Johnson more likely than not would not have sustained the injuries described above and her emotional issues would have been managed so as to allow her to function as a productive individual.

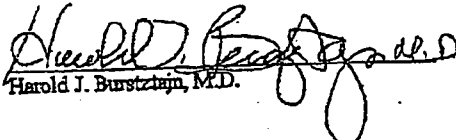
8. Further, I am of the opinion that to a reasonable degree of medical certainty, more likely than not, Clair Craver Johnson did not regain the mental capacity to understand and appreciate the harm she suffered as a consequence of the negligent acts or omissions specified above, particularly the extended involuntary treatment with ECT, until she sought help in reviewing her medical records in June 2010, two years after ECT was concluded. Her capacity to comprehend what was going on in her life, already diminished by mental illness, was further diminished by the physical and emotional trauma and cognitive impairments associated with an

~~extended period of ECT, which foreseeably resulted in prolonged confusion and demoralization.~~

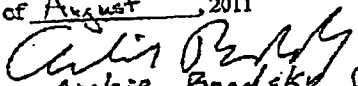
~~She recovered the ability to process her experiences during those years only by reestablishing ties with a supportive community that helped her recreate her autobiographical memory.~~

9. This affidavit does not include all of my opinions and I reserve the right to modify and/or formulate additional new opinions should additional, pertinent records be submitted for my review.

Further affiant sayeth not.


Harold J. Burstzajn, M.D.

Sworn to before me this 10th day
of August, 2011


Archie Bradsky (L.S.)
Notary Public for Massachusetts

My Commission expires: June 22, 2012

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIRE Johnson

Plaintiff(s)

vs.

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

CASE NO. 2010-CP-105135

Medical University of South Carolina, Plaintiff First, et al.

and John F. Johnson, M.D. Defendant(s)

(Please Print)

Submitted by: CLAIR Johnson

Address: 2747 E. Cove Lane

IRMO, SC 29063

SC Bar #: _____

Telephone #: 803-781-8078

Fax #: 803-781-8079

E-mail: _____

E-mail: HICKER@SC.PE.COM

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

DOCKETING INFORMATION (Check all that apply)

*If Action is Judgment/Settlement do not complete

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

NATURE OF ACTION (Check One Box Below)

Contract

- ☐ Construction (100)
☐ Other Contract (110)
☐ Employment (120)
☐ General (130)
☐ Breach of Contract (140)
☐ Other (150)

Torts - Professional Malpractice

- ☐ Dental Malpractice (200)
☐ Legal Malpractice (210)
☐ Medical Malpractice (220)
☒ Medical File Med Mal (230)
☐ Other (299)

Torts - Personal Injury

- ☐ Assault/Battery (300)
☐ Conversion (310)
☐ Motor Vehicle Accident (320)
☐ Products Liability (330)
☐ Professional Liability (340)
☐ Personal Injury (350)
☐ Wrongful Death (360)
☐ Other (399)

Real Property

- ☐ Claim & Delivery (400)
☐ Eminent Domain (410)
☐ Foreclosure (420)
☐ Mechanics' Lien (430)
☐ Partition (440)
☐ Possession (450)
☐ Building Code Violation (460)
☐ Other (499)

Business Relations

- ☐ PCR (500)
☐ Mediation (510)
☐ Mediation (520)
☐ Other (599)

Judgment/Settlements

- ☐ Death Settlement (700)
☐ Foreign Judgment (710)
☐ Mediator's Settlement (720)
☐ Minor Settlement (730)
☐ Trustee's Settlement (740)
☐ Lost Payers (750)
☐ Transfer of Settlement
☐ Settlement Payment Rights
☐ Application (760)
☐ Other (799)

Administrative Law/Relief

- ☐ Railroad Worker's Lien (800)
☐ Judicial Review (810)
☐ Review (820)
☐ Professional Liability (830)
☐ Bankruptcy (840)
☐ Foreclosure - Consumer Order (850)
☐ Other (899)

Appeals

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

Special/Complex Order

- ☐ Environmental (600)
☐ Automobile Acc. (610)
☐ Medical (620)
☐ Other (699)

Professional/Trade

- ☐ Professional/Trade (630)
☐ Unfair Trade Practices (640)
☐ Out-of-State Depositions (650)
☐ Sexual Predator (660)

Submitting Party Signatures

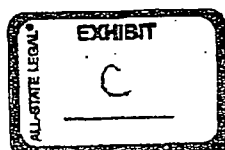
CLAIR Johnson Date 6-24-10

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

SCCA / 234 (01/09)

Page 1 of 2

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P68

0031

FOR MANDATED ADR COUNTIES ONLY

Allendale, Anderson, Beaufort, Colleton, Florence, Greenville,
Hampton, Horry, Jasper, Lexington, Pickens (Family Court Only), and Richland

**SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE
DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.**

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

Please Note: You must comply with the Supreme Court Rules regarding ADR.
Failure to do so may affect your case or may result in sanctions.

STATE OF MASSACHUSETTS)
COUNTY OF MIDDLESEX)

AFFIDAVIT

1. I, Harold J. Burstzajn, M.D., am a physician currently licensed by the states of Massachusetts and New Hampshire. I am board-certified in psychiatry by the American Board of Psychiatry and Neurology. I serve as an Associate Clinical Professor of Psychiatry, Co-Founder of the Program in Psychiatry and the Law, and Principal Mentor for students at Harvard Medical School. A copy of my current curriculum vitae is attached hereto as Exhibit A.

2. This affidavit is provided pursuant to S. C. Code Ann. §§15-36-100 and 15-79-125.

3. Based upon my medical education, knowledge, training and experience, I am familiar with the generally accepted principles and standards of care in the diagnosis and treatment of Bipolar Disorder with psychotic features and a history of head trauma, for which Clair Craver Johnson was being treated.

4. I have, to date, reviewed records of Clair Craver Johnson's education, certain observations by the parents of Clair Craver Johnson over a significant period of time, court records, hospital and physicians' and psychologists' records, all documenting Clair Craver Johnson's emotional condition and the treatment of Clair Craver Johnson by the Medical University of South Carolina hospital and by John Roberts, M.D. and Milton Faust, M.D.

5. I interviewed Clair Craver Johnson in my office for 4 ¼ hours after reviewing the referenced materials.

6. After reviewing the described records and meeting with Clair Craver Johnson, and relying upon my education, knowledge, training and experience, I am of the opinion that based upon a reasonable degree of medical certainty, more likely than not, the treatment provided by



0033

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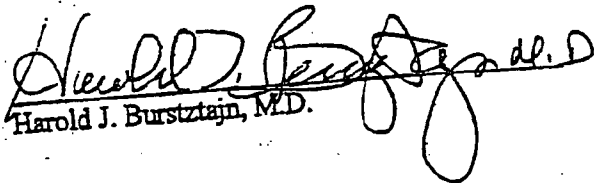
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8. Further, I am of the opinion that to a reasonable degree of medical certainty, more likely than not, Clair Craver Johnson did not regain the mental capacity to understand and appreciate the harm she suffered as a consequence of the negligent acts or omissions specified above, particularly the extended involuntary treatment with ECT, until she sought help in reviewing her medical records in June 2010, two years after ECT was concluded. Her capacity to comprehend what was going on in her life, already diminished by mental illness, was further diminished by the physical and emotional trauma and cognitive impairments associated with an

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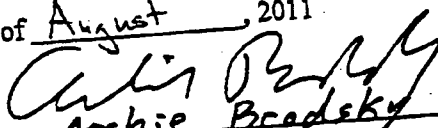
9. This affidavit does not include all of my opinions and I reserve the right to modify and/or formulate additional new opinions should additional, pertinent records be submitted for my review.

Further affiant sayeth not.


Harold J. Burstzajn, M.D.

Sworn to before me this 10th day

of August, 2011.

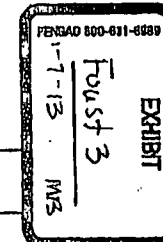

Archie Bradsky (L.S.)
Notary Public for Massachusetts

My Commission expires: June 22, 2012

ID# 14758
 Primary Psychiatric Dx: Major Depressive Disorder (296.24)
 Medical History: hypertension, asthma
 Date at time of first TX: _____

DOB 4/23/66

Handwritten signature



0037

Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEG	Device	PT STAT	Comments
12/10/03	0.2	70	60	Phen 12.5 Tor 30	50	352	4.7	0.9	60	0.5	1010	(B)	27	36	Th	I	
12/12/03	0.2	70	60	Phen 12.5 Tor 30	50	252	4.7	0.9	60	0.5	770	(B)	28	30	Th	I	Thyroid Dx.
12/15/03	0.2	70	60	Phen 12.5 Tor 30	50	252	4.7	0.9	60	0.5	2550	(B)	21	42	Th	I	CP 10/2/12
12/18/03	0.2	100	60	Phen 12.5 Tor 30	50	252	4.7	0.9	60	0.5	2090	(B)	20	41	Th	I	
12/19/03	0.2	130	60	Phen 12.5 Tor 30	60	302	5.6	0.9	60	0.5	2310	(B)	25	27	Th	I	
4/4/05	0.2	100	60	Phen 12.5 Tor 30	50	250	7	0.89	40	0.5	2190	(B)	NA	16	IV	I	7/2/05
4/11/05	0.2	100	60	Phen 12.5 Tor 30	60	288.9	6.7	0.89	50	0.5	2790	(B)	7	17	IV	I	7/2/05
4/12/05	0.2	100	60	Phen 12.5 Tor 30	70	349.1	7.8	0.89	50	0.5	2600	(B)	6	25	IV	I	
4/14/05	0.2	100	60	Phen 12.5 Tor 30	80	399.7	7.5	0.89	60	0.5	2630	(B)	10	17	IV	I	Micro stim to 95%
7/14/05	.2	100	60	P 12.5 Tor 30	95	474.6	7.6	.89	70	.5	2200	(B)	13	23	IV	I	
4/18/05	0.2	100	60	Phen 12.5 Tor 30	100	499.9	8	0.89	70	0.5	2000	(B)	7	18	IV	I	

me: Johnson, Clara ID# 747758 DOB 8/15/66

Primary Psychiatric Dx: BPD, Depressed 296.44

Medical History: hypertension, negative

ds at time of first Tx: _____

Hollman
Savings

0038

Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEG	Device	PT STAT	Comments
4/10/05	0.2	100	60	Phen 12.5 100 30	100	489.3	8	0.89	70	0.5	220 2100	13	16	32	TV	I	
10/18/05	0.2	100	60	Phen 12.5 100 30	15%	248.6	7.9	0.89	40	0.5	250 1310	13	15	19	TV	I	
10/21/05	0.2	100	60	Phen 12.5 100 30	60	259.8	6.2	0.89	50	0.5	240 1540	13	14	32	TV	I	
10/24/05	0.2	100	60	Phen 12.5 100 30	70	243.1	7.8	0.89	50	0.5	220 1230	13	23	31	TV	I	
10/26/05	0.2	100	60	Phen 12.5 100 30	70	348.9	7.8	0.89	50	0.5	230 1580	13	23	31	TV	I	
10/28/05	0.2	100	60	Phen 12.5 100 30	70	351.0	7.8	0.89	50	0.5	230 1510	13	23	35	TV	I	
10/29/05	0.2	100	60	Phen 12.5 100 30	70	254.0	7.8	0.89	50	0.5	240 1740	13	13	37	TV	I	
11/2/05	0.2	100	60	Phen 12.5 100 30	80	400.0	7.5	0.89	60	0.5	250 1400	13	9	31	TV	0	
11/15/05	0.2	100	60	Phen 12.5 100 30	90	449.7	7.7	0.89	70	0.5	260 1720	13	16	32	TV	0	
11/23/05	0.2	100	60	Phen 12.5 100 30	90	450.8	7.2	0.89	70	0.5	250 1610	13	7	25	TV	0	? E form 7.31 am

Inter/ectreat.frm/1

Rev A19A FOR

977758

DOB

8/25/1966

Primary Psychiatric Dx: BPAID

st Medical History:

ids at 'time' of first Tx:

Westhore
Smith

#	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedence	EP	EMG	EEG	Device	PT STAT	Comments
1	11/28/05	0.2	100	60	Phen 12.5 100 30	100	520.8	8	0.89	70	0.5	240 150.0	(13)	18	38	IV	I	E form?
1	11/30/05	0.2	100	60	Phen 12.5 100 30	100	520.1	8	0.89	70	0.5	250 174.0	(13)	33	47	IV	I	
1	12/8/05	0.2	100	60	Phen 12.5 100 30	100	498.6	8	0.89	70	0.5	260 168.0	(13)	28	55	IV	I	
1	12/15/05	0.2	100	60	Phen 12.5 100 30	100	498.8	8	0.89	70	0.5	250 218.0	(13)	31	55	IV	I	
1	12/22/05	0.2	100	60	Phen 12.5 100 30	100	477.1	8	0.89	70	0.5	310 257.0	(13)	25	52	IV	I	
1	12/28/05	0.2	100	60	Phen 12.5 100 30	100	495.6	8	0.89	70	0.5	330 274.0	(13)	29	60	IV	I	
1	1/13/06	0.2	100	60	Phen 12.5 100 30	100	478.3	8	0.89	70	0.5	290 222.0	(13)	32	57	IV	I	
1	1/24/06	0.2	100	60	Phen 12.5 100 30	100	478.0	8	0.89	70	0.5	270 200.0	(13)	28	47	IV	I	
1	1/27/06	0.2	100	60	Phen 12.5 100 30	100	498.1	8	0.89	70	0.5	290 147.0	(13)	38	49	IV	I	
1	1/30/06	0.2	100	60	Phen 12.5 100 30	100	498.78	8	0.89	70	0.5	280 189.0	(13)	47	28	IV	I	↑ Sur
1	2/3/06	0.2	100	60	Phen 12.5 100 30	100	478.	8	0.89	70	0.5	270 270.0	(13)	29	50	IV	I	Consider Rhabd to - 3

11per/pc.t.treat from/1

name Johnson, Vae

ID# 947738

DOB 8/23/66

Primary Psychiatric Dx: BPD

Medical History: _____

eds at time of first Tx: _____

Heathcare Sunny
(Wednes)

0040

#	Date	Antichol	Anesib	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedence	EP	EMG	EEG	Device	PT STAT	Comments
1	2/10/06	0.2	Eto 12	80	Phen 17.5 100 30	100	497.4	8	0.89	20	0.5	310 2860	B	29	42	IV	0	1 succ.
1	2/16/06	0.2	Eto 12	100	Phen 17.5 (+0.2 1206) 100 30	100	487.2	8	0.89	20	0.5	300 1760	B	36	70	IV	0	
1	2/23/06	0.2	Eto 12	100	Phen 17.5 100 30	100	488.5	8	0.89	20	0.5	280 1610	B	NA	12/IV	0		
1	3/7/06	0.2	Eto 12	100	Phen 17.5 100 30	100	488.4	8	0.89	20	0.5	280 1780	B	31	76	IV	0	
1	3/9/06	0.2	Eto 12	100	Phen 17.5 100 30	100		8	0.89	20	0.5	270 1440	B	27	46	IV	0	
1	3/13/06	0.2	Eto 12	100	Phen 17.5 100 30	100	477.1	8	0.89	20	0.5	280 1540	B	28	32	IV	0	
1	3/16/06	0.2	Eto 12	100	Phen 17.5 100 30	100	489.3	8	0.89	20	0.5	260 1760	B	NA	50	IV	0	
1	3/21/06	0.2	Eto 12	100	Phen 17.5 100 30	100	489.7	8	0.89	20	0.5	260 1160	B	30	43	IV	0	
1	3/27/06	0.2	Eto 12	100	Phen 17.5 100 30	100	478.1	8	0.89	20	0.5	290 1400	B	29	29	IV	0	
1	4/4/06	0.2	Eto 12	100	Phen 17.5 100 30	100	488.7	8	0.89	20	0.5	240 220	B	28	28	IV	0	
1	4/12/06	0.2	Eto 12	100	Phen 17.5 100 30	100	561.5	8	0.89	20	0.5	520 220	B	32	73	IV	0	

Incr/ecttreat.frm/1

Primary Psychiatric Dx: BIPAD (296.62)

ID# 247758

DOB 8/25/68

Past Medical History: _____

Meds at time of first Tx: _____

medication / See par

ref. D. [Signature]

0041

Tx#	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEG	Device	PT STAT	Comments
U	4/15/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	499.7	8	0.89	70	0.5	250 1100 (13)	31	55	IV	0	
U	4/22/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	500.3	8	0.89	70	0.5	250 840 (13)	21	44	TV	0	
U	5/2/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	499.1	8	0.89	70	0.5	270 1180 (13)	30	61	IV	0	
U	5/9/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.0	8	0.89	70	0.5	250 1120 (13)	29	42	IV	0	
U	5/16/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.4	8	0.89	70	0.5	280 1310 (13)	26	63	IV	0	
U	5/25/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	500.5	8	0.89	70	0.5	240 840 (13)	30	60	IV	0	
U	6/8/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.3	8	0.89	70	0.5	280 1390 (13)	28	59	IV	0	
U	6/22/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.9	8	0.89	70	0.5	270 1230 (13)	30	52	IV	0	
U	7/3/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.0	8	0.89	70	0.5	290 1480 (13)	29	54	IV	0	
U	8/1/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.9	8	0.89	70	0.5	290 1230 (13)	35	91	IV	0	
U	8/12/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.1	8	0.89	70	0.5	270 1040 (13)	30	60	IV	0	

Iner/ectreat, from/

Primary Psychiatric Dx: Bipolar 296.21

ID# 747758

DOB 8/25/66

Medical History: _____

Medical/Signs

Is at time of first Tx: _____

Dr. Robert T 81-0455 T 81-6828 (Fax)

Location: Rehab

Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEG	Device	PT STAT	Comments
9/1/06	0.2	Eto	100	Phen 12.5 100 30	100	478.6	8	0.87	70	0.5	280 1210	15	50	166	IV	0	
9/2/06	0.2	Eto	100	Phen 12.5 100 30	100	478.3	8	0.87	70	0.5	280 1400	15	29	70	IV	0	
10/5/06	0.2	Eto	100	Phen 12.5 100 30	100	472.8	8	0.87	70	0.5	300 1570	15	47	50	IV	0	
10/12/06	0.2	Eto	100	Phen 12.5 100 30	100	472.8	8	0.87	70	0.5	300 1500	15	35	39	IV	0	
10/19/06	0.2	Eto	100	Phen 12.5 100 30	100	472.0	8.0	0.87	70	0.5	300 2000	15	30	64	IV	0	
11/2/06	0.2	Eto	100	Phen 12.5 100 30	100	472.0	8.0	0.87	70	0.5	300 1920	15	17	20	IV	0	
11/6/06	0.2	Eto	100	Phen 12.5 100 30	100	478.8	8	0.87	70	0.5	280 1100	15	27	62	IV	0	
11/8/06	0.2	Eto	100	Phen 12.5 100 30	100	472.3	8	0.87	70	0.5	310 2020	15	25	42	IV	0	
11/16/06	0.2	Eto	100	Phen 12.5 100 30	100	471.7	8	0.87	70	0.5	320 1570	15	33	51	IV	0	
11/28/06	0.2	Eto	100	Phen 12.5 100 30	100	471.7	8	0.87	70	0.5	320 1600	15	32	8	IV	0	
12/13/06	0.2	Eto	100	Phen 12.5 100 30	100	472.6	8	0.87	70	0.5	270 1680	15	33	70	IV	0	

rectrest.fm/1

Medical University of South Carolina
Electroconvulsive Therapy Record Sheet

Name: Johnson, C/er

ID #: 947756

8/25/66
D.O.B. 8/25/26

Primary Psychiatric Diagnosis: BPAD

Insurance: Cigna

Allergies: None known

Referrer: Dr. John Roberts

Significant Risk Factors: hypertension (on med)

Weight: 80 kg

Medications at Time of First Treatment: 12/20/06 Fluoxetine 50 BID, Lorazepam 1mg PRN, Risperidone 4mg BID, Lithium 500mg qid

0043

#	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedence	EP	EMG	EEG	Device	Pt Stat	Comments
	12/15/06	0.2	Eto	100	Phen 12.5 cor 30	100	498.1	8	0.87	70	0.5	270 1270	13	17	35	IV	I	
3	12/18/06	0.2	Eto	100	Phen 12.5 cor 30	100	497.6	8	0.87	70	0.5	300 1200	13	22	43	IV	C	
4	12/18/06	0.2	Eto	100	Phen 12.5 cor 30	100	497.6	8	0.87	70	0.5	300 1200	13	26	46	IV	O	
1	1/3/07	0.2	Eto	100	Phen 12.5 cor 30	100	496.4	8	0.87	70	0.5	310 1250	13	32	58	IV	O	+ Resp. count 32.5
1	1/11/07	0.2	Eto	100	Phen 12.5 cor 30	100	498.2	8	0.87	70	0.5	310 1260	13	31	45	IV	O	
1	1/18/07	0.2	Eto	100	Phen 12.5 cor 30	100	498.4	8	0.87	70	0.5	310 1270	13	33	42	IV	O	+ Resp. count 32.5
1	2/1/07	0.2	Eto	100	Phen 12.5 cor 30	100	498.0	8	0.87	70	0.5	310 1280	13	ND	42	IV	O	+ Resp. 32.5
1	2/15/07	0.2	Eto	100	Phen 12.5 cor 30	100	498.9	8	0.87	70	0.5	310 1270	13	ND	43	IV	O	+ Resp. 32.5
1	3/1/07	0.2	Eto	100	Phen 12.5 cor 30	100	498.4	8	0.87	70	0.5	310 1270	13	ND	54	IV	O	+ Resp. 32.5
1	3/15/07	0.2	Eto	100	Phen 12.5 cor 30	100	496.7	8	0.87	70	0.5	310 1270	13	25	42	IV	O	+ Resp. 32.5
1	3/29/07	0.2	Eto	100	Phen 12.5 cor 30	100	499.1	8	0.87	70	0.5	310 1280	13	34	43	IV	O	Risperidone 32.5

**Medical University of South Carolina
Electroconvulsive Therapy Record Sheet**

Name: Johnson, Clair

ID #: 9-7758

D.O.B.: 8/5/66

Primary Psychiatric Diagnosis: BPAD

Insurance: Cigna (Wawa)

Allergies: Penicillin, L. Hives

Referrer: Dr. John R. B. B.

Significant Risk Factors: h/o hypothyroidism

Weight: 80kg

Medications at Time of First Treatment: _____

0044

#	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEG	Device	Pt Stat	Comments
M	4/26/07	0.2	Eto	100	Phen 12.5	100	497.5	8	0.87	70	0.5	1490	T3	54	51	TV	0	+Kip 37.5
M	5/24/07	0.2	Eto	100	Phen 12.5	100	494.3	8	.88	70	.5	310	B	37	48	IV	0	+Kip 37.5
M	6/28/07	0.2	Eto	100	Phen 12.5	100	486.1	8	0.87	70	0.5	330	T3	40	46	IV	0	+Kip 37.5
M	7/19/07	0.2	Eto	100	Phen 12.5	100	487.1	8	0.87	70	0.5	1280	T3	44	54	IV	0	+Kip 37.5
M	8/30/07	0.2	Eto	100	Phen 12.5	100	488.5	8	0.87	70	0.5	1590	B	36	49	IV	0	+Kip 37.5
M	10/10/07	0.2	Eto	100	Phen 12.5	100	498.7	8	0.87	70	0.5	1420	T3	35	57	IV	0	
M	11/21/07	0.2	Eto	100	Zofen	100	498.3	8	0.87	70	0.5	1670	T3	NA	39	IV	0	20gram 4
M	1/17/08	0.2	Eto	100	Zofen	100	498.7	8	0.87	70	0.5	1950	T3	33	51	IV	0	
M	3/26/08	0.2	Eto	100	Zofen	100	498.7	8	0.87	70	0.5	1790	T3	44	54	IV	0	
M	6/26/08	0.2	Eto	100	Zofen	100	498.7	8	0.87	70	0.5	1630	T3	36	47	IV	0	

v.

MEDICAL UNIVERSITY OF SOUTH
CAROLINA

Defendants.

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT
CASE NO. 2011-CP-10-8318

ANSWER TO COMPLAINT

FILED
2011 DEC 14 AM 9:40
JULIE J. ARMSTRONG
CLERK OF COURT
BY
COMPLAINT

Defendant The Medical University of South Carolina (hereinafter "MUSC") answers the Complaint of the Plaintiff as follows:

FOR A FIRST DEFENSE

1. Defendant denies each and every allegation contained in the Complaint except those which are hereinafter admitted, qualified, or explained.
2. Paragraph 1 is admitted upon information and belief.
3. With regards to Paragraph 2, MUSC admits that it is and was a governmental entity entitled to all protections afforded by the South Carolina Tort Claims Act. The remaining allegations contained in Paragraph 3 state legal conclusions to which no response is required.
4. MUSC is without sufficient knowledge at this time to admit or deny the allegations contained in Paragraph 3 and 4 and deny same. Furthermore, MUSC craves reference to the medical records and denies anything inconsistent therewith.
5. Paragraph 5 is denied.
6. With regards to the allegations contained in Paragraph 6, MUSC craves reference to the medical records and denies anything inconsistent therewith.
7. Paragraph 7 is denied

8. With regards to the allegations contained in Paragraph 8, MUSC asserts that Dr. Burstzajn's affidavit speaks for itself and denies the contents thereof at this time.

9. Paragraph 9 is denied.

10. Paragraphs 10, 11, and 12, including all sub-parts, are denied.

FOR A SECOND DEFENSE

~~11. MUSC reiterates and realleges the allegations contained in Paragraphs 1 through~~
10 of this Answer as if realleged herein verbatim.

12. MUSC would show that any damages or injuries alleged in the Complaint, without admitting the same to be true, were due to and proximately caused by the sole negligence, recklessness, and willfulness of a third party over which MUSC had no control and MUSC is, therefore, not liable to the Plaintiffs for such actions in any way.

FOR A THIRD DEFENSE

13. MUSC reiterates and realleges the allegations contained in Paragraphs 1 through 12 of this Answer as if realleged herein verbatim.

14. MUSC would show that it is immune from suit pursuant to the South Carolina Tort Claims Act, S.C. Code Ann. §15-78-10 et seq., including but not limited to S.C. Code Ann. §15-78-60 (5), (20), and (25).

FOR A FOURTH DEFENSE

15. MUSC reiterates and realleges the allegations contained in Paragraphs 1 through 14 of this Answer as if realleged herein verbatim.

16. MUSC, as a governmental entity of the State of South Carolina, asserts the defense of sovereign immunity, pursuant to the terms of the South Carolina Tort Claims Act, S.C. Code Ann. §15-78-10 et seq., including but not limited to the damages caps set forth in S.C. Code Ann. §15-78-120.

FOR A FIFTH DEFENSE

17. MUSC reiterates and realleges the allegations contained in Paragraphs 1 through 16 of this Answer as if realleged herein verbatim.

18. MUSC asserts that they are entitled to an Order striking or reforming any paragraph or prayer in the Complaint, and all other portions of the Complaint which purport to ~~allege an entitlement to punitive damages, attorneys fees, or actual damages exceeding those~~ amounts set forth in S.C. Code Ann. §15-78-120.

FOR A SIXTH DEFENSE

19. MUSC reiterates and realleges the allegations contained in Paragraphs 1 through 18 of this Answer as if realleged herein verbatim.

20. MUSC asserts that their care and treatment of the Plaintiff was proper and within the applicable standard of care. MUSC asserts that it breached no duty to their patient.

FOR A SEVENTH DEFENSE

21. MUSC reiterates and realleges the allegations contained in Paragraphs 1 through 20 of this Answer as if realleged herein verbatim.

22. The state of the medical and scientific knowledge, art and practice was at all material times such that MUSC did not breach any alleged duty owed to Plaintiffs.

FOR AN EIGHTH DEFENSE

23. MUSC reiterates and realleges the allegations contained in Paragraphs 1 through 19 of this Answer as if realleged herein verbatim.

24. MUSC asserts that this matter is barred by the applicable statute of limitations as set forth in the South Carolina Tort Claims Act.

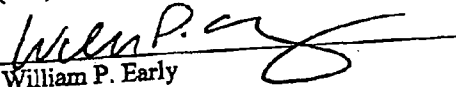
FOR A NINTH DEFENSE

25. MUSC reiterates and realleges the allegations contained in Paragraphs 1 through 19 of this Answer as if realleged herein verbatim.

26. MUSC reserves the right to add additional defenses and additional facts and circumstances in support of its defenses as the facts become available.

RESPECTFULLY SUBMITTED,

Pierce, Hems, Sloan & McLeod, LLC
321 East Bay Street
P.O. Box 22437
Charleston, SC 29413
(843) 722-7733

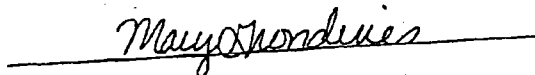

William P. Early
willearly@phsm.net
Attorney for Defendant MUSC

December 14, 2011
Charleston, South Carolina

CERTIFICATE OF SERVICE

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

This 14th day of December, 2011



STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON
CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

JOHN ROBERTS, M.D.,

DEFENDANT.

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON
CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

MEDICAL UNIVERSITY OF SOUTH
CAROLINA

DEFENDANT.

IN THE COURT OF COMMON PLEAS

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

CONSENT ORDER TO CONSOLIDATE

IN THE COURT OF COMMON PLEAS

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

FILED
2012 OCT -8 AM 9:37
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

This matter comes before the Court pursuant to the parties' request to consolidate these actions for purpose of discovery pursuant to South Carolina Rules of Civil Procedure, Rule 42(a) in an effort to avoid unnecessary costs and delay and in the interest of judicial economy.

With consent of all counsel of records, and for good cause shown,

IT IS HEREBY ORDERED that these cases are hereby consolidated for discovery purposes.


The Honorable Diedra Jefferson

Charleston, South Carolina

Dated: 10/3/12

1-2-3
279

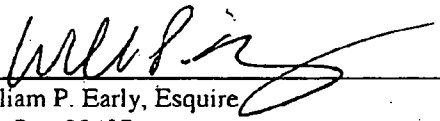
WE CONSENT:

YOUNG CLEMENT RIVERS, LLP

By: _____
James E. Scott, IV
P.O. Box 993, Charleston, SC 29402
(843) 720-5402; jscott@ycrlaw.com
Attorneys for the Defendant John Roberts, MD

WE CONSENT:

PIERCE, HERNS, SLOAN & MCLEOD, LLC

By: 
William P. Early, Esquire
P.O. Box 22437
Charleston, SC 29401
(843) 722-7733; e-mail: willearly@phsm.net
Attorneys for the Defendant Medical University of
South Carolina (MUSC)

WE CONSENT:

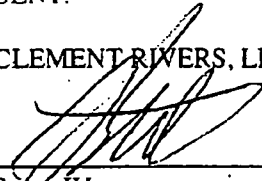
BAKER, RAVENEL & BENDER, L.L.P.

By: _____
D. Cravens Ravenel, Esquire
P.O. Box 8057
Columbia, SC 29202
(803) 799-9091; e-mail: cravenel@brblegal.com
Attorneys for Plaintiff

2013
2/19
2

WE CONSENT:

YOUNG CLEMENT RIVERS, LLP

By: 

James E. Scott, IV
P.O. Box 993, Charleston, SC 29402
(843) 720-5402; jscott@yclaw.com
Attorneys for the Defendant John Roberts, MD

WE CONSENT:

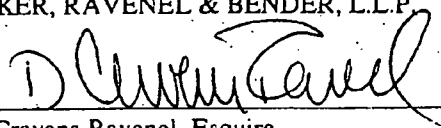
PIERCE, HERNS, SLOAN & MCLEOD, LLC

By: _____

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Charleston, SC 29401
(843) 722-7733; e-mail: willearly@phsm.net
Attorneys for the Defendant Medical University of
South Carolina (MUSC)

WE CONSENT:

BAKER, RAVENEL & BENDER, L.L.P.

By: 

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Columbia, SC 29202
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Attorneys for Plaintiff

3843
2/19

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

JOHN ROBERTS, M.D.,

DEFENDANT.

) IN THE COURT OF COMMON PLEAS

) NINTH JUDICIAL CIRCUIT

) CASE NO. 2012-CP-10-2867⁸²

DEFENDANT'S MOTION FOR
SUMMARY JUDGMENT

FILED
2013 OCT 31 PM 3:55
JULIE ARMSTRONG
CLERK OF COURT

TO: D. CRAVENS RAVENEL, ATTORNEY FOR THE PLAINTIFF:

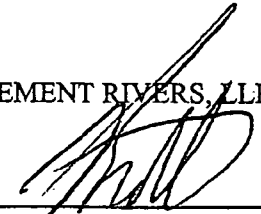
YOU WILL PLEASE TAKE NOTICE that the Defendant John Roberts, M.D. will move before the Presiding Judge in his chambers at the Charleston County Courthouse, Charleston South Carolina, South Carolina, within ten (10) days of service of this notice, or as soon thereafter as counsel may be heard, for an Order entering summary judgment in favor of the Defendant and dismissing the Plaintiff's Complaint pursuant to Rule 56 of the South Carolina Rules of Civil Procedure on the grounds that there is no genuine issue of material fact and that the Defendants are entitled to judgment as a matter of law.

More specifically, the grounds for summary judgment are as follows:

Plaintiff's claims are time-barred by the three-year statute of limitations and/or statute of repose for medical malpractice actions set forth in S.C. Code Ann. § 15-3-545(A).

This Motion is also based on the applicable rules and case law as well as the memorandum to be filed in this matter.

YOUNG CLEMENT RIVERS, LLP

By: 

D. Jay Davis, Jr.

James E. Scott, IV

Perry M. Buckner, IV

P.O. Box 993, Charleston, SC 29402

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Attorneys for the Defendant John Roberts

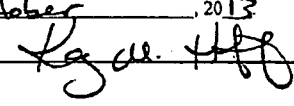
Charleston, South Carolina

Dated: 10/30/13

CERTIFICATE OF MAILING

I hereby certify that a copy of the foregoing pleading was mailed to all counsel of record in this proceeding this 21st day of

October, 2013



STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

MEDICAL UNIVERSITY OF SOUTH
CAROLINA,

DEFENDANT.

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

JOHN ROBERTS, M.D.,

DEFENDANT.

) IN THE COURT OF COMMON PLEAS

) NINTH JUDICIAL CIRCUIT

) CASE NO. 2011-CP-10-8318

FILED
2011 JAN -9 AM 9:15
JULIE J. ARMSTRONG
CLERK OF COURT

) IN THE COURT OF COMMON PLEAS

) NINTH JUDICIAL CIRCUIT

) CASE NO. 2012-CP-10-2867

) MEMORANDUM IN SUPPORT OF
) MOTION FOR SUMMARY JUDGMENT
) BY DEFENDANT JOHN ROBERTS, M.D.

TO: D. CRAVENS RAVENEL, ATTORNEY FOR THE PLAINTIFF:

The Defendant, John Roberts, M.D. (hereinafter "this Defendant" or "Dr. Roberts), by and through his undersigned counsel, hereby moves pursuant to Rule 56 of the South Carolina Rules of Civil Procedure for an Order granting summary judgment as to this Defendant in the above-captioned matter. The grounds for this motion are that the Plaintiff's claims are 1) time-barred by the statute of repose set forth in S.C. Code Ann. § 15-3-545 (A) and 2) otherwise untimely pursuant to the statute of limitations set forth in S.C. Code Ann. § 15-3-545 (A).

BRIEF STATEMENT OF THE FACTS

Dr. Roberts is a licensed psychiatrist in private practice who began sporadic treatment of the Plaintiff as early as 1997. In this matter, Plaintiff alleges that Dr. Roberts' negligent acts and omissions have caused her to suffer cognitive impairment and memory loss, primarily as a result of electroconvulsive therapy ("ECT") treatment administered at the Medical University of South Carolina ("MUSC"). Plaintiff's Complaint explicitly alleges that Dr. Roberts' treatment of the Plaintiff in 2003 was negligent because, while Plaintiff was under his care, ECT was improperly administered at MUSC, a treatment that continued sporadically until 2008. (See Plt's Complaint at ¶s 2 & 7.) Plaintiff contends that Dr. Roberts, as her primary psychiatrist, had a duty to prevent such treatment and intervene on her behalf. However, based the deposition testimony and discovery conducted in this matter, the 2003 allegations are not the Plaintiff's first contention of wrongdoing against Dr. Roberts.

Indeed, Plaintiff has also alleged negligence as to this Defendant beginning in February of 2002 for his prescribing of Wellbutrin and Concerta which, in his opinion, accelerated her manic episodes, cognitive impairment, and ultimately brought about symptoms which led to the ECT treatment. Plaintiff's expert, Dr. Peter Breggin, offered the following in depicting Plaintiff's acts of negligence:

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

A: 2/13/02 is a start.

(See Deposition of Dr. Peter Breggin, Page 101, Line 24-Page 102, Line 6 attached hereto as Exhibit A)

Although the ECT treatment ended in June of 2008, Plaintiff maintains that she suffered cognitive impairment which prevented her from recognizing her resulting condition until June of 2010. (See Expert Affidavit of Harold Bursztajn, attached hereto as Exhibit B.) On November 4, 2011, well over nine years after Dr. Robert's first alleged negligent act, Plaintiff commenced the instant lawsuit by filing a "Notice of Intent to File Suit."

STANDARD OF REVIEW

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

ARGUMENT AND CITATION OF AUTHORITY

I. PLAINTIFF'S COMPLAINT IS UNTIMELY AS A MATTER OF LAW PURSUANT TO THE APPLICABLE STATUTE OF REPOSE

South Carolina law provides for both a three year statute of limitations for medical malpractice claims and a six year statute of repose. S.C. Code Ann. § 15-3-545 (A) mandates that:

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

A statute of limitations is a "procedural device that operates as a defense to limit the remedy from an existing cause of action" while the statute of repose actually "creates a substantive right in those protected to be free from liability after a legislatively determined period of time." *Langley v. Pierce*, 313 S.C. 401, 438 S.E.2d 242 (1993)(citing *Goad v. Celotex*, 831 F.3d 508 (4th Cir. 1987)). Notwithstanding the date of discovery of any claim, the six year

statute of repose begins to run upon an "occurrence" of medical negligence. See *O'Tuel v. Villani*, 318 S.C. 24, 455 S.E.2d 698 (Ct. App. 1995) *overruled on other grounds by I'On, LLC v. Town of Mount Pleasant*, 338 S.C. 406, 526 S.E.2d 716 (2000).

To be sure, the statute of repose ignores the discovery, knowledge and even the existence of any injury altogether in barring claims as the focus of the statute of repose centers squarely on the act of negligence underlying any claim. *Hoffman v. Powell*, 298 S.C. 338, 380 S.E.2d 821 (1989). Furthermore, the expiration of a statute of repose extinguishes all causes of action, including those that may later accrue and those that have already accrued. *Columbia/CSA-HS Greater Columbia Healthcare System v. South Carolina Medical Malpractice Liability Joint Underwriting Ass'n*, 394 S.C. 68, 713 S.E.2d 639 (Ct. App. 2011)

In the instant matter, Plaintiff's own pleadings allege an act of negligence by Dr. Roberts as early as 2003. (See Plt's Complaint at ¶s 2 & 7.) Undoubtedly, this constitutes an occurrence for purposes of ascertaining when the statute of repose first began to run. Further, Plaintiff's own expert, Dr. Breggin, assigns fault as to Dr. Roberts beginning in February of 2002 in prescribing medication which supposedly brought about symptoms necessitating ECT. (See Deposition of Dr. Peter Breggin, Page 101, Line 24-Page 102, Line 6 attached hereto as Exhibit A) In either scenario, Plaintiff's commencement of this action was untimely, as a matter of law, by at least two years under the six statute of repose set forth in S.C. Code Ann. § 15-3-545(A),

which began to run in either February of 2002 or December of 2003 and exhausted in either February of 2008 or December of 2009 respectively.

A. South Carolina Has Rejected Both The Continuous Treatment And The Continuous Tort Rule

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

B. The Disability Tolling Statute Does Not Apply To Six Year Statute of Repose

Similarly, Plaintiff's alleged disability does not toll the running of the statute of repose. Plaintiff alleges that her cognitive impairment prevented her from realizing her claims until June of 2010 at which time she "regain[ed] the mental capacity to understand and appreciate the harm." ((See Expert Affidavit of Harold Bursztajn, attached hereto as Exhibit B.) Even presuming that the Plaintiff qualifies, the disability tolling statute set forth in S.C. Code Ann. § 15-3-40 does not apply to the six year statute of repose set forth in S.C. Code Ann. § 15-3-545.

In rejecting the application of the "moving" non-resident defendant tolling statute to the medical malpractice statute of repose in *Langley v. Pierce*, 313 S.C. 401, 438 S.E.2d 242 (1993), the Supreme Court noted the following:

"§15-3-545 specifically provides that an action for medical malpractice must be commenced within 'six years from date of occurrence, or as tolled by this section.' Subsection (D) of 15-3-545 provides a limited tolling provision, applicable only to minors. Inclusion of the phrase 'or as tolled by this section' in subsection (A) clearly indicates that the *only* tolling of § 15-3-545(A) intended by the legislature is that contained in subsection (D)."

This rationale is of equal application to the disability tolling provisions, which like the "moving" non-resident tolling provisions, are not found within the statutory language of § 15-3-545. Furthermore, the *Langley* Court reiterated that the statute of repose is designed to set forth a "an absolute time limit beyond which liability no longer exists and is not tolled for any reason because to do so would upset the economic balance struck by the legislative body." *Id.* (quoting *First United Methodist Church v. U.S. Gypsum Co.*, 882 F.2d 862, 865-866 (4th Cir 1989)(emphasis added). Quite clearly, the legislative intent was to limit tolling of the statute of repose strictly to minors and explicitly reject any other potential for tolling. As a result, Plaintiff's Complaint is nonetheless untimely as a matter of law.

II. PLAINTIFF'S COMPLAINT IS UNTIMELY AS A MATTER OF LAW PURSUANT TO THE APPLICABLE STATUTE OF LIMITATIONS

Plaintiff's Complaint is otherwise time-barred by the three year statute of limitations set forth in S.C. Code Ann. § 15-3-545 (A). Unlike the statute of repose, the statute of limitations accrues pursuant to the legislatively enacted discovery rule which requires Plaintiff to commence her action within three years of either the date of discovery or when the date by which it reasonably ought to have been discovered. S.C. Code Ann. § 15-3-545(A).

Notice of a potential claim is imputed when a person, through the exercise of reasonable diligence, should have known of the existence of a wrongful act. In *Dean v. Ruscon Corp.*, 321 S.C. 360, 468 S.E.2d 645 (1996), the exercise of reasonable diligence was defined to mean:

"that the injured party must act with some promptness where the facts and circumstances of an injury place a reasonable person of common knowledge and experience on notice that a claim against another party might exist. Moreover, the fact that the injured party may not comprehend the full extent of the damage is immaterial."

In this case, notice need not be imputed as Plaintiff, in her own words, readily concedes she was aware of her memory and cognitive issues between 2006 and 2008 arising from the ECT. (See Deposition of Plaintiff, Page 68-69, attached hereto as Exhibit C); (See Deposition of Plaintiff, Pages 81-82, attached hereto as Exhibit D). While Plaintiff does not assign a specific date, Plaintiff clarified that prior to her last ECT treatment in June of 2008, she was able to attribute her memory loss to the ECT. *Id.* As a result, the applicable statute of limitations began to run, at the latest, at that time and was exhausted in June of 2011, nearly five months prior to the commencement of this action thus rendering Plaintiff's Complaint untimely as a matter of law.

A. The Disability Tolling Statute Only Extends The Applicable Limitations Period To One Year After The Disability Ends And Thus Does Not Revive Plaintiff's Complaint.

Plaintiff argues that the disability tolling statute should be interpreted so as to extend the applicable limitations period by an additional five years thus giving the Plaintiff eight years from the date of accrual to bring this action against Dr. Roberts. Such an interpretation fails to consider the full scope of the statutory language. § 15-3-40 provides the following:

"If a person entitled to bring an action mentioned in Article 5 of this chapter or an action under Chapter 78 of this title.....is at the time the cause of action accrued either:

- (1) Within the age of eighteen years; or
- (2) Insane;

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

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

(emphasis added). Because Plaintiff failed to commence the instant action within one year of the cessation of her disability, the five year provision is of no avail to Plaintiff's argument and provides no support for Plaintiff's otherwise untimely action.

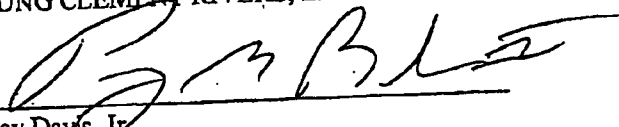
Further, it should be noted that the express language of the statute acknowledges that disability does not affect the date of accrual. By allowing individuals who are disabled "at the time the cause of action accrued" to have the statute of limitations extended, the language specifically implies that accrual may take place while that person is in fact under a disability. Indeed, the South Carolina Supreme Court has rejected contrary interpretations on multiple occasions. See *Miller v. Dickert*, 259 S.C. 1, 190 S.E.2d 459 (1972); *Fricks v. Lewis*, 26 S.C. 237, 1 S.E.2d 884 (1887). Therefore, it remains clear that her recognition of her claim prior to the end of her ECT treatment is the date by which this action accrued. Because Plaintiff failed to file the action by June of 2011, one year after her disability ceased, the action is untimely as a matter of law.

CONCLUSION

Based on the foregoing, this Defendant respectfully requests that this Court grant their Motion for Summary Judgment.

[SIGNATURE BLOCK ON FOLLOWING PAGE]

YOUNG CLEMENT RIVERS, LLP

By: 

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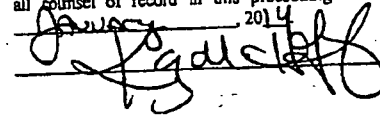
Attorneys for the Defendant John Roberts, M.D.

Charleston, South Carolina

Dated: 1/8/14

CERTIFICATE OF MAILING

I hereby certify that a copy of the foregoing pleading was mailed to
all counsel of record in this proceeding this 9th day of
January, 2014



⁹
P105

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1 Q Doctor, I don't want to stop you from
2 offering any opinion --

3 A Well, I want you to help me find -- you
4 asked me to go into the records and I want to try
5 to find that, where it starts to get those, and
6 I'm having trouble locating anything -- wait a
7 minute.

8 WITNESS: Can you help me with this?

9 MR. RAVENEL: If they let me. Is it
10 okay if I help him look for the records?

11 MR. SCOTT: That's fine.

12 WITNESS: These records are out of
13 order, the way they were sent to me.

14 MR. RAVENEL: They were provided to
15 us by Dr. Roberts' office, I think, in this
16 form.

17 A The records are in disarray. We can work
18 on the chronology, I have the computerized
19 version of these records, I can go into them.

20 Q Let me see if I can.

21 A If you can help me locate Dr. Roberts'
22 reports where they start. I'm not seeing the
23 start. I went through it digitally.

24 Q Here's my concern, you have said

MAGNA
P106 LEGAL SERVICES



1 repeatedly in this deposition, not only was there
2 negligence, there was gross negligence in the
3 fact he was prescribing Wellbutrin while she was
4 in a manic phase. I just wanted you to get
5 specific and point it out to me in the medical
6 records.

7 A 2/13/02 is a start. I'll do the best I
8 can from the chronology and then if you want to
9 take a break, I'll set up my computer and then I
10 can go into the computerized records, which I was
11 hoping I could just print out these 500 pages and
12 work with them, but it's not working very well.

13 So, we have got the 2/13/02 visit and
14 she's got mood instability, history of mood
15 disorder, he nonetheless puts her on Wellbutrin,
16 BID, for the first week, Concerta, 18 milligrams.

17 Q From your chronology, did this result in
18 her going into a manic phase and hospitalization?

19 A No. I can't tell from this chronology,
20 other than toward the end of year she is
21 delusional and psychotic and admitted to the
22 hospital, it's 10 months later. I'd have to fill
23 that in some more.

24 Q Okay.

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LEGAL SERVICES
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STATE OF MASSACHUSETTS
COUNTY OF MIDDLESEX

AFFIDAVIT

1. I, Harold J. Burstzajn, M.D., am a physician currently licensed by the states of Massachusetts and New Hampshire. I am board-certified in psychiatry by the American Board of Psychiatry and Neurology. I serve as an Associate Clinical Professor of Psychiatry, Co-Founder of the Program in Psychiatry and the Law, and Principal Mentor for students at Harvard Medical School. A copy of my current curriculum-vitae is attached hereto as Exhibit A.

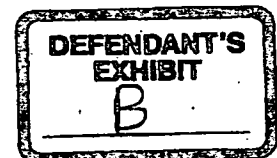
2. This affidavit is provided pursuant to S. G. Code Ann. §§15-36-100 and 15-79-125.

3. Based upon my medical education, knowledge, training and experience, I am familiar with the generally accepted principles and standards of care in the diagnosis and treatment of Bipolar Disorder with psychotic features and a history of head trauma, for which Clair Craver Johnson was being treated.

4. I have, for date, reviewed records of Clair Craver Johnson's education, certain observations by the parents of Clair Craver Johnson over a significant period of time, court records, hospital and physicians' and psychologists' records, all documenting Clair Craver Johnson's emotional condition and the treatment of Clair Craver Johnson by the Medical University of South Carolina hospital and by John Roberts, M.D. and Milton Faust, M.D.

5. I interviewed Clair Craver Johnson in my office for 4 1/2 hours after reviewing the referenced materials.

6. After reviewing the described records and meeting with Clair Craver Johnson, and relying upon my education, knowledge, training and experience, I am of the opinion that based upon a reasonable degree of medical certainty, more likely than not, the treatment provided by



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[REDACTED]

the Medical College of South Carolina hospital, John Roberts, M.D., and Milton Faust, M.D., did not meet the standard of care imposed upon hospitals and physicians under like circumstances. I am of the opinion that the Medical University of South Carolina failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with electroconvulsive therapy (ECT), (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; that Dr. Roberts failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT, (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, by failing to conduct an adequate psychopharmacological assessment of alternate medication choices, by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; and that Dr. Faust failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, and by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence.

[REDACTED]

7. I am likewise of the opinion that based upon a reasonable degree of medical certainty, more likely than not, as a direct and proximate result of the negligent acts or omissions on the part of the Medical University of South Carolina, John Roberts, M.D., and Milton Faust, M.D., Clair Craver Johnson sustained the following injuries: prolonged and, to a degree, permanent exacerbation of cognitive impairments, including memory loss; impaired capacity to participate in her divorce proceedings; impairments in the post-traumatic spectrum resulting from the physically and emotionally traumatic experience of extended involuntary treatment with ECT, which produced feelings of helplessness, terror, and personal violation; a prolonged period of confusion and demoralization, resulting in a loss of access to a significant segment of her life experience and a loss of continuity of autobiographical memory; diminished trust in mental health care providers; diminished hope for the future; and loss of the potential benefits of appropriate treatment with psychotherapy, medications, and a meaningful informed consent process. Had Clair Craver Johnson been properly diagnosed and treated, I am of the opinion that to a reasonable degree of medical certainty, Ms. Johnson more likely than not would not have sustained the injuries described above and her emotional issues would have been managed so as to allow her to function as a productive individual.

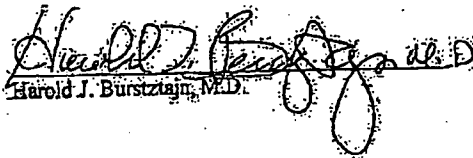
8. Further, I am of the opinion that to a reasonable degree of medical certainty, more likely than not, Clair Craver Johnson did not regain the mental capacity to understand and appreciate the harm she suffered as a consequence of the negligent acts or omissions specified above, particularly the extended involuntary treatment with ECT, until she sought help in reviewing her medical records in June 2010, two years after ECT was concluded. Her capacity to comprehend what was going on in her life, already diminished by mental illness, was further diminished by the physical and emotional trauma and cognitive impairments associated with an

[REDACTED]

extended period of ECT, which foreseeably resulted in prolonged confusion and demoralization. She recovered the ability to process her experiences during those years only by reestablishing ties with a supportive community that helped her recreate her autobiographical memory.

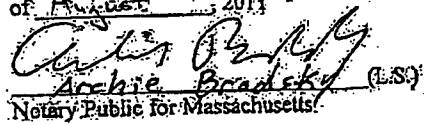
9. This affidavit does not include all of my opinions and I reserve the right to modify and/or formulate additional new opinions should additional, pertinent records be submitted for my review.

Further affiant saith not.


Harold J. Burstzajn, M.D.

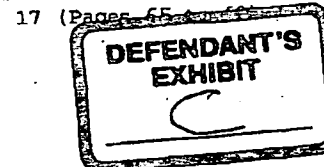
Sworn to before me this 10th day

of August, 2011


Archie Bradsky (L.S.)
Notary Public for Massachusetts

My Commission expires: June 22, 2012

Page 65	Page 67
1 were divorced. 2 Q: Do you remember any of your ECT treatments? 3 A: I remember a couple of them. For like one, you 4 know, that instance when I refused to sign the 5 - papers that they have you sign before every 6 time you go. 7 Q: And you did sign those, correct? 8 A: Well, I always did up until when I actually 9 read what I was signing and then I refused to 10 sign it and they did it anyway. 11 Q: So up until then you had never read it, you 12 just signed it? 13 A: Pretty much. 14 Q: Why would you do that? 15 A: I guess because it had been made clear to me if 16 I didn't do it, I'd either wind up in the 17 hospital or if I was in the hospital, if I did 18 it, then they'd let me out. 19 Q: Who told you that? Who made that clear to you 20 as you put it? 21 A: Well, I'm not sure how. See, I don't remember 22 being a patient, but I know that there were a 23 lot of different physicians that treated me, so 24 I'm not - it's not clear to me who was 25 involved in what. I just assumed Foust is the	1 A: Yes. 2 Q: You know, I've only got just a little bit, not 3 too much longer, but I do want to look at a 4 couple things and my bladder is a little small 5 today so let's take another small break. 6 MR. RAVENEL: Sure. 7 Q: And then I don't think I'm going to have too 8 much further, Ms. Johnson. 9 VIDEOGRAPHER: Off the record at 11:40. 10 (Off the Record) 11 VIDEOGRAPHER: Back on the record at 11:51 a.m. 12 Q: All right. Ms. Johnson, we took another little 13 break. And you know, prior to today I had 14 intended to go by all your admissions to MUSC. 15 I've got seven different inpatient admissions 16 where you were admitted as an inpatient, spent 17 the night in the hospital, just not maintenance 18 ECT, but based on some of your responses, I may 19 be able to short circuit some of that. 20 A: Okay. 21 Q: Today is my only day to ask you questions to 22 find out what you would say in front of a jury. 23 And I need to know what, if anything other than 24 what you've already told me, you've already 25 told me about one specific instance with Dr.
Page 66	Page 68
1 one, that he's in charge of the whole program. 2 Q: All right. Just let me ask, because you just 3 said something that I need to find out. Do you 4 have a memory, as we sit here today, of 5 somebody telling you that if you don't do ECT 6 we're going to put you back in the hospital as 7 inpatient? 8 A: I do. 9 Q: And who told you that? 10 A: Dr. Foust. 11 Q: Do you know when that was, when he said that? 12 A: It was when I pointed out to you earlier that 13 I read the form. It was during '06 to '08. 14 Q: It was during the maintenance ECT, if you will? 15 A: Correct. 16 Q: And he said to you that notwithstanding you 17 having any manic episode or bipolar episode 18 that he was going to put you in the hospital 19 anyway, is that what you're saying? 20 A: Correct. And I even told Dr. Roberts about it 21 and he made a comment that that is considered 22 an assault and coercion. 23 Q: Dr. Roberts said that to you? 24 A: (Nods head affirmatively.) 25 Q: Is that a yes? You shook your head.	1 Foust, other than that, what memory or memories 2 do you have regarding any of your ECT 3 treatments at MUSC, whether they're inpatient 4 or outpatient? 5 A: The only memories I have is when it was 6 outpatient and I have one other memory, like 7 when you go, I can't remember if you have to 8 change or not. 9 Q: Well, before, can you tell me what date that 10 was or what time? 11 A: No. 12 Q: '06 to '08? 13 A: '06 to '08. 14 Q: And is it just one time you remember or more 15 than one time? 16 A: Well, I remember these, the one instance that 17 I refused to sign and then I remember another 18 instance, well, I guess I have three memories. 19 Q: Well, we've already talked about the one you 20 refused to sign. 21 A: Right. One time the anaesthesiologist had to 22 stick me like ten times. And Dr. Foust had to 23 let me go. I remember that. And then one time 24 I remember, prior to going in, he had two 25 nurses and I was upset, in tears, crying that.



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1 that I -- something I just remember telling 2 them that I had no way to support myself and 3 that it was since the ECT had started, I was, 4 you know, I was aware that, what was happening 5 and described it to them and I just remember 6 one of the nurses saying yes you can or 7 something like that. 8 Q: What do you mean by that? You were aware of 9 what was happening. Are you talking about	1 Q: Okay. And you understand this is my only time 2 to get to ask you today? 3 A: Right. 4 Q: We're not going to come back here to Mr. 5 Ravenel's office two weeks from now and say you 6 remember something else. So this is my only 7 time. 8 A: Okay. 9 Q: You understand that?
10 memory loss? 11 A: I guess so. I mean, I just remember being 12 upset and talking about the fact that I was no 13 longer capable of supporting myself in any way. 14 Q: Well, did you attribute that to the ECT or to 15 other things? 16 A: To the ECT. 17 Q: So, just so I understand, you told a nurse 18 during one of your ECT treatments that you were 19 upset with the ECT because it was causing you 20 to not be able to support yourself, is that 21 right? 22 A: Well, I don't remember verbatim exactly. I 23 just, you know, remember that I was crying. 24 Q: And you were upset because of the ECT? 25 A: Correct.	10 A: Yes. 11 Q: Okay. And I'm not trying to limit you, I'm 12 just trying to figure out everything you 13 remember right now and you're telling me that's 14 all you remember, correct? 15 A: Those three instances are -- that's all I 16 recall. 17 Q: All right. Did you also, did you tell Dr. 18 Roberts any issues you were having with your 19 ECT treatments? 20 A: I don't remember what I might have told him. 21 You know, it's been several years since I was 22 his patient. 23 Q: I understand. You don't have any recollection 24 of telling Dr. Roberts that you had issues with 25 the ECT treatment one way or another?
Page 70	Page 72
1 Q: And what effect did the ECT have on you that 2 was causing you -- to make you cry? 3 A: Well, it was right before I had to go have a 4 treatment and I was just talking to them about 5 -- I don't know. I mean you'll have to ask the 6 nurses that. 7 Q: All right. Do you remember anything about the 8 procedures themselves? 9 A: I mean, I remember, no. I mean, you just go in 10 there and lay down and they put you to sleep. 11 Q: So you're asleep when the procedure happens, 12 correct? 13 A: Correct. 14 Q: And you don't remember, you don't have any 15 recollection as we sit here today about 16 anything happening during these procedures, it 17 that fair? 18 A: No. 19 Q: Is that right? 20 A: Correct. 21 Q: And we've talked about three things that you do 22 remember surrounding your time in having these 23 ECT treatments. Do you remember anything other 24 than what we just talked about? 25 A: No.	1 A: I don't remember. I barely remember ever 2 working with him. 3 Q: With who? 4 A: Dr. Roberts. 5 Q: As we sit here today, are you claiming that the 6 ECT you had at MUSC has caused you anything 7 other than memory loss? 8 A: Well, it's affected everything. I mean it's 9 devastated my life. 10 Q: Because of the memory loss or other things? 11 A: Well, that as well as other things. 12 Q: Tell me about the other things. That's what 13 I'm getting at. 14 A: Well, it basically left me in a -- I mean it 15 was so severe, I mean it's been five years now. 16 You know, the first few years, I was basically 17 in a coma-type state. And I didn't talk to 18 anyone, no one saw me. I had to relearn 19 everything, even, you know, just daily 20 activities. And things like putting on makeup 21 and things that everybody takes for granted and 22 I still, you know, don't have the confidence to 23 travel by myself, you know, when I sold 24 pharmaceuticals I know enough, you know, 25 Georgia and North Carolina, you know,

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1 stuff like that. 2 Q: Did you ever tell any of your physicians 3 whether it be Dr. Roberts, private physician, 4 somebody at MUSC, that you had forgotten how to 5 take care of your activities of daily living? 6 Did you ever tell anybody that? 7 A: Well, I don't recall. I didn't see anyone for 8 quite a while after I stopped talking to Dr. 9 Roberts and even then, see I don't, we just 10 talked on the phone. I never even saw him. So, 11 Q: Let me ask it this way. It's my understanding 12 from reading your records and I can show you 13 the log book again that your last ECT treatment 14 at MUSC would have been in June of 2008. 15 A: Okay. 16 Q: Do you agree with that? Want me to show you? 17 A: I know it was '08. 18 Q: Okay. 19 A: But I didn't realize it was June. 20 Q: At what point did you lose the ability to stop 21 taking care of the activities of daily living 22 on your own and have to seek other people to 23 help you do that? When was it after June of 24 2008? 25 A: It was probably that --	1 couldn't participate in my divorce proceeding. 2 I totally dropped out of sight. Stayed in bed 3 all the time. You know, quit having any kind 4 of a social life and well, when I say physical, 5 I mean it was as if I was almost in a comatose 6 type state. I mean I could barely speak and 7 you know -- 8 Q: How long did that last after your last ECT? 9 A: Several years. See, but I don't remember when, 10 I just have seen, well obviously it was during 11 my divorce proceedings because I never, never 12 was able to -- I know I didn't meet Lon Shull, 13 but I don't remember anything about that or 14 when it got to the point where I couldn't 15 participate, so I don't remember. 16 Q: All right. Let me switch gears one more time. 17 Without asking anything, I don't want to know 18 anything you talked to Mr. Ravenel about or any 19 other lawyers about with regards to ECT or do 20 you remember the first lawyer you sought out, 21 the first lawyer you contacted for about what 22 we're here about today? 23 A: I have no idea. 24 Q: Do you remember meeting with Mark Hardee here 25 in Columbia?
Page 82	Page 84
1 Q: So it was during your ECT? 2 A: I mean the divorce went on for three and a half 3 years. 4 Q: I understand. But just so the record's clear, 5 you lost your ability to take care of your 6 activities of daily living prior to, before 7 your last treatment of ECT? 8 A: (Nods head affirmatively.) 9 Q: Is that a yes? 10 A: Right. 11 Q: And you attributed that to the ECT? 12 A: Oh, absolutely. I mean -- 13 Q: You did then and you do now? 14 A: (Nods head affirmatively.) 15 Q: Is that a yes? 16 A: Yes. 17 Q: And that was because of memory? You had 18 forgotten how to do those things? 19 A: It was not only memory, it was a much more of 20 a physical deterrent that I was going through. 21 I mean physically, it effected everything. 22 Q: That's the first I've heard of anything 23 physical now. Tell me what affected you 24 physically. 25 A: Well, I mean, like I mentioned, well, I	1 A: Oh, yeah. I do remember that. 2 Q: Did you meet with anybody before Mr. Hardee or 3 was that the first lawyer you met with? 4 A: Well, there was one other attorney's office, 5 but I never actually met the attorney. He had 6 a nurse in his office and I met with her a 7 couple of times, but I don't even remember who 8 it was or the firm or anything. 9 Q: Does your dad or your brother or your sister- 10 in-law or your sister or your brother-in-law 11 have to do anything for you these days or are 12 you able to do everything on your own as far as 13 activities and daily living are concerned? 14 A: Well, I don't do much. I mean -- 15 Q: Is that a no? 16 A: Daily activities, I think I've pretty much 17 mastered, you know, that. 18 Q: Is your only income your alimony from John 19 Johnson? 20 A: It is. 21 Q: Do you have any disability? 22 A: Oh, yes, I do. I forgot. 23 Q: And who pays you that and how much? Is it the 24 Social Security disability? 25 A: See, my dad handles all that.

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DEFENDANT'S
EXHIBIT

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1 Q: Do you know when that started? When you started getting Social Security disability? 2 A: Dad had it, it happened sometime during my divorce proceedings. 3 Q: All right. Do you know what the disability is or was that — 4 A: You mean the amount? 5 Q: No, ma'am. What your disabling condition or diagnosis is. Is it memory problems or is it depression, bipolar disorder?	1 Q: One year? 2 A: Beginning the last hospitalization which was January. 3 Q: So it's in effect until January of 14? 4 A: That's my — I guess it would be December. I don't know. Sometime, you know, the last hospitalization was December. It would be a year from then. 5 Q: All right. Ms. Johnson, I think I may be done. I'm going to — while Mr. Scott is asking you some questions, flip through some notes, but I think I may be done. I hope I wasn't too overbearing or too intrusive. If I did seem to be, that wasn't my intention today, okay?
6 A: It — bipolar disorder. 7 Q: All right. 8 A: See, I don't know though. Again, my dad handled all that. I have no idea. 9 Q: Have you've gotten ECT from any other hospital other than MUSC? 10 A: Not that I'm aware of. 11 Q: Who is Will Close? 12 A: He's a person that I've known for a long time. 13 Q: Is it a friend or former romantic interest or — 14 A: Well, I thought he was a friend, but apparently not. 15 Q: Who is Lester Bates? 16 A: That was someone that I was friends with.	15 A: Okay. 16 Q: Thank you. 17 MS. JOHNSON - EXAMINATION BY MR. SCOTT: 18 Q: Everybody good to go? Ms. Johnson, my name is Jim Scott. I represent Dr. John Roberts in this lawsuit. Will has done a good job of covering most of the topics, so what I'm going to do is jump around a little bit on some issues that you've already discussed to make sure I understood them and maybe ask a few follow-up questions, okay?
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1 MR. RAVENEL: He's dead. He was a lawyer. 2 A: Yeah, he's an attorney. He's dead. 3 Q: You don't have to say any more. I just saw his name somewhere. When is the last time you talked to Mr. Close? 4 A: Gosh, I can't — I don't even recall. Sometime in the last year. It wasn't a pleasant — it was kind of like the Michael issue. I was hoping to get some people that I've known for a long period of time to sit down with me and you know, fill in some blanks, but he was, he's not a very kind person. 5 Q: Did you call him? 6 A: I did. 7 Q: Where does he live? 8 A: Up in the Rock Hill area. Fort Mill. And he pretty much sees me as nothing more than a mental patient which is beyond — 9 Q: All right. We mentioned earlier, the probate court order that you're under now. Do you know when that expires? I think they last a certain amount of time. How long you're under that order? The one you're currently under? The court order? 10 A: It's for a year.	1 A: Okay. 2 Q: So it won't be quite as orderly as Will's line of question. As I understand it, although you went to Winthrop, you obtained your degree from Columbia College? 3 A: Yes. 4 Q: And do you recall the year you obtained your degree? 5 A: It was 2003. 6 Q: 2003 from Columbia College? 7 A: No, 1993. 8 Q: Okay. All right. And you lived, you said you lived in dorms at Winthrop, correct? 9 A: Correct. 10 Q: How about Columbia? Did you also live in a dormitory setting? 11 A: No, I lived with my parents. 12 Q: Okay. So you lived at home at 2 Turtle Cove? 13 A: Yes. 14 Q: And then you commuted over to Columbia College? 15 A: Yes. 16 Q: All right. And how did you get to college everyday? Were they driving you or did you drive yourself? 17 A: I had a car.

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STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

JOHN ROBERTS, M.D.,

DEFENDANT..

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON
CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

MEDICAL UNIVERSITY OF SOUTH
CAROLINA

DEFENDANT.

IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT
CASE NO. 2012-CP-10-2867

IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT
CASE NO. 2011-CP-10-8318

**NOTICE OF MOTION AND MOTION
FOR SUMMARY JUDGMENT**

2013 NOV -1 PM 2:22
JULIE J. ALBERT KONE
CLERK OF COURT
BY

TO: D. CRAVENS RAVENEL, ESQUIRE, ATTORNEY FOR PLAINTIFF:

PLEASE TAKE NOTICE that pursuant to Rule 56 of the South Carolina Rules of Civil Procedure, the Defendant Medical University of South Carolina ("MUSC"), by and through the undersigned counsel, will move before this Court for an Order granting summary judgment as to Plaintiff's complaint. The Defendant will so move ten (10) days after the date of service hereof or at such time as counsel may be heard. The grounds for this motion are that Plaintiff's claims are procedurally barred pursuant to the applicable statute of repose and the statute of limitations

provided by Title 15 of the South Carolina Code. The Plaintiffs claims against MUSC are further barred by the common law theories of intervening and superseding negligence.

This motion is based on, and may be further supplemented with, applicable pleadings, discovery, affidavits, exhibits, deposition transcripts, controlling law, supporting memorandum of law, and such other and further material as the Court may deem appropriate. The basis for this motion will be more fully set forth by supporting memorandum filed in conjunction with the hearing scheduled for this matter.

Respectfully submitted,

PIERCE, HERNS, SLOAN & WILSON, LLC
The Blake House
321 East Bay Street
Post Office Box 22437
Charleston, SC 29403

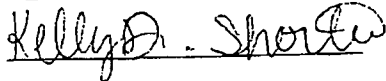

Will Early
Attorney for Defendant MUSC

Oct 31, 2013
Charleston, SC

CERTIFICATE OF SERVICE

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

This 31 day of October, 2013.


Kelly D. Shorter

IN THE COURT OF COMMON PLEAS

NINTH JUDICIAL CIRCUIT

CASE NO 2012-CP-10-2867

PLAINTIFF,

VS.

JOHN ROBERTS, M.D.,

DEFENDANT.

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

VS.

MEDICAL UNIVERSITY OF SOUTH
CAROLINA,

DEFENDANT.

**DEFENDANT MEDICAL UNIVERISTY
OF SOUTH CAROLINA'S
MEMORANDUM IN SUPPORT OF
MOTION FOR SUMMARY JUDGMENT**

This matter is before the court on the motion of Defendant Medical University of South Carolina ("MUSC") for an order granting summary judgment pursuant to Rule 56 of the South Carolina Rules of Civil Procedure as to Plaintiff's complaint. This motion is based on the grounds that Plaintiff's claims are barred pursuant to the applicable statute of repose, the statute of limitations, the pre-suit requirements of Title 15 of the South Carolina Code, and common law theories of intervening and superseding negligence. For the purposes of this motion, there are no factual disputes as to the legal and statutory limitations barring Plaintiff's claims. Therefore, the

central question before the court concerns purely legal issues, the resolution of which mandate summary judgment in favor of MUSC.

INTRODUCTION

This medical malpractice case arises out of Plaintiff's treatment for bi-polar disorder through electroconvulsive therapy ("ECT") administered at MUSC from 2003 until 2008. In South Carolina, the limitations period for claims arising out of medical malpractice is deemed to run from the date of the first treatment—in this case, 2003. Beginning from the date of occurrence, the South Carolina Legislature has established an outside limit of six years in which a medical malpractice claim can be brought. The legislature has further enacted certain pre-suit procedural requirements specific to medical malpractice actions, for which noncompliance will serve as a procedural bar. Due to the late filing of Plaintiff's complaint on November 16, 2011, this motion calls into question straightforward legal issues of statutory interpretation concerning the statute of repose, the statute of limitations and the procedural pre-requisites for filing medical malpractice actions contained in §§ 15-79-125 and 15-36-100.

Even assuming Plaintiff's claims survive the statute of repose and statute of limitations bar, Plaintiff's claims against MUSC are further barred by the intervening and superseding negligence of Defendant Dr. Roberts, whose negligence Plaintiff alleges caused the symptoms that required Plaintiff to undergo ECT. The uncontroverted facts and allegations relevant to Dr. Roberts' intervening and superseding negligence is likewise a matter of law for the court, the resolution of which bars Plaintiff's claims against MUSC.

UNDISPUTED FACTS

Plaintiff initiated this medical malpractice action against MUSC on November 16, 2011, asserting claims of cognitive impairment and memory loss as a result of ECT treatment

administered sporadically from 2003 until 2008 for the treatment of severe depression and mania. (See Complaint attached hereto as Exhibit "A"). Plaintiff filed a separate action against her private psychiatrist, Dr. John Roberts, associated with his prescription of certain medication which caused Plaintiff's need for ECT treatment, as well as the ECT treatment itself. Both cases have been consolidated. The events giving rise to this action are as follows.

Since the mid-1980s Plaintiff has been suffering from bi-polar disorder and depression. She was formally diagnosed with borderline bipolar disorder while attending Winthrop in the mid-1980s. According to Plaintiff's father, her mania peaked from 1984—1986, after which she dropped out of college and went into a deep depression. Thereafter, for a period of about six years, Plaintiff was relatively stable and led a normal life. In 1997, her mania spiked once again, requiring hospitalization. Dr. John Roberts began treating Plaintiff at this time. Over the next few years, Plaintiff required several hospitalizations in Rock Hill, Columbia and Charleston, during which she was treated with several different psychiatric medications.

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

Notwithstanding evidence to the contrary, Plaintiff's expert claims that the Plaintiff did not "regain the mental capacity to understand and appreciate the harm she suffered as a result" of

ECT until June of 2010. (See Affidavit of Harold J. Burstzajn, M.D. attached hereto as Exhibit "B").

On June 25, 2010, prior to filing the Summons and Complaint in the instant action, Plaintiff filed a Notice of Intent to File Suit, wherein she sought an extension of time to file an expert affidavit as provided by S.C. Code Ann. §§ 15-79-125 and 15-36-100. The notice stated "time constraints" prevented Plaintiff from filing an affidavit of a medical expert. While § 15-36-100 provides a period of forty-five days within which to file the expert witness affidavit, no extension was provided by the Court. By Plaintiff's own admission, as stated in the Notice of Intent to File Suit, the limitations period was believed to expire within ten days from the date of the Notice of Intent to File Suit, dated June 25, 2010. Thus, according to Plaintiff, her claims would expire on July 5, 2010.

On August 25, 2010, Plaintiff dismissed the matter without prejudice. Plaintiff eventually obtained an expert witness affidavit on August 10, 2011, and the instant Complaint was subsequently filed on November 16, 2011, nearly eight years after Plaintiff began receiving ECT treatments.

STANDARD OF REVIEW

The statute of limitations or statute of repose defense may be raised in a summary judgment motion. See McDonnell v. Consolidated School Dist. of Aiken, 315 S.C. 487, 445 S.E.2d 638 (1994). Pursuant to Rule 56 of the South Carolina Rules of Civil Procedure, summary judgment may be granted if there is no genuine issue as to any material fact and the moving party is entitled to a judgment as a matter of law. Rule 56, SCRPC. In addition, it must be shown that further inquiry into the facts is not needed to clarify the application of the law.

Charleston Lumber Co., Inc. v. Miller Hous. Corp., 318 S.C. 471, 478, 458 S.E.2d 431, 436 (Ct. App. 1995).

ARGUMENT

I. PLAINTIFF'S CLAIMS ARE BARRED BY THE APPLICABLE STATUTE OF REPOSE AND STATUTE OF LIMITATIONS.

There is no factual dispute as to Plaintiff's failure to adhere to the statute of repose, statute of limitation, and pre-suit requirements of §§ 15-79-125 and 15-36-100. The limiting effect of the referenced statutes and their application to the instant matter are, therefore, questions of statutory construction to be resolved as a matter of law by the Court. See Ross v. Waccamaw Cmty. Hosp., 404 S.C. 56, 62-63, 744 S.E.2d 547, 550 (2013) (internal quotations omitted) ("Questions of statutory interpretation are questions of law, which we are free to decide without any deference to the court below."). Guiding this inquiry is the seminal principle of statutory interpretation that "[a]ll rules of statutory construction are subservient to the one that legislative intent must prevail if it can be reasonably discovered in the language used, and that language must be construed in the light of the intended purpose of the statute." Bass v. Isochem, 365 S.C. 454, 469, 617 S.E.2d 369, 377 (Ct. App. 2005) (citing McClanahan v. Richland County Council, 350 S.C. 433, 567 S.E.2d 240 (2002); Ray Bell Constr. Co. v. School Dist. of Greenville County, 331 S.C. 19, 501 S.E.2d 725 (1998)). When a statute's terms are clear and unambiguous on their face, there is no room for statutory construction and a court must apply the statute according to its literal meaning. Grier v. AMISUB of S.C., Inc., 397 S.C. 532, 535, 725 S.E.2d 693, 695 (2012) (citing Miller v. Aiken, 364 S.C. 303, 613 S.E.2d 364 (2005)).

The instant matter calls into question the six-year repose provision for medical malpractice actions of § 15-3-545 and the tolling of claims due to insanity under the disability statute contained in § 15-3-40. Specifically, because the instant action was not filed until nearly

eight years after the ECT treatment giving rise to Plaintiff's claim—two years after the expiration of the statute of repose—Plaintiff's claims are barred. Plaintiff is presumably attempting to toll Plaintiff this period by offering expert testimony indicating that prior to June of 2010 "her capacity to comprehend what was going on in her life" was diminished by her ECT and underlying mental illness. The legislature has codified a means by which to toll the statute of an insane person in § 15-3-40. However, as set forth herein, this statute is inapplicable to medical malpractice actions under the plain and unambiguous language of § 15-3-545. Moreover, even assuming § 15-3-40 were to apply, this action, having been commenced more than one year after the Plaintiff's disability ceased, is still time-barred.

A. Plaintiff's claims are barred by the absolute six-year statute of repose for medical malpractice actions.

Pursuant to section 15-3-545 of the South Carolina Code, medical malpractice actions are governed by a six year statute of repose which "constitutes an outer limit beyond which a medical malpractice claim is barred, regardless of whether it has or should have been discovered." Hoffman v. Powell, 298 S.C. 338, 339-40, 380 S.E.2d 821, 821 (1989). Specifically, § 15-3-545 provides:

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

S.C. Code Ann. § 15-3-545 (emphasis added). "[A] statute of repose is typically an absolute time limit beyond which liability no longer exists and is not tolled for any reason because to do so would upset the economic balance struck by the legislative body." Langley v. Pierce, 313 S.C. 401, 404, 438 S.E.2d 242, 243 (1993) (citation omitted). The expiration of a statute of

repose extinguishes all causes of action, including those that may later accrue and those that have already accrued. Capco of Summerville, Inc. v. J.H. Gayle Constr. Co., 368 S.C. 137, 142, 628 S.E.2d 38, 41 (2006); see e.g. Columbia/CSA-HS Greater Columbia Healthcare Sys. v. S. Carolina Med. Malpractice Liab. Joint Underwriting Ass'n, 394 S.C. 68, 74-75, 713 S.E.2d 639, 642 (Ct. App. 2011) (finding equitable indemnification claim brought ten years after event giving rise to medical malpractice action barred by six-year statute of repose).

Thus, construing the plain and unambiguous language of § 15-3-545, the six-year repose provision “imposes an outer limit for filing a medical malpractice action, regardless of when it is discovered.” Dunbar v. Carlson, 341 S.C. 261, 269, 533 S.E.2d 913, 917 (Ct. App. 2000) (citing O'Tuel v. Villani, 318 S.C. 24, 27, 455 S.E.2d 698, 700 (Ct. App. 1995), overruled on other grounds by I'On, L.L.C. v. Town of Mt. Pleasant, 338 S.C. 406, 526 S.E.2d 716 (2000)). The stated legislative purpose of the medical malpractice repose provision is to foster the delivery of quality health care services by reducing liability exposure. Hoffman, 298 S.C. 338, 380 S.E.2d 821. As such, the six-year repose provision of § 15-3-545 applies to both government and private hospitals. See Kerr v. Richland Mem'l Hosp., 383 S.C. 146, 149, 678 S.E.2d 809, 811 (2009) (finding the six year repose provision of § 15-3-545 applies to government hospitals under the Tort Claims Act).

Further, as noted in Langley v. Pierce, the only tolling provided by Section 15-3-545 is contained in Subsection (D) which provides for limited tolling applicable only to minors. Id. at 403, 438 S.E.2d at 243. “Inclusion of the phrase “or as tolled by this section” in subsection (A) clearly indicates that the **only** tolling of § 15-3-545(A) intended by the legislature is that contained in subsection (D).” Id. (emphasis in original). Consistent with this finding, South Carolina has rejected such tolling mechanisms as the continuous treatment rule or the continuous

tort doctrine as a means of tolling the statute of limitations in medical malpractice cases. The rationale for doing so was explained in Harrison v. Bevilacqua, wherein the South Carolina Supreme Court reasoned that adoption of the continuous treatment/continuous tort doctrine “would run afoul of the absolute limitations policy the Legislature has clearly set” through statute, including the six year repose provision of § 15-3-545. 354 S.C. 129, 138, 580 S.E.2d 109, 114 (2003).

Applying the six-year repose provision in the instant case, Plaintiff’s Complaint against MUSC having arisen out of ECT treatment initiated in 2003 is time-barred. Because Plaintiff’s claims arise out of her course of ECT treatment, the trigger date for the statute of repose is the date of her first treatment in December 2003. See Harrison, 354 S.C. at 138, 580 S.E.2d at 114 (rejecting the continuous treatment rule, finding claims not brought within six years of onset of treatment are barred pursuant to the medical malpractice statute of repose). It is from this date that the absolute outer limit of the six year repose provision established by the legislature was set to run. Thus, Plaintiff was required to bring the instant action no later December 2009, six years from the date of the onset of treatment.

Furthermore, because the only tolling provided by § 15-3-545 is contained in Subsection (D) and applicable only to minors, the disability statute is inapplicable. See Langley, 313 S.C. at 403, 438 S.E.2d at 243. Courts in other jurisdictions have similarly declined to apply statutes such as South Carolina’s disability statute § 15-3-40 to medical malpractice statutes of repose. In Calaway ex rel. Calaway v. Schucker, 193 S.W.3d 509 (Tenn. 2005), the Supreme Court of Tennessee found no tolling exception for minority with regard to its three-year medical malpractice statute of repose, premising its holding on the clear language of the statute and its consistent characterizations of the medical malpractice statute of repose as an absolute three-year

bar to such claims. In so finding, the Calaway court emphasized that the Tennessee disability statute “serves to toll only statutes of limitations and not statutes of repose.” Quoting an earlier holding, the court further stated:

To accept the argument that the legal disability statute trumps the medical malpractice statute of repose “would be to defeat the very purposes behind the enactment” of the latter. . . We cannot, under the guise of judicial interpretation of the statute, in effect rewrite the law and thus substitute our own policy preferences for the Legislature’s.

Calaway ex rel. Calaway, 193 S.W.3d at 517 (quoting Penley v. Honda Motor co., 31 S.W.3d 181, 186 (Tenn. 2000)).

Here, as in Calaway, application of the discovery rule or tolling provided by the disability statute will not revive a claim that is filed outside the absolute limitations period established by the statute of repose. Consequently, Plaintiff’s claims, having been brought nearly eight years from the onset of treatment, are barred by the absolute six-year statute of repose within § 15-3-545.

B. Even assuming Plaintiff lacked the mental capacity to comprehend her injuries, Plaintiff’s claims are barred by the expiration of the limitations period set by the disability statute.

Assuming, arguendo, that the disability statute applied, and taking as true Plaintiff’s assertion that her mental impairment prevented her from comprehending her injuries, this action is barred by the limitations period established under § 15-3-40. Pursuant to the disability statute, an action may be tolled for the period within which the Plaintiff may be disabled due to “insanity” but the time for commencement of the action must not be extended “more than five

years by any such disability” nor “in any case longer than one year after the disability ceases.”

S.C. Code Ann. § 15-3-40.¹ Specifically, § 15-3-40 provides:

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

(1) within the age of eighteen years; or

(2) **insane;**

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

(a) **more than five years** by any such disability, except infancy; nor

(b) **in any case longer than one year after the disability ceases.**

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

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

Wiggins v. Edwards, 314 S.C. 126, 129, 442 S.E.2d 169, 170 (1994) (quoting 54 C.J.S.

Limitations of Actions § 117 at 159-169 (internal footnotes omitted)).

Here, the Plaintiff and her expert assert that she “...did not regain the mental capacity to understand and appreciate the harm...” allegedly caused by ECT **until** June 2010. (See Notice of Intent, dated June 25, 2010, attached hereto as Exhibit “C”). Therefore, construing the facts in the light most favorable to Plaintiff, the disability statute required Plaintiff to file the instant action by June 25, 2011. Although Plaintiff filed a Notice of Intent on June 25, 2010, the dismissal of the action without prejudice on August 25, 2010, precluded Plaintiff from tolling the action. See Davis, 287 S.C. at 243, 335 S.E.2d at 799 (“When an action is dismissed without prejudice, the statute of limitations will bar another suit if the statute has run in the interim.”).

¹ The repose provision of § 15-3-545 limits the time during which the insanity provisions of § 15-3-40 would permit an action to be brought.

Accordingly, the instant action filed on November 16, 2011—more than one year after the disability ceased—is time-barred.

Furthermore, while Plaintiff claims she could not appreciate the damage until as late as June 2010, substantial evidence, including her admissions in her deposition, statements to her treating physicians, and evidence in her divorce proceedings indicate her acknowledgment of these alleged problems much earlier than June of 2010. Specifically, she testified in her deposition that, between 2006 and 2008, she was upset and aware of alleged memory loss and not being able to take care of herself as a result of ECT. (See Deposition of Plaintiff, p. 68, l. 9 – p. 69, l. 25, attached hereto as Exhibit “D”). She later acknowledged that she lost the ability to take care of herself prior to her last ECT treatment in June of 2008 and that she attributed that *at the time* to ECT. (See Exhibit D, p. 81, l. 20 – p. 82, l. 21). She reiterated later in her deposition that it was during her maintenance ECT (2005-2008) that she first started believing that she was suffering from memory problems as a result of ECT. (See Exhibit D, pp. 124, l. 12-19). She also stated to Dr. Roberts, and reiterated in her deposition, that on January 6, 2009, she was upset at the effect that ECT had on her at the time. (See Exhibit E, January 6, 2009 Notes of Dr. Roberts; Exhibit D, p. 125, l. 19 - 126, l. 9). Similarly, there are also references to Plaintiff’s memory loss from ECT dating back to Plaintiff’s divorce proceedings in 2007. For instance, Plaintiff’s Life Care Plan, dated January 30, 2007, notes “[Plaintiff] has been having increasing problems with her memory.” (See Exhibit F, Life Care Plan for Clair Johnson, p. 4). Plaintiff’s Life Care Plan further notes that Plaintiff “has reportedly developed increasing problems with directionality and memory” and that Plaintiff admitted being “afraid to drive due to increased problems with memory. . .” (See Exhibit F, pp. 5 & 13).

Assuming Plaintiff comprehended her injuries in 2007 and 2009, she had one year within which to bring a claim under the disability statute. Consequently, neither the disability statute nor the discovery rule can serve to revive the instant action.

C. Plaintiff's claims are not subject to the tolling provision of 15-79-125 where the Notice of Intent was defective.

Section 15-79-125(A) of the South Carolina Code imposes pre-litigation filing requirements upon individuals intending to file suit for medical malpractice, which provide, in pertinent part:

Prior to filing or initiating a civil action alleging injury or death as a result of medical malpractice, the plaintiff shall contemporaneously file a Notice of Intent to File Suit and an affidavit of an expert witness, subject to the affidavit requirements established in Section 15-36-100...

The filing of the notice of intent will toll the limitations period. However, "[w]hen an action is dismissed without prejudice, the statute of limitations will bar another suit if the statute has run in the interim." Davis v. Lunceford, 287 S.C. 242, 243, 335 S.E.2d 798, 799 (1985); see cf. Mende v. Conway Hospital, Inc., 304 S.C. 313, 404 S.E.2d 33 (1991) (recognizing the ruling in Davis, but finding the statute of limitations defense had been waived).

Here, despite filing the Notice of Intent on June 25, 2010, Plaintiff dismissed the matter without prejudice on August 25, 2010. Adopting Plaintiff's assertion that the limitations period accrued as late as July 5, 2010, the dismissal without prejudice filed on August 25, 2010 deprived Plaintiff from benefiting from the tolling provision of § 15-79-125, barring Plaintiff's November 16, 2011 Complaint.

Moreover, a notice of intent will not toll the limitations period if the notice is defective. See Grier v. Amisub of South Carolina, 397 S.C. 532, 725 S.E.2d 693 (2012) (observing failure to conform pre-suit affidavit to requirements of § 15-79-125 would bar medical malpractice

action). Pursuant to section 15-79-125(A), an affidavit of an expert witness must be filed contemporaneously with the notice of intent to file suit. S.C. Code Ann. § 15-79-125(A) (Supp. 2012). In contravention of the pre-suit requirements of § 15-79-125(A), Plaintiff failed to file an expert witness affidavit with the Notice. Rather, the Notice sought an extension of time to file the affidavit, citing "time constraints" as preventing Plaintiff from filing an affidavit of a medical expert. In certain circumstances and upon approval from the court, the rule provides a plaintiff an additional forty-five days to file an expert affidavit. However, Plaintiff failed to file an expert witness affidavit until August 10, 2011, over one year after the expiration of the forty-five day period provided by § 15-36-100(C)(1).

Thus, even assuming the action was tolled despite the subsequent dismissal without prejudice, the tolling provision of § 15-79-125 was never triggered because the Notice of Intent failed to comply with §§ 15-79-125 and 15-36-100. Accordingly, the statute of limitations having expired on July 5, 2011, bars Plaintiff's claims.

II. PLAINTIFF'S CLAIMS FOR MEDICAL MALPRACTICE ARE BARRED BY THE COMMON LAW THEORIES OF INTERVENING AND SUPERSEDING NEGLIGENCE.

Alternatively, Plaintiff's claims are barred by the intervening and superseding negligence of defendant Dr. Roberts in prescribing certain medication which caused the symptoms, i.e. mania, that required Plaintiff to undergo the ECT treatment at issue in this case. Specifically, on May 21, 2013, Dr. Peter Breggin testified that "if the prescription of the Wellbutrin had not been made . . . [Plaintiff] would not have had the need for, or the perceived need for, ECT treatment." (See Deposition of Dr. Peter Breggin, p. 213, l. 10-15, attached hereto as Exhibit "G"). In other words, but for the prescription of Wellbutrin by Dr. Roberts, Plaintiff would never have manifested the symptoms that necessitated treatment by ECT.

“To exculpate a negligent defendant, the intervening cause must be one which breaks the sequence or causal connection between the defendant’s negligence and the injury alleged.” Gause v. Smithers, 403 S.C. 140, 150, 742 S.E.2d 644, 649 (2013) (quoting Matthews v. Porter, 239 S.C. 620, 628, 124 S.E.2d 321, 325 (1962)). “For an intervening act to break the causal link and insulate the tortfeasor from further liability, the intervening act must be unforeseeable.” Keeter v. Alpine Towers Int’l, Inc., 399 S.C. 179, 193, 730 S.E.2d 890, 897-98 (Ct. App. 2012) (quoting McKnight v. S.C. Dep’t of Corr., 385 S.C. 380, 387, 684 S.E.2d 566, 569 (Ct. App. 2009)). Here, the prescription of Wellbutrin, a stimulant, allegedly caused the manic symptoms that required Plaintiff to undergo the ECT treatment. Having caused the symptoms that necessitated treatment by ECT, the negligence of Dr. Roberts in prescribing Wellbutrin broke the causal connection between the alleged negligence of MUSC and Plaintiff’s injuries.

While South Carolina courts have held that the negligence of an attending physician is reasonably foreseeable, this presumption is generally applied where the negligence of the attending physician aggravates an already existing injury suffered by Plaintiff. See Graham v. Whitaker, 282 S.C. 393, 399, 321 S.E.2d 40, 44 (1984) (noting aggravation of injury resulting from negligent act of physician is part of immediate and direct damages naturally flowing from the original injury). Here, the negligence of Dr. Roberts in prescribing Wellbutrin preceded the alleged negligence of MUSC and was, therefore, unforeseeable. By prescribing a stimulant which caused the mania that in turn resulted in the administration of ECT treatment, it was the sole negligence of Dr. Roberts that caused Plaintiff to undergo ECT. In this instance, the negligence of an attending physician preceding, but effectively causing, the injury was not reasonably foreseeable to MUSC. Accordingly, Plaintiff’s claims are barred by the independent

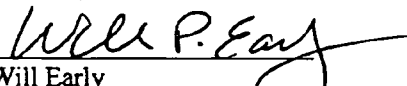
and unforeseeable negligence of Dr. Roberts in prescribing stimulant medication which caused Plaintiff to require ECT.

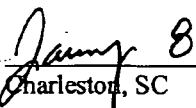
CONCLUSION

In sum, Plaintiff's action against MUSC having been commenced neither within six years of the occurrence, nor within one year after the alleged disability of the Plaintiff was removed, is barred by the absolute limitations period established by the legislature. Moreover, construing the undisputed facts in accordance with the referenced legal principles guiding this matter, Plaintiff's claims against MUSC are barred pursuant to the common law principles of intervening and superseding negligence. Accordingly, based upon the foregoing, summary judgment in favor of MUSC as to Plaintiff's complaint is proper.

Respectfully submitted,

PIERCE, HERNS, SLOAN & WILSON, LLC
The Blake House
321 East Bay Street
Post Office Box 22437
Charleston, SC 29403


Will Early
Attorney for Defendant MUSC

 8, 2014
Charleston, SC

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

Clair Craver Johnson,

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

Plaintiff(s)

vs.

Medical University of South Carolina,

Defendant(s)

(Please Print)

Submitted By: D. Cravens Ravenel

Address: 3710 Landmark Drive, Suite 400
Columbia, SC 29204

SC Bar #: 4642

Telephone #: 803-799-9091

Fax #: 803-779-3423

Other:

E-mail: cravenel@brble.com

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

DOCKETING INFORMATION (Check all that apply)

*If Action is Judgment/Settlement do not complete

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

NATURE OF ACTION (Check One Box Below)

☐ Contracts ☐ Constructions (100) ☐ Debt Collection (110) ☐ Employment (120) ☐ General (130) ☐ Breach of Contract (140) ☐ Other (199)	☐ Torts - Professional Malpractice ☐ Denial Malpractice (200) ☐ Legal Malpractice (210) ☒ Medical Malpractice (220) ☐ Previous Notice of Intent Case # 20 -CP- ☐ Notice/ File Med Mal (230) ☐ Other (299)	☐ Torts - Personal Injury ☐ Assault/Slander/Label (300) ☐ Conversion (310) ☐ Motor Vehicle Accident (320) ☐ Premises Liability (330) ☐ Products Liability (340) ☐ Personal Injury (350) ☐ Wrongful Death (360) ☐ Other (399)	☐ Real Property ☐ Claim & Delivery (400) ☐ Condemnation (410) ☐ Foreclosure (420) ☐ Mechanic's Lien (430) ☐ Partition (440) ☐ Possession (450) ☐ Building Code Violation (460) ☐ Other (499)
☐ Inmate Petitions ☐ PCR (500) ☐ Mandamus (520) ☐ Habeas Corpus (530) ☐ Other (599)	☐ Judgments/Settlements ☐ Death Settlement (700) ☐ Foreign Judgment (710) ☐ Magistrate's Judgment (720) ☐ Minor Settlement (730) ☐ Transcript Judgment (740) ☐ Lis Pendens (750) ☐ Transfer of Structured Settlement Payment Rights Application (760) ☐ Other (799)	☐ Administrative Law/Relief ☐ Reinstate Driver's License (800) ☐ Judicial Review (810) ☐ Relief (820) ☐ Permanent Injunction (830) ☐ Forfeiture-Petition (840) ☐ Forfeiture-Consent Order (850) ☐ Other (899)	☐ Appeals ☐ Arbitration (900) ☐ Magistrate-Civil (910) ☐ Magistrate-Criminal (920) ☐ Municipal (930) ☐ Probate Court (940) ☐ SCDOT (950) ☐ Worker's Comp (960) ☐ Zoning Board (970) ☐ Public Service Commission (990) ☐ Employment Security Comm (991) ☐ Other (999)
☐ Special/Complex /Other ☐ Environmental (600) ☐ Automobile Arb (610) ☐ Medical (620) ☐ Other (699)	☐ Pharmaceuticals (630) ☐ Unfair Trade Practices (640) ☐ Out-of-State Depositions (650) ☐ Motion to Quash Subpoena in an Out-of-County Action (660) ☐ Sexual Predator (510)		

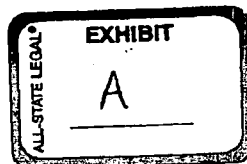
Submitting Party Signature:

D. Cravens Ravenel

Date: November 15, 2011

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

SCCA / 234 (11/09)



Page 1 of 2

FOR MANDATED ADR COUNTIES ONLY

Allendale, Anderson, Beaufort, Colleton, Florence, Greenville,
Hampton, Horry, Jasper, Lexington, Pickens (Family Court Only), and Richland

**SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE
DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.**

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

**Please Note: You must comply with the Supreme Court Rules regarding ADR.
Failure to do so may affect your case or may result in sanctions.**



BAKER RAVENEL BENDER

ATTORNEYS AT LAW

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BRADLEY L LANFORD
SAMUEL M MOKGBA
SUSAN DRAKE DUBOSE
ROBERT L BROWN
JENNY A DRAFFIN
ELIZABETH A BLACKWELL

CHARLES E BAKER
(1935-2010)

*OF COUNSEL

**ALSO ADMITTED IN GEORGIA

November 15, 2011

The Honorable Julie J. Armstrong
Clerk of Court - Charleston County
100 Broad Street, #106
Charleston, South Carolina 29401

Re: Clair Craver Johnson v. Medical University of South Carolina
Our File No.: 10517.0 2011-CP-10-8319

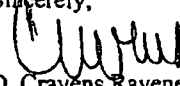
Dear Ms. Armstrong:

Due to our error, I have enclosed a corrected Civil Action Coversheet reflecting the correct defendant as the Medical University of South Carolina. The style of the action on the Civil Cover Sheet that was originally filed with the Summons and Complaint does not reflect the correct defendant. I have enclosed a copy of the one that is incorrect for your review.

Enclosed for filing in the above-referenced matter are the original and one (1) copy of the corrected Civil Action Coversheet. Please clock in the extra copy of the Civil Action Coversheet and return to me in the enclosed, self-addressed, stamped envelope provided. I have also enclosed a copy of the clocked Summons and Complaint that do reflect the correct defendant.

Should you have any questions, please do not hesitate to contact me.

Sincerely,


D. Cravens Ravenel
DCR:sr
Enclosure

BAKER, RAVENEL & BENDER, LLP
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shipping 3710 LANDMARK DRIVE suite 400 | COLUMBIA, SC 29204
phone 803 799 9091 | fax 803 779 3423

STATE OF SOUTH CAROLINA)

COURT OF COMMON PLEAS

COUNTY OF CHARLESTON)

CASE NUMBER: 2011-CP-10-8318

Clair Craver Johnson,

Plaintiff,

vs.

Medical University of South
Carolina,

Defendant.

SUMMONS
(MEDICAL MALPRACTICE ACTION)

2011 NOV -8 PM 12:53
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

TO: THE DEFENDANT(S) NAMED ABOVE:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, a copy of which is hereby served upon you, and to serve a copy of your Answer to the said Complaint on the subscriber hereto at their office at 3710 Landmark Drive, Suite 400, Columbia, South Carolina 29204, within thirty (30) days after service hereof, exclusive of the day of such service; and if you fail to answer the Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Complaint.


D. Cravens Ravenel
BAKER, RAVENEL & BENDER, L.L.P.
3710 Landmark Drive, Suite 400
Post Office Box 8057
Columbia, South Carolina 29202
Telephone (803) 799-9091
Facsimile (803) 779-3423
File No.: 10517 cravcnel@brblegal.com
ATTORNEY FOR PLAINTIFF

NOV 9th
August 2011

STATE OF SOUTH CAROLINA)

COURT OF COMMON PLEAS

COUNTY OF CHARLESTON)

CASE NUMBER: 2011-CP-10-8318

Clair Craver Johnson,)

Plaintiff,)

vs.)

Medical University of South
Carolina,)

Defendant.)

COMPLAINT
(MEDICAL MALPRACTICE ACTION)

2011 NOV -8 PM 12:53
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

The Plaintiff, complaining of the Defendant, Medical University of South Carolina in Charleston, South Carolina, alleges:

1. Plaintiff is a resident of the County of Richland, State of South Carolina.
2. Upon information and belief, pursuant to the provisions of S.C. Code Ann. § 15-78-10 et seq (S.C. Tort Claims Act), Medical University of South Carolina in Charleston, South Carolina, a governmental entity, is subject to liability for medical malpractice, employed healthcare providers who negligently treated the Plaintiff with electroconvulsive therapy (hereinafter ECT) which was given without proper informed consent and with inadequate consideration for the foreseeable effects of such severe and extended treatment given the Plaintiff's history of mental impairments.
3. The ECT treatment by the defendant's employees took place between 2003 to 2008.
4. On or about 2003, psychiatrists in Charleston, South Carolina began treating the Plaintiff with ECT despite Plaintiff's refusal to give consent.

5. The treating physician's sought informed consent from the Plaintiff's then estranged and now ex-husband in spite of potential conflicts of interest.

6. This involuntary treatment extended for two years until 2008.

7. During, after and a direct and proximate result of this extensive and involuntary ECT treatment, the Plaintiff lacked the mental capacity to understand and appreciate the detrimental effect the ECT had upon her until 2010 when Clair Craver Johnson retained counsel, records of her ECT treatment were gathered, and a medical expert was retained to analyze those records.

8. Plaintiff's medical expert, Harold J. Burstzajn, M.D., reported on or about August 10, 2011, that in his opinion physicians and other healthcare providers at the Medical University of South Carolina, Charleston, South Carolina, failed to exercise the care that medical professionals under like circumstances would have exercised as more fully appears in the copy of the expert's affidavit attached hereto as Exhibit A and which is incorporated herein by reference thereto and plaintiff alleges that the healthcare provider at the Medical University of South Carolina, Charleston, South Carolina's, negligence and gross negligence as employees of Medical University of South Carolina, Charleston, South Carolina, directly and proximately resulted in excruciating, intractable pain and suffering, loss of memory, and exacerbation of preexisting mental impairments which the Plaintiff could have avoided had an adequate assessment of alternative medical options been made by Medical University of South Carolina, Charleston, South Carolina.

9. Plaintiff, while in the care of the Medical University of South Carolina, Charleston, South Carolina, was involuntarily, repeatedly and improperly given ECT treatment by the Medical University of South Carolina, Charleston, South Carolina, for two years,

exposing her to intractable pain, memory loss, and Post-traumatic Stress Disorder, which Plaintiff's exacerbated mental impairment so as to prevent Plaintiff from discovering the negligent acts or omissions of the Medical University of South Carolina, Charleston, South Carolina, until two years after the conclusion of said treatment due to the degree of mental incompetency said treatment rendered the Plaintiff.

10. The Defendant owed the Plaintiff the following duties of care in connection with her 2003 to 2008 treatment and breached one or more of these duties:

- A) The duty to exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances to accomplish the purpose for which they were employed;
- B) The duty to receive informed consent by the patient for such treatment or recognize professional standards such as guardianship when faced with a potential conflict of interest;
- C) The duty to provide timely and appropriate treatment when confronted with mental impairments that require such treatment;
- D) The duty to exercise a greater degree of care and to respond appropriately when a risk of substantial danger and foreseeable long term affects is present;
- E) The duty to perform thorough and careful mental assessments, such as the mental condition of the patient and attending circumstances vulnerability due to cognitive impairment, with such

diligence and methods for treatment the mental impairment as are usually approved and practiced by psychiatrists of ordinary or average learning, judgment and skill; and

- F) The duty to administer mental tests or examinations in aid of diagnosis when the recognized professional standards of skill and care, existing state of medical knowledge, and the like, required the making of tests or examinations which are generally accepted by the profession.

11. As a direct and proximate result of the negligence and gross negligence of the employees of Medical University of South Carolina, Charleston, South Carolina, Clair Craver Johnson, has suffered loss of memory and exacerbated mental impairments under circumstances above in violation of S.C. Code Ann. § 15-79-110 *et seq.*

12. Plaintiff is entitled to recover actual damages for the unnecessary, avoidable pain and suffering, long term memory loss, and exacerbated mental impairment which were inflicted upon her involuntarily by the defendant's employees negligence and gross negligence and for costs of medical treatment proximately caused by the defendant's employees' treatment of her condition.

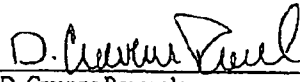
Plaintiff demands:

- 1. A trial by jury on Plaintiff's causes of action for Medical Malpractice.
- 2. Judgment under the S.C. Tort Claim Act for actual damages including damages under S.C. Code Ann. § 15-79-110 *et seq* for (1) pecuniary loss caused by the negligent treatment rendered by the employees of the Defendant; (2) mental shock and suffering caused by the extended and involuntary two year ECT treatment; (3)

psychological and mental impairments further exacerbated by the ECT treatments

which have rendered the Plaintiff incapable of a normal life.

3. And for such other and further relief as the Court deems just and proper.



D. Cravens Ravenel
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cravenel@brblegal.com
File No.: 10517
ATTORNEYS FOR PLAINTIFF

Columbia, SC
Filed August 2, 2011

STATE OF MASSACHUSETTS)

AFFIDAVIT

COUNTY OF MIDDLESEX)

1. I, Harold J. Burstzajn, M.D., am a physician currently licensed by the states of Massachusetts and New Hampshire. I am board-certified in psychiatry by the American Board of Psychiatry and Neurology. I serve as an Associate Clinical Professor of Psychiatry, Co-Founder of the Program in Psychiatry and the Law, and Principal Mentor for students at Harvard Medical School. A copy of my current curriculum vitae is attached hereto as Exhibit A.

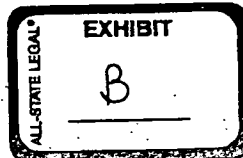
2. This affidavit is provided pursuant to S. C. Code Ann. §§15-36-100 and 15-79-125.

3. Based upon my medical education, knowledge, training and experience, I am familiar with the generally accepted principles and standards of care in the diagnosis and treatment of Bipolar Disorder with psychotic features and a history of head trauma, for which Clair Craver Johnson was being treated.

4. I have, to date, reviewed records of Clair Craver Johnson's education, certain observations by the parents of Clair Craver Johnson over a significant period of time, court records, hospital and physicians' and psychologists' records, all documenting Clair Craver Johnson's emotional condition and the treatment of Clair Craver Johnson by the Medical University of South Carolina hospital and by John Roberts, M.D. and Milton Faust, M.D.

5. I interviewed Clair Craver Johnson in my office for 4 ½ hours after reviewing the referenced materials.

6. After reviewing the described records and meeting with Clair Craver Johnson, and relying upon my education, knowledge, training and experience, I am of the opinion that based upon a reasonable degree of medical certainty, more likely than not, the treatment provided by



the Medical College of South Carolina hospital, John Roberts, M.D., and Milton Faust, M.D., did not meet the standard of care imposed upon hospitals and physicians under like circumstances. I am of the opinion that the Medical University of South Carolina failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with electroconvulsive therapy (ECT) (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; that Dr. Roberts failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, by failing to conduct an adequate psychopharmacological assessment of alternate medication choices, by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; and that Dr. Faust failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, and by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence.

7. I am likewise of the opinion that based upon a reasonable degree of medical certainty, more likely than not, as a direct and proximate result of the negligent acts or omissions on the part of the Medical University of South Carolina, John Roberts, M.D., and Milton Faust, M.D., Clair Craver Johnson sustained the following injuries: prolonged and, to a degree, permanent exacerbation of cognitive impairments, including memory loss; impaired capacity to participate in her divorce proceedings; impairments in the post-traumatic spectrum resulting from the physically and emotionally traumatic experience of extended involuntary treatment with ECT, which produced feelings of helplessness, terror, and personal violation; a prolonged period of confusion and demoralization, resulting in a loss of access to a significant segment of her life experience and a loss of continuity of autobiographical memory; diminished trust in mental-health care providers; diminished hope for the future; and loss of the potential benefits of appropriate treatment with psychotherapy, medications, and a meaningful informed-consent process. Had Clair Craver Johnson been properly diagnosed and treated, I am of the opinion that to a reasonable degree of medical certainty, Ms. Johnson more likely than not would not have sustained the injuries described above and her emotional issues would have been managed so as to allow her to function as a productive individual.

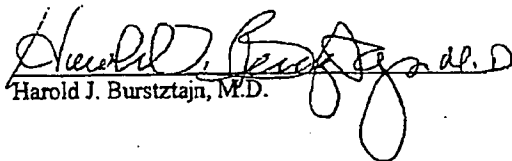
8. Further, I am of the opinion that to a reasonable degree of medical certainty, more likely than not, Clair Craver Johnson did not regain the mental capacity to understand and appreciate the harm she suffered as a consequence of the negligent acts or omissions specified above, particularly the extended involuntary treatment with ECT, until she sought help in reviewing her medical records in June 2010, two years after ECT was concluded. Her capacity to comprehend what was going on in her life, already diminished by mental illness, was further diminished by the physical and emotional trauma and cognitive impairments associated with an

~~extended period of ECT, which foreseeably resulted in prolonged confusion and demoralization.~~

~~She recovered the ability to process her experiences during those years only by reestablishing ties with a supportive community that helped her recreate her autobiographical memory.~~

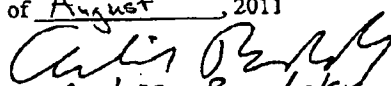
9. This affidavit does not include all of my opinions and I reserve the right to modify and/or formulate additional new opinions should additional, pertinent records be submitted for my review.

Further affiant sayeth not.


Harold J. Burstzajn, M.D.

Sworn to before me this 10th day

of August, 2011


Archie Bradsky (L.S.)
Notary Public for Massachusetts

My Commission expires: June 22, 2012

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIRE C. JOHNSON

Plaintiff(s)

vs.

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

CASE NO. 2010-CP-105135

Medical University of South Carolina, Midan Foust, M.D.
AND John FRED Johnson, M.D.

Defendant(s)

(Please Print)

Submitted By: CLAIRE JOHNSON

Address: 2 TURTLE GIVE LAKE

IRMO, S.C. 29063

SE Bar #:

Telephone #: 803-781-8078

Fax #: 803-781-8079

Other:

E-mail: HCRAYER@SC.PC.COM

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

DOCKETING INFORMATION (Check all that apply)

*If Action is Judgment/Sentiment do not complete

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

NATURE OF ACTION (Check One Box Below)

☐ Contracts	☐ Torts - Professional Malpractice	☐ Torts - Personal Injury	☐ Real Property
☐ Construction (100)	☐ Dental Malpractice (200)	☐ Assault/Battery (100)	☐ Easement & Delivery (400)
☐ Debt Collection (110)	☐ Legal Malpractice (210)	☐ Conversion (310)	☐ Condominium (410)
☐ Employment (120)	☐ Medical Malpractice (220)	☐ Motor Vehicle Accident (320)	☐ Foreclosure (420)
☐ General (130)	☒ Medical File Malpractice (230)	☐ Premises Liability (330)	☐ Mechanic's Lien (430)
☐ Breach of Contract (140)	☐ Other (299)	☐ Products Liability (340)	☐ Partition (440)
☐ Other (199)		☐ Personal Injury (350)	☐ Possession (450)
		☐ Wrongful Death (360)	☐ Building Code Violation (460)
		☐ Other (199)	☐ Other (499)
☐ Maritime Petitions	☐ Judgments/Sentiments	☐ Administrative Law/Relief	☐ Appeals
☐ PCR (500)	☐ Death Sentences (700)	☐ Repealed Driver's License (800)	☐ Arbitration (900)
☐ Marriages (510)	☐ Foreign Judgments (710)	☐ Judicial Review (810)	☐ Magistrate-Civil (910)
☐ Habeas Corpus (520)	☐ Magistrate's Judgment (720)	☐ Relief (820)	☐ Magistrate-Criminal (920)
☐ Other (599)	☐ Minor Settlements (730)	☐ Permanent Injunction (830)	☐ Municipal (930)
	☐ Transcript Adjudgment (740)	☐ Foreclosure-Possession (840)	☐ Probate Court (940)
	☐ Lis Pendens (750)	☐ Foreclosure-Consent Order (850)	☐ SCDCOT (950)
	☐ Transfer of Structured Settlement Payment Rights Application (760)	☐ Other (899)	☐ Worker's Comp (960)
	☐ Other (799)		☐ Zoning Board (970)
☐ Special/Complex/Other	☐ Pharmaceuticals (630)		☐ Administrative Law/Judge (980)
☐ Environmental (600)	☐ Unfair Trade Practices (640)		☐ Public Service Commission (990)
☐ Automobile Acc. (610)	☐ Out-of-State Depositions (650)		☐ Employment Security Comm. (991)
☐ Medical (620)	☐ Sexual Predator (670)		☐ Other (999)
☐ Other (699)			

Submitting Party Signature:

CLAIRE C. JOHNSON

Date: 6-24-10

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

SCCA / 234 (03/09)

Page 1 of 2



FOR MANDATED ADR COUNTIES ONLY

Allendale, Anderson, Beaufort, Colleton, Florence, Greenville,
Hampton, Horry, Jasper, Lexington, Pickens (Family Court Only), and Richland

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE
DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT:

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code § 15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

Please Note: You must comply with the Supreme Court Rules regarding ADR.
Failure to do so may affect your case or may result in sanctions.

STATE OF SOUTH CAROLINA
 COUNTY OF CHARLESTON
 CLAIR C. JOHNSON

IN THE COURT OF COMMON PLEAS
 FOR THE NINTH JUDICIAL CIRCUIT
 CASE NO. 2010-CP-10-5135

Plaintiffs,

vs.

MEDICAL UNIVERSITY OF
 SOUTH CAROLINA, MILTON FOWST, MD
 AND JOHN FRED JOHNSON, MD
 Defendant.

NOTICE OF INTENT TO FILE SUIT
 S.C. Code Sec. 15-79-125 AND 15-36-100

FILED
 2010 JUN 25 AM 11:11
 JULIE J. JONES
 CLERK OF COURT

1. ADVERSE PARTIES:

a. MUSC - through its agents and employees.

2. SHORT AND PLAIN STATEMENT OF THE FACTS SHOWING THAT THE PARTY FILING THIS NOTICE IS ENTITLED TO RELIEF.

STATEMENT

I, Clair Johnson, due to having ECT- electroconvulsive therapy for an extended period of time between 2003 and 2008 am now left with cognitive impairment and excessive memory loss. This condition is greatly affecting my ability to have a normal life.

Clair C. Johnson
 C-25-10

State of South Carolina)
County of Charleston)

In the Court of Common Pleas
For the Ninth Judicial Circuit
Case No. 2010-cp-10- 5135

Clair Johnson,)
Plaintiff,)

Affidavit of Clair Johnson Pursuant to
S.C. Code Sec. 15-79-125 and 15-36-100

vs.)
Medical University of)
South Carolina and Milton)
FOUST, M.D. and John FRED.)
Johnson, Defendants.

The undersigned, first being duly sworn, deposes and states the following:

1. I am Clair Johnson over the age of 18 and the plaintiff in this matter.
2. I have filed a Notice of Intention to file suit against the above-named Defendants.
3. Pursuant to the statutes above named I am informed and have a good faith belief that the statute of limitation on my cause of action in this matter (absent a discovery exception) will expire within the next 10 days from the date my Notice of Intent to File Suit is filed.
4. Because of these time constraints I do not have time to obtain an affidavit of an expert to file in this matter.
5. Therefore I seek an extension of time to file such an expert affidavit as provided by S.C. Code Sec. 15-79-125 and 15-36-100.

Further the affiant sayeth not:

Clair C. Johnson
Clair Johnson

Sworn to and subscribed before me
this 25th day of June, 2010.

Paul Kornahrens
Notary for the State of South Carolina
My Commission Expires: March 6, 2016

JUN 24, 2010 02:59P

PAUL KORNAHRENS
Notary Public - State of South Carolina
My Commission Expires March 6, 2016

18037794822

page 1

*Additional plaintiff may be added per court rule 1-8-10-100

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIRE C. JOHNSON

Plaintiffs,

vs.

MEDICAL UNIVERSITY OF
SOUTH CAROLINA, MILTON FOUST, MD
AND JOHN FRED JOHNSON, MD
Defendant.

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT
CASE NO. 2010-Cp-10-5135

PLAINTIFFS' ANSWERS TO
STANDARD INTERROGATORIES

FILED
2010 JUN 25 AM 11:15
JULIE J. ARMSTRONG
CLERK OF COURT

TO WHOM IT MAY CONCERN:

The following information is provided in compliance with the provisions of §15-79-125(A), South Carolina Code of Laws, as amended, which requires that the Notice of Intent to File Suit include "any standard interrogatories or similar disclosures required by the South Carolina Rules of Civil Procedure."

1. Give the names and addresses of persons known to the parties or counsel to be witnesses concerning the facts of the case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.

ANSWER:

a. CLAIR JOHNSON
2 TURTLE COVE LANE
IRMO, S.C. 29063

b. MILTON FOUST, MD
MUSC - INSTITUTE OF PSYCHIATRY
CHARLESTON, S.C.

c. Agents and Employees of the Medical University of South Carolina Hospital, hereinafter identified.

8-6-10 { d. John Fred Johnson, MD
Southeastern Spine Institute
1106 Chuck Dawky Blvd., Ste. 200
Mt. Pleasant, SC 29464

JUN 23, 2010 09:00

e. John M. Roberts, MD
222 W. Coleman Blvd.
Mt. Pleasant, SC 29464

2. Set forth a list of photographs, plats, sketches or other prepared documents in the possession of the party that relate to the claim or defense in the case.

ANSWER:

Plaintiffs are in possession of various records from the Medical University of South Carolina Hospital from 2003 to 2008. Plaintiff also has records from

1. Dr. John Roberts - Mt. Pleasant, S.C. 29464
2. Dr. Johnny Smith - 1037 St. Andrews Rd. Columbia, S.C. 29212

3. In cases involving personal injury set forth the names and addresses of all physicians who have treated the party and all hospitals to which the party has been committed in connection with said injuries and also set forth a statement of all medical costs involved.

ANSWER:

Plaintiff's claims were based on her care at MUSC. She was under the care of Dr. Milton Foust

This Answer will be supplemented as more information becomes available.

4. Set forth the names and addresses of all insurance companies which have liability insurance coverage relating to the claim and set forth the number or numbers of the policies involved and the amount or amounts of liability coverage provided in each policy.

ANSWER:

Plaintiff has no liability insurance which would relate to this claim. He assumes that MUSC is covered by the South Carolina Insurance Reserve Fund, or some similar policy.

5. Set forth an itemized statement of all damages, exclusive of pain and suffering, claimed to have been sustained by the party.

ANSWER:

PLAINTIFF HAS BEEN LEFT WITH COGNITIVE IMPAIRMENT AND EXCESSIVE MEMORY LOSS. THIS CONDITION IS GREATLY AFFECTING HER ABILITY TO HAVE A NORMAL LIFE.

THE SPECIFIC ECONOMIC DAMAGES WILL CONSIST OF THOSE MEDICAL EXPENSES INCURRED IN THE EVALUATION AND TREATMENT OF HER CONDITION. THEY HAVE NOT YET BEEN CALCULATED. / Additional damages to be sought per counsel.

6.

List the names and addresses of any expert witnesses whom the party proposes to use as a witness at the trial of the case.

ANSWER:

BECAUSE OF TIME CONSTRAINTS I AM IN THE PROCESS OF SECURING EXPERT WITNESSES.

Additionally, it is anticipated that those medical witnesses who provided care for the Plaintiff while he was a patient at MUSC will be qualified to render opinions within the fields of their expertise.

7. For each person known to the parties or counsel to be a witness concerning the facts of the case, set forth either a summary sufficient to inform the other party of the important facts known to or observed by such witness; or provide a copy of any written or recorded statements taken from such witnesses.

ANSWER:

PLAINTIFF WILL TESTIFY TO THE FACTS OUTLINED IN THE NOTICE OF INTENT.

AUG 11, 2010 08:09A

000-000-00000

page 9

Medical personnel will presumably testify in accordance with the records which they authored.

DATE 6-25-10

Clair C. Johnson
CLAIRE JOHNSON
2 TURTLE CREEK LANE
IRMA, S.C. 29063
803 781-8078

4

SUN 23, 2010 09:06P

18037744822

page 12

STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS IN
THE NINTH JUDICIAL CIRCUIT

Clair Craver Johnson,)
Plaintiff,)

CASE NOS.: 2012-CP-10-2867
AND 2011-CP-10-8318

v.)

John Roberts, M.D.,)
Defendant.)

**MEMORANDUM IN OPPOSITION TO
DEFENDANTS' MOTIONS FOR SUMMARY
JUDGMENT**

Clair Craver Johnson,)
Plaintiff,)

v.)

Medical University of South Carolina,)
Defendant.)

Defendants John Roberts, M.D., (Roberts) and Medical University of South Carolina (MUSC) have moved for summary judgment based on Roberts and MUSC's assertion that plaintiff's claims for medical malpractice are time barred by S.C. Code Ann. §15-3-545(A). It is respectfully submitted defendants' motions should be denied on the following grounds:

1. Roberts was a referring physician to MUSC for "Electro Convulsive Therapy (ECT)" in 2003 and continued in that capacity from 2003 through 2008 when plaintiff received ECT.

See, MUSC bate stamp 230, 231, 197, 979, 980, 981, 607, 609, 610, 611, 612, 1983-1986, 2508, 2437-2439, 1968-1969, 1944, 1955, 1956, 1958, 1963, 2799-2802, 1645-1646, 1648, 1652-1654 attached hereto as Exhibit A.

2. Roberts prescribed medication including Wellbutrin for plaintiff when Wellbutrin

Wissner Edward
442 5122 169

contributed to the mania for which plaintiff was being treated by ECT. See attached notes of Wellbutrin prescriptions from Dr. Roberts' notes through 11-09-2005 until MUSC IOP discharge when Dr. Roberts advised discontinuing Wellbutrin secondary to plaintiff's mania, attached hereto as Exhibit B.

3. MUSC treated plaintiff both inpatient and outpatient with ECT from 12-10-2003 through and including 6-26-2008.

The depositions of the plaintiff and a witness, Ana Maia, and expert witnesses, Harold J. Burstztajn, M.D. and Peter Breggin, M.D. provide evidence that plaintiff was so mentally disturbed by the effect of the medical care provided by MUSC and John Roberts, M.D. that it was not until June of 2010 that she could have reasonably have discovered the existence of a claim for medical malpractice.

The time an injured party has to initiate a tort claim against a governmental agency/organization such as MUSC is two (2) years, however, §15-3-40, the controlling statute for action under the Tort Claims Act would by its express term set a five (5) year limit for the commencement of tort actions against the state by a plaintiff who is laboring under a disability other than infancy. See footnote 5, *Harrison v. Bevilacqua*, 354 S.C. 129, 580 S.E.2d 109 (2003). See also §§15-78-110, 15-3-40.

Given this is a medical malpractice action, there is also a six (6) year statute of repose found at §15-3-545 which should be considered.

The deposition testimony and affidavit of Harold J. Burstztajn, M.D., filed in these cases, and the deposition testimony of Peter Breggin, M.D. conclude that the treatment by MUSC and Roberts so impaired plaintiff's cognitive ability that she did not regain the mental capacity to understand and appreciate the harm she suffered as a consequence of the negligence of MUSC

and Roberts until June of 2010. Plaintiff's last ECT was performed on June 26, 2008.

Both Peter Breggin, M.D. (deposition) and Harold J. Burstztajn, M.D. (affidavit filed with the court and deposition) hold opinions that plaintiff by virtue of the negligent treatment of MUSC and Dr. Roberts sustained serious permanent cognitive damage and until June of 2010 was laboring under a disability other than infancy.

Under the applicable statutes an insane patient would have seven (7) years to bring a negligence action under the tort claim act. However, since this negligence action is a medical malpractice action, there appears to be a six (6) year statute of repose which further limits initiation of actions in medical malpractice cases to six years. See, *Kerr v. Richland Memorial Hospital*, 383 SC. 146, 678 S.E.2d 809 (2009).

There is evidence that Roberts and MUSC were continuing to treat plaintiff in a negligent manner at least through December 21, 2006 and likewise there is evidence that the plaintiff remained incompetent until no earlier than June of 2010.

Assuming the accuracy of the above, plaintiff, based on the statute of repose, would have had six (6) years to initiate an action against either of these defendants from the dates of the last of such negligent acts.

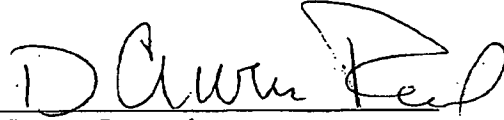
Relying upon medical records, it is reasonable to conclude that plaintiff was last negligently treated by these defendants on or about June 26, 2006, and since she remained incompetent until June of 2010, she would have the six (6) years provided under the statute of repose to initiate an action. This would require initiation of suit by June 26, 2012.

Suit was instituted against MUSC in November of 2011 and an amended complaint was served in May of 2012.

Suit was initiated against John Roberts in April of 2012 and an amended complaint was

filed and served on May 7, 2012.

It is respectfully submitted that the defendants' motion for summary judgment based on the applicable limitation of action provisions including the six (6) year statute of repose should be denied.



D. Cravens Ravenel
BAKER, RAVENEL & BENDER, L.L.P.
3710 Landmark Drive, Suite 400
Post Office Box 8057
Columbia, South Carolina 29202
Phone: (803) 799-9091; Fax (803) 779-3423
cravenel@brblegal.com File No.: 10517.0
Attorneys for Plaintiff

January 8, 2014

Columbia, South Carolina

EXHIBIT A

MUSC Medical Center
INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY
Patient Name: JOHNSON, CLAIR
MRN: 000947758
Patcom: 103308250
Admitted: 12/12/2006
Discharged: 12/21/2006
Service: Psychiatry
Attending: BENJAMIN WEINSTEIN, MD

Referring:

REASON FOR HOSPITALIZATION: Patient is a 40-year-old white female with history of bipolar disorder type 1 who was getting weakly ECT treatments for the past year who was referred by Dr. Fast secondary to increased manic and bizarre behavior. Specifically, she was extremely delusional, disorganized in thought process and endorsed vague suicidal ideation. She was also hypersexual and not making sense.

SIGNIFICANT FINDINGS:

PHYSICAL EXAMINATION: On physical exam, there is 1+ edema on the right ankle and 2+ edema on the left ankle.

LABORATORY DATA: CMP was within normal limits. CBC was within normal limits. TSH is 6.7 and T4 is 0.2, both were normal.

MENTAL STATUS EXAMINATION: Patient was alert and oriented times 4. She appeared well groomed and adequate hygiene. Behavior was irritable with poor eye contact. Speech was slow but normal volume and prosody. Motor movements were tense and agitated. Mood was dysphoric. Affect was labile and congruent. Thought process was disorganized. Thought content included bizarre delusions and positive suicidal ideation but with no plan. She denied any auditory or visual hallucinations. Concentration was distractible. Memory was unable to assess. Insight and judgment were both significantly impaired.

HOSPITAL COURSE: Patient was admitted involuntarily (papers filled out via Charleston County) to 1 North Institute of Psychiatry and placed on suicide, elopement, and violence precautions. Outpatient medications of Geodon was discontinued while () was tapered off completely in the hospital. Patient was also restarted on Synthroid 150 mcg daily, thiamine 100 mg, and Risperdal M-tab 1 mg in the morning and 2 mg at bedtime was initiated. Patient was initially very labile and angry for being in the hospital, threatening a lawsuit. She continued to be disorganized, delusional, and hypersexual; propositioning staff members. Lamictal 25 mg daily was started to target bipolar depression while Topamax 25 mg daily was added for weight control. Patient was very concerned and ruminated over her weight early in hospitalization. Patient underwent 3 ECT treatments while in the hospital and tolerated these well. A forced medication and ECT protocol was obtained by patient's father but patient agreed to all treatments voluntarily. Patient's mood became more euthymic, thought process more linear after these treatments. She remained quiet and isolative on the unit, but pleasant and cooperative with staff. She was much less confused and gained more insight into her condition. Patient's Risperdal was titrated up to 4 mg at bedtime. She received a Consta 37.5 mg IM injection on 12/19 and tolerated all medications without adverse effect. Her next Risperdal Consta shot is due on 01/03 and it will be given by Dr. Fast and his staff during her ECT appointment.

CONDITION ON DISCHARGE: Patient is stable with no SI, HI, or delusions.

DISCHARGE DIAGNOSES: Principal diagnosis: Bipolar type 1.
AXIS I: Bipolar type 1 disorder.

MUSC230 OF 2835

AXIS II: Deferred.
AXIS III: Hypothyroidism.
AXIS IV: Moderate.
AXIS V: Global Assessment of Functioning of 50.

DISCHARGE MEDICATIONS:

1. Risperdal 4 mg p.o. at bedtime times 20 days then stop.
2. Risperdal Consta 37.5 mg IM injection scheduled for 01/03. Patient is to take this medication and syringe to ECT appointment which will be given at that time. Prescription given.
3. Lamotrigine 25 mg by mouth every morning times 6 days, then 50 mg daily times 2 weeks.
4. Topamax 25 mg p.o. every morning.
5. Synthroid 150 mcg by mouth every morning.
6. Thiamine 100 mg p.o. every morning.

FOLLOW-UP APPOINTMENT:

1. Dr. John Roberts in Mount Pleasant. Phone number is 881-0455. Fax number: 881-6878. Appointment date and time: Thursday, 01/04 at 2 p.m.
2. Dr. Fast at the Institute of Psychiatry 5th floor IOP. Appointment date and time: 12/27/2006 at 9:30 a.m. for ECT.

SPECIAL INSTRUCTIONS OR REASONS FOR CONCERNS: Please take all medications as indicated. Make all followup appointments. Please fill all prescriptions as soon as possible. This is especially important for the Risperdal Consta 37.5 mg medication since pharmacies typically have to order this medication in advance and do not have it in stock. Please take the Risperdal Consta 37.5 mg medication with syringe to your ECT appointment with Dr. Fast on 01/03/2007. Staff will administer this injection at this time. Please take Lamictal 25 mg daily for 6 more days. On 12/27/2006 you will be taking a higher dose, 50 mg daily. Dr. Roberts is aware of this medication and will make further adjustments in dosage at future appointments. If you develop a rash, stop taking this medication and call Dr. Roberts as soon as possible. Your next appointment with Dr. Roberts is scheduled for Thursday, 01/04/2007 at 2 p.m. Please stop Lamictal 2 days prior to your ECT treatments. Do not eat or drink after midnight the day before ECT treatments.

ACTIVITY RESTRICTIONS: No restrictions.

SPECIAL FOOD OR MEAL INSTRUCTIONS: Eat 3 meals per day.

SOCIAL WORKER: Betsy Hodges.

Dictated by: Jonathan C. Bosman, MD

Jonathan C. Bosman, MD

BENJAMIN WEINSTEIN, MD
Attending

252309 / 41177 /
JOB: 311298
DD: 12/21/06 06:03 PM

MUSC231 OF 2835

Presenting

CLINICAL INFORMATION

Johnson: becoming manic and disorganized over the week and is needing to come into the hospital and is in a manic state, starting to become delusional and disorganized, needing ECT it looks, per the caller. Pt is well known to Dr Jack Foust (has an appt with him next week) Pt has cut off four inches of her hair, pacing, vague SI, making repeated phone calls to Dr. Roberts office.
Plan: expedite onto 1 North.- Fred

Self-harm Behavior?

☐ Yes ☒ No

Violent History?

☐ Yes ☒ No

height

weight

Any current legal involvement? none

Medications/dose/frequency

Past

Current see discharge summary from last visit

Past Hospitalization, Placements and other interventions

Pt has been to the IOP x5

Outpatient Therapy: Dr. John Roberts-Mt. Pleasant

Present Therapist

Phone

Present Psychiatrist

Phone

Medical Acute hypothyroidism, current "drug rash" or contact dermatitis

Conditions Chronic

Goals/Objectives of Hospitalization

Stabilization and meds mgt

DISCHARGE DISPOSITION Home ☒ Yes Placement Arranged

Other

FOLLOW-UP APPOINTMENT(S)

Date

Time

Therapist

Psychiatrist

Other

05280EE0T

3/4 9961/52/8

81835 KCSH00

85LL46

90/21/21

900000

atient: JOHNSON, CLAIR

MRN: 947758

Encounter: 103308250

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0118

MUSC Medical Center
INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY
Patient Name: JOHNSON, CLAIR
MRN: 000947758
Patcom: 103088142
Admitted: 11/22/2005
Discharged: 11/30/2005
Service: Psychiatry
Attending: Thomas E. Steele, MD

Referring:

Discharged to home with parents.

REASON FOR HOSPITALIZATION: Patient is a 39-year-old white female with history of bipolar affective disorder currently manic who was last hospitalized at the Institute of Psychiatry from 10/13/2005 to 11/01/2005 who was recommitted for agitated, paranoid, and manic behaviors after missing 1 ECT treatment and starting on Wellbutrin, Relpax, and Topamax as an outpatient.

HISTORY OF PRESENT ILLNESS: On admission, this is a 39-year-old white female with BPAD, currently manic, who was last admitted to the IOP on October, that was brought in by Mobile Crisis secondary to agitation, paranoia, and persecutory ideations in the context of her acute mania.

The patient was started with EC treatments with good response during her last IOP hospitalization, and she has continued ECT as an outpatient. Instead of coming to her ECT appointment today she called Dr. Foust in a state of extreme agitation; subsequent to this Mobile Crisis was contacted for assistance. Upon arrival to the unit patient was agitated, labile, and paranoid with loud, pressured speech, and she was very hostile. She denies SI, AVH, or sleep disturbance. The patient's father was contacted and he states that the patient has been rapidly decompensating since 11/17/2005 and he wanted the team to be aware that the patient had been taking Relpax recently for headaches. In addition, the patient's outpatient psychiatrist, Dr. John Roberts, was contacted. Topamax and Wellbutrin were added to the patient's medication regimen since IOP discharge in November. Dr. Roberts advised discontinuing the Wellbutrin secondary to her mania. Patient states that she stopped taking her Risperdal because she believes she does not need it. Patient's information suggests that she has been taking Wellbutrin SR 100 mg q. day, Topamax 25 mg p.o. b.i.d., Relpax, and Synthroid as opposed to her discharge medication list from her most recent hospitalization. No known alcohol or drug abuse, however, in retrospect it was stated from the patient that she had been drinking consistently for 4 days prior to admission and had gotten less sleep than usual. No known history of abuse or trauma. Patient is currently living with her parents. Patient abruptly terminated the initial interview has been mostly uncooperative throughout her admission process. She is scheduled for a ECT tomorrow morning (11/23/2005).

ADMISSION MEDICATIONS: As stated previously:

1. Wellbutrin SR 100 mg p.o. q. day.
2. Relpax, unknown dosage.
3. Topamax 25 mg p.o. b.i.d.
4. Risperdal 2 mg nightly which the patient states she has been noncompliant with.
5. Synthroid 100 mcg p.o. q. day.

PAST MEDICAL HISTORY: Significant for hypothyroidism and migraine headaches. She has had a breast reduction and nipple reconstruction with partial facelift. No history of seizure disorder. Positive history of closed head injury when she was hit with a baseball as a child.

MUSC979 OF 2835

ALLERGIES: Lithium and Haldol.

PAST PSYCHIATRIC HISTORY: Patient has been hospitalized at the Institute of Psychiatry multiple times since 2003 for bipolar disorder and manic episodes. Dr. John Roberts is her outpatient psychiatrist. She has been hospitalized at GWB once. She has had ECT previously with stabilization of her affect and her psychosis. She has had previous medication trials on Geodon, Trileptal, and Ativan.

FAMILY HISTORY: Unable to assess medically or psychiatrically as the patient is adopted and does not know any of her biological family's history.

SOCIAL HISTORY: She is currently living with her parents. She was adopted at the age of 6 months. Per her old records, she is separated from her husband. She completed high school and college. She has not worked since 1997 and it is unknown her financial income. Patient denies any history of alcohol or drug use on admission but was uncooperative and later stated that she did have 4 days of binge drinking prior to admission.

SIGNIFICANT FINDINGS:

LABORATORY RESULTS AND PERTINENT PHYSICAL FINDINGS: Physical exam within normal limits. UDS negative. UA negative. CBC within normal limits. CMP within normal limits except for chloride of 111, decreased total protein and albumin of 3.3. Thyroid function tests within normal limits.

MENTAL STATUS ON ADMISSION: Orientation: Alert and oriented except for to time. Appearance: Well groomed. Dressed appropriately. Appears stated age. Behavior: Uncooperative, irritable. Good eye contact. Speech: Rapid, pressured, normal prosody. Motor: Agitated. Mood: Unable to assess. Affect: Labile. Thought content: Paranoid with persecutory delusions. Thought process: Racing, flight of ideas, tangential. Concentration: Distractible. Memory: Intact except for delayed recall which is 0/3. Insight: Significantly impaired. Judgment: Significantly impaired.

HOSPITAL COURSE: Patient was initially admitted to 1 North and placed on appropriate precautions. She was initially quite guarded, hostile, and grandiose. She refused her Risperdal multiple times but after her 1st ECT treatment on 11/23 she began to comply somewhat with her medication regimen. Her behavior improved, and she was transferred to 3 North where she began to complain of depressed mood. Of note, this is different for her as she is not usually a rapid cyler. She received ECT #2 on 11/28/2005 and tolerated these well. Her mood stabilized and she began to be very compliant with her medications. ECT #3 was done on 11/30/2005. As she will be staying with her parents when receiving outpatient ECT, it was felt that she would be likely more compliant with this after discharge and was found suitable for discharge and sent home on 11/30.

DISCHARGE DIAGNOSES:

AXIS I: Bipolar affective disorder, currently manic; nicotine dependence.

AXIS II: Deferred.

AXIS III: Hypothyroidism, migraine headaches.

AXIS IV: Mild.

AXIS V: 55.

PRINCIPAL DIAGNOSIS: Bipolar affective disorder 1, currently manic.

PATIENT CONDITION ON DISCHARGE: Stable. Denies SI, HI, or AVH.

MUSC980 OF 2835

DISCHARGE MEDICATIONS:

1. Maintenance ECT as scheduled by Dr. Foust.
2. Risperdal 2 mg b.i.d. Prescriptions given.
3. Synthroid 100 mcg p.o. q. day. Prescriptions given.

FOLLOW-UP APPOINTMENT:

1. ECT, Dr. Foust, Institute of Psychiatry 5 North, 792-5734, fax #792-5997. Appointment date and time: 12/08/2005 9:30 a.m.
 2. ~~John Roberts, Mount Pleasant office, 881-0455, fax #881-6878.~~
- Appointment date and time: 12/06/2005 4 p.m.

SOCIAL WORKER: Jessica Rogers, LSIW.

Dictated by: Kari B. Law, MD

Kari B. Law, MD

Thomas E. Steele, MD
Attending

360575 / 38169 /
JOB: 244458
DD: 12/07/05 03:57 PM
YT: 12/08/05 11:34 AM

Additional CC: John Roberts, MD, Mt. Pleasant

Electronically signed by THOMAS STEELE, MD on 01-23-2006

MUSC981 OF 2835

3N

***** MUSC MEDICAL RECORD FACE SHEET *****

Admit Date	10/13/05	Admission Time	19:25
Medical Record #	000947758	Source Code	807
Episode Counter	006	Pat Com. #	103064762
Discharge Date		Patient Sex	F
Race	W	Birth Date	[REDACTED]
Pat. Age at Admit	039	Marital Status	M
Preadmit/Reg by		Adm/Reg by	raj.ipr
Patient Name	*** JOHNSON	CLAIR	
Pat. Address 1	[REDACTED]	Advanced Directive? P	
Patient City	[REDACTED]	AD on File at MUSC? P	
Patient State	[REDACTED]	AD Info Provided? P	
Patient Zip	[REDACTED]		
County Code	10	Vip Code Desc	
Pat. Phone	[REDACTED]	Pat. SSN	[REDACTED]
Fin. Class	NF HMO-MANAGC	Refer. Name	
Employer Name		Pat. Emp. Phone	
Pat. Emp. Addr 1			
Pat. Emp. City			
Pat. Emp. State			
Pat. Emp. ZIP	00000 - D	Room-Bed PH3N P301	Y
Patient Type	Y	Attnd. Doc Name	MCLEOD-BRYANT, STEPHE
Medical Serv	PSY	Admit. Doc Name	MCLEOD-BRYANT, STEPHE
TAR Number		Elig. Det. Date	10/14/05
NOK Last Name	JOHNSON	NOK First Name	JOHN
NOK Relationship	02	NOK Home Phone	(843)849-7796
NOK Bus. Phone		Family Doctor	UNK., DR
Ref. Phys. Name	ROBERTS, JOHN	PCP Doc Name	
Ref. Phys. Phone	(843)881-0455	PCP Doc Phone	
Ref. Phys. Addr1		PCP Address 1	
Ref. Phys. Addr2	222 WEST COLEMAN BLV	PCP Address 2	
Ref. Phys. Addr3	MT PLEASANT SC 29464	PCP Address 3	
Ref. Phys. Addr4		PCP Address 4	
Ref. Facility		E/R Referral	
Complaint	BPAD		
Procedure	PSY-EVAL		
Primary Ins.Co.	CI15	Secondary Ins.Co	
Principal Diagnosis		Code Number	

Secondary Diagnosis

Operation or Special Procedures

Attending

Date

Discharge Summary:

[] Date Dictated

Job #

Beeper #

OP Note:

[] Date Dictated

Job #

Beeper #

Patient: JOHNSON, CLAIR

MRN: 947758

Encounter: 103064762

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101305



MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

TOPDCSUM

Institute of Psychiatry, Adult Division
67 President St., P.O. Box 250881, Charleston, SC 29425
(843-792-8888)

DISCHARGE SUMMARY

Page 1 of 2

Form Origination Date: 1/00
Version: 2

Version Date: 1/04

94775
JOHNSON CLAIR
W/F
103064762

10/13/05

Patient Name
MRN

STAMP PLATE AREA

Clinical Information for Referring and Follow-up Agencies

Patient Name: Clare Johnson
Date of Birth: 10/13/05
Medical Record Number: 947758
Admission Date: 10/13/05
Discharge Date: 11/1/05

Attending Psychiatrist: Dr. Stephen Medford Bryant
Discharged To: Home - Parents
Address: _____
Phone: _____

REASON FOR ADMISSION: Ms. Johnson is a 39 y/o W/F E BPAD I admitted in a manic phase, referred from her outpatient psychiatrist, John Roberts in Mt. Pleasant. She was delusional, believing pharmacists were poisoning her, & disorganized thinking in the setting of medication non-compliance.

ADMISSION EVALUATION AND LABORATORIES:

Mental Status on Admission: Orientation _____ Appearance/Behavior In scrubs, comp.
Speech/Motor pressured, normal Mood/Affect Irritable/Anxious
Thought content and process AD, delusions of reference, LPA, disorganized
Concentration/Memory Distractible/Impaired Insight/Judgment sig. impaired
Laboratory Results and Pertinent Physical Findings: comp wnl, TFT's wnl, CBT 2.3% (set 1) 17
CAC wnl UDS neg U/A

HOSPITAL COURSE:

Ms. Johnson was admitted to 3N in a manic phase of her illness. Initially she was delusional, refusing medications and resistant to any treatment. She was believed that she would not possess the capacity to consent or refuse treatment. We gained alternative consent for ECT from her parents.

She received a total of six ECT treatments & outstanding results. Over the course of ECT, her affect stabilized, her sleep improved, she became more organized, her delusions and less delusional. We discontinued the prospect of maintenance ECT. Ms. Johnson, her parents, and her outpatient psychiatrist, Dr. Roberts. It was agreed by all that outpatient maintenance ECT would be an excellent option for her.

Also, Responded drug po she was started on this admission for psychosis. She tolerates w/psychosis. It was well tolerated & will be used as an outpt.

DISCHARGE DIAGNOSIS: BPAD I - manic
Axis I: BPAD I - manic
Axis II: schizophrenia
Axis III: hypothyroidism, myopia
Axis IV: poor social support
Axis V: 165

SAFD (provisional)

Attending Psychiatrist: Stephen Medford Bryant
lopadulide

Pager ID: 1407

Date/Time: 11/1/05
OTE 700963 Rev 1/04

Patient: JOHNSON, CLAIR

MRN: 947758

Encounter: 103064762

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101305

N 947750
JOHNSON

CLAIR

12/13/05

103064762

**MUSC**
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

OPDCSUM

Institute of Psychiatry, Adult Division
67 President St., P.O. Box 250861, Charleston, SC 29425
(843-792-9888)**DISCHARGE SUMMARY**

Page 2 of 2

Form Origination Date: 1/00
Version: 2

Version Date: 1/04

Patient Name
MRN

STAMP PLATE AREA

Patient, Family and Caregiver Information**MEDICINES** - It is VERY important that all medicines be taken as prescribed. Ask your outpatient doctor or pharmacist if there are any questions about the medicines.

Medicine	Reason for Medicine	Instructions for Taking Medicine	Prescriptions Given	Samples Given
Risperdal	thinking	2mg by mouth at bedtime	☒ Y ☐ N	☐ Y ☐ N
Synthroid	thyroid	100 micrograms by mouth daily	☒ Y ☐ N	☐ Y ☐ N
			☐ Y ☐ N	☐ Y ☐ N
			☐ Y ☐ N	☐ Y ☐ N
			☐ Y ☐ N	☐ Y ☐ N
			☐ Y ☐ N	☐ Y ☐ N

FOLLOW-UP APPOINTMENTS and OTHER AGENCIES WORKING WITH THE PATIENT - It is important that all follow-up appointments be kept. If you cannot keep an appointment at the time scheduled, please call the provider to re-schedule. For questions and issues following discharge, please contact your community care provider.

A*	Name/Agency	Address	Phone Number	Fax Number	Appointment Date and Time
	ECT@MUSC	67 President St.	843 725-5774		11/7/05, MON 9 AM
	Dr. Roberts		843 881-0455	843 881-6878	11/9/05, WED 4 PM
	Primary Care Physician				

A* - Checkmark in column indicates Authorization to Disclose Protected Health Information has been signed for release to this provider/agency.

A copy of the Discharge Summary is to be faxed sent to each of the Providers/Agencies checked above.

Special Instructions or Reason(s) for Concern: Please take all medications as prescribed and attend all follow up appointments as scheduledActivity Restrictions: as toleratedSpecial Food or Meal Instructions: Regular dietAttending Psychiatrist: S. Robert Pappert, MD

Resident/Fellow Psychiatrist: _____

Social Worker: _____

Discharge Date: 11/11/05Inpatient Unit: 3A

lopdu/dlc

OTE 700063 Rev. 1/04

Patient: JOHNSON, CLAIR

MRN: 947758

Encounter: 103064762

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0124

MUSC Medical Center
INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY
Patient Name: JOHNSON, CLAIR
MRN: 000947758
Patcom: 103064762
Admitted: 10/13/2005
Discharged: 11/01/2005
Service: PSYCHIATRY 3 NORTH
Attending: STEPHEN A MCLEOD-BRYANT, MD

Referring:

CHIEF COMPLAINT: Delusions, disorganization.

ADMITTING DIAGNOSES:

AXIS I: Bipolar disorder.

AXIS II: Deferred.

AXIS III: Hypothyroidism, migraines.

REASON FOR HOSPITALIZATION: Ms. Johnson is a 39-year-old white female with a history of bipolar disorder type 1 who was admitted in a manic phase. She was referred from her outpatient psychiatrist, Dr. John Roberts, in Mount Pleasant. She was delusional believing pharmacies were poisoning her, and displayed disorganized thinking in the setting of her medication noncompliance.

PAST MEDICAL HISTORY: Surgeries: Breast reduction. Illnesses: Hypothyroidism, migraines.

MEDICATIONS:

1. Geodon 60 b.i.d.
2. Trileptal 300 b.i.d.
3. Ativan 1 t.i.d.

ALLERGIES: Lithium, Haldol.

PAST PSYCHIATRIC HISTORY: Multiple admissions to the IOP and GWB. Outpatient psychiatrist is Dr. John Roberts.

SOCIAL HISTORY: Lives alone.

MENTAL STATUS EXAMINATION ON ADMISSION IS AS FOLLOWS: Oriented x2. Appearance: In scrubs. Behavior: Cooperative. Speech: Pressured. Motor: Normal. Mood: Irritable. Affect: Blunted. Thought content and process: Auditory hallucinations, delusions of reference. Loose associations. Disorganization. Concentration: Distractible. Memory: Impaired. Insight: Significantly impaired. Judgment: Significantly impaired.

HOSPITAL COURSE: On admission, the patient was placed on appropriate precautions. She was admitted to 3 North in a manic phase of her illness. Initially, she was belligerent, refusing medication and resistance to any sort of treatment. It was felt that she did not possess the capacity to consent or refuse treatment, so alternative consent for ECT was obtained from her parents. They were advised of the risks and benefits of the procedure. She received a total of 6 ECT treatments with an improvement in her symptoms. Over the course of her ECT, her affect stabilized, her sleep improved, she began more organized, less grandiose, and less delusional. The prospect of maintenance ECT was discussed with Ms. Johnson, her parents, and her outpatient psychiatrist, Dr. Roberts. It was agreed by all that outpatient maintenance ECT would be an excellent option for her. In addition, Risperdal 2 mg PO nightly was started at this admission for her psychosis. She tolerated it well, and it will be continued as an

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outpatient. At discharge, she denied any SI, HI or AVH.

DISCHARGE DIAGNOSES:

AXIS I: Schizoaffective disorder.

AXIS II: Deferred.

AXIS III: Hypothyroidism, migraines.

AXIS IV: Fair.

AXIS V: Global Assessment of Functioning 65.

DISCHARGE MEDICATIONS:

1. Risperdal 10 mg nightly.

2. Synthroid 100 mcg daily.

Patient was given a prescription for her Risperdal and Synthroid.

DISPOSITION: To home.

~~DISCHARGE PLAN:~~ Follow up with ECT maintenance at MUSC, 67 President St, Charleston, SC, 29425. Phone number 792-5734. Next appointment 11/07/2005, Monday, at 9 a.m. Follow up with Dr. Roberts at phone number 843-881-0455, fax number 843-881-6878, on 11/09/2005 at 4 p.m.

SPECIAL INSTRUCTIONS: Please take all medications as prescribed and attend all followup appointments as scheduled. Do not use drugs or alcohol. Return to the ER if you feel suicidal or homicidal. Activity is as tolerated. Diet: Regular.

Dictated by: Rabiya K. Hasan, MD

Rabiya K. Hasan, MD

STEPHEN A MCLEOD-BRYANT, MD
Attending

856733 / 32320 /

JOB: 241661

DD: 11/20/05 10:43 PM

DT: 11/21/05 11:01 AM

Additional CC: _____

MUSC612 OF 2835

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
Institute of Psychiatry
(843) 792-9888

67 President Street
PO Box 250861
Charleston, SC 29403-5712

INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY

Patient Name: JOHNSON, CLAIR
MRN: 000947758
Patcom: 102684891
Admitted: 11/26/2003
Discharged: 12/23/2003
Service: Institute of Psychiatry
Attending: STEPHEN A MCLEOD-BRYANT, MD

Referring:

DISCHARGE DIAGNOSES:

NE, SMB 11/9/04
AXIS I: Bipolar 1, mixed/manic episode with psychosis. This is the primary diagnosis.
AXIS II: Deferred.
AXIS III: Hypothyroidism.
AXIS IV: Marital difficulties.
AXIS V: Less than 30 on admission. Global assessment of function 45-50 at discharge.

REASON FOR ADMISSION: Clair Johnson is a 37-year-old white female with an 18-year history of bipolar 1 disorder with frequent manic and depressive episodes. The patient has been in psychiatric hospitalization 3 of the past 6 months prior to presenting with symptoms of usual episode that are consistent with mania, grandiosity, psychosis and threat of harm to self or others. The patient was readmitted to the Institute of Psychiatry 11/26/03 after threatening her caseworker and showing evidence of increasing grandiosity, paranoia and irritability. Order for detention was placed by parents.

(She was initially hospitalized at GUB - transferred to IOP 11/24/03 on request of parents) SMB 11/9/04
PAST PSYCHIATRIC HISTORY: As mentioned above, the patient has had several inpatient hospitalizations, most recently at the Medical University of South Carolina Institute of Psychiatry 09/03. The patient has also been at G. Weber Bryan and other inpatient hospitalizations. She has a long history of medical noncompliance.

ADMISSION MEDICATIONS: Trileptal 600 mg p.o. b.i.d., Topamax 250 mg p.o. q.h.s., Wellbutrin 100 mg p.o. q.a.m., Synthroid 50 mcg p.o.

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Institute of Psychiatry
(843) 792-9888

67 President Street
PO Box 250861
Charleston, SC 29403-5712

INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY

MRN: 000947758

PATIENT: JOHNSON, CLAIR

q.a.m., and Vioxx 12.5 mg p.o. q. day p.r.n. for pain.

PAST MEDICAL HISTORY: Significant for hypothyroidism. Surgeries include breast reduction.

FAMILY HISTORY: The patient is adopted.

ALLERGIES: No known drug allergies.

EXAMINATION ON ADMISSION: Temperature 97.4, pulse 76, blood pressure 115/69, respirations 18. Height 5 feet 4 inches. Weight 123 pounds. Physical and neurologic exam were unremarkable.

MENTAL STATUS EXAMINATION: The patient was unkempt, uncooperative, defensive, with poor eye contact. She was irritable. Her motor activity was normal. Her speech was loud. Her mood was irritable and anxious. Her affect was blunted. The patient denied auditory or visual hallucinations. Her thought process is illogical and disorganized. Her thought content is characterized by paranoia and grandiosity. She is alert and oriented x3. Insight and judgment are both significantly impaired at the time of admission.

No lab data was obtained at admission.

PROCEDURES AND TREATMENT RENDERED: A thorough review of the patient's psychiatric history revealed that over the past year she had become increasingly psychotic, with rapid cycling, which had become more resistant to treatment with medication. In addition, the patient has a long history of medication noncompliance. After review of patient's outside medical record and additional consultation with her outside psychiatrist, Dr. John Roberts, of Mt. Pleasant, and consultation with our inpatient ECT attending, Dr. Milton Pouet, an ECT consult was placed, the workup of which was without significant contraindication for electroconvulsive therapy treatment. Although the patient refused ECT treatment prior to initiation, it was decided that

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INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY

MRN: 000947758

PATIENT: JOHNSON, CLAIR

electroconvulsive therapy represented her best current hope for stabilization. To this end, proxy consent was obtained from the patient's husband and parents, and a course of 5 ECT treatments was administered, after which a marked improvement in patient's affective and psychotic symptoms was noted. At the time of discharge, the patient still had some residual effects from the ECTs, such as affective flattening, mild memory and concentration deficits, but was significantly stable at the time of discharge.

PATIENTS CONDITION ON DISCHARGE: Stable.

ACTIVITY RESTRICTIONS: None.

FOOD AND MEAL RESTRICTIONS: None.

SPECIFIC INSTRUCTIONS: Take all medications as prescribed. Attend all followup appointments as scheduled.

DISCHARGE MEDICATIONS:

1. Topamax 100 mg p.o. b.i.d.
2. Trileptal 600 mg p.o. b.i.d.
3. Synthroid 25 mcg q. day.
4. Vicxx 12.5 mg p.o. q. day.
5. Ortho Tri-Cyclen 1 p.o. q. day.

FOLLOW-UP APPOINTMENT: Follow up with Dr. John Roberts in Mt. Pleasant Monday, 12/29/03 at 4 p.m. In addition, the patient will be seen by Dr. Jim Ballenger on 01/12/04 for a second opinion consultation.

Dictated by: Richard L. Holt, MD

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
Institute of Psychiatry
(843) 792-9888

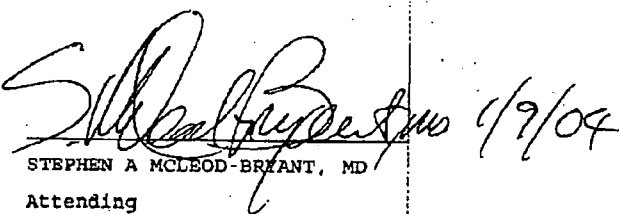
67 President Street
PO Box 250861
Charleston, SC 29403-5712

INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY

MRN: 000947758

PATIENT: JOHNSON, CLAIR

Richard L. Holt, MD


STEPHEN A MCLEOD-BRYANT, MD

Attending

407871 / 33265 /

JOB: 110560

DD: 12/23/03 02:24 PM

DT: 12/24/03 10:53 AM

cc: John Roberts, MD

881-6878

Additional CC:

For more information, call the Institute of Psychiatry at (843) 792-9888

CLINICAL INFORMATION

Presenting

Johnson: 37 year old white female suffering from BPAD presents at hospital in Rock Hill this morning, caller wants to be able to transfer pt to MUSC IOP 1 North. Pt is c/o irritable, delusional, non compliant with meds, pressured speech, flight of ideas, disorganized thoughts, difficult to redirect. Pt is refusing meds (geodon, topomax). Pt feels that nothing is wrong with her, paranoid. Dr Roberts is the outpt psychiatrist. Pt had a hearing this morning and is being court ordered to be sent here. Dr Roberts and Dr Malcolm want to be involved with the pt's care. Pt's sleep is decreased, appetite varies, somatic, complaints of head and back aches. Pt has a UTI and anti-biotics have been started. Pt is also on Synthroid (hyperthyroidism). Plan: admit pt to 1 North. - Fred

Self-harm Behavior?

☐ Yes ☒ No

Violent History?

☐ Yes ☒ No

height

weight

Any current legal involvement? none

Medications/dose/frequency

Past Geodon 60mg bid, Topomax 100mg am and 200mg hs, Ativan 1mg am and 2mg hs, Ambien 10mg hs
Current pm, Synthroid 0.05mg am, Levaquin 500mg qd, Docolax 1-2 tabs, Geodon 20mg IM for extreme agitation

Past Hospitalization, Placements and other interventions

Outpatient Therapy Dr Valite

Present Therapist

Present Psychiatrist

Phone

Phone

Medical Acute

Conditions Chronic none; Allergy to Lithium and Haldol

Goals/Objectives of Hospitalization

Stabilization and meds mgt

DISCHARGE DISPOSITION Home ☒ Yes Placement Arranged
Other

FOLLOW-UP APPOINTMENT(S)

Therapist Dr Valite

Psychiatrist

Other

Date

Time

MUSC2508 OF 2835

EDICAL UNIVERSITY HOSPITAL AUTHORITY
Institute of Psychiatry
(843) 792-9888

67 President Street
PO Box 250861
Charleston, SC 29403-5712

INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY

Patient Name: JOHNSON, CLAIR
MRN: 000947758
Patcom: 102650777
Admitted: 09/24/2003
Discharged: 10/21/2003
Service: Psychiatry 1 North IOP
Attending: Stephen A. Mcleod-Bryant, MD

Referring:

DISCHARGE DIAGNOSES:

AXIS I: Bipolar disorder, *Manic with psychotic features sub 10/29/03*
AXIS II: Deferred.
AXIS III: Hypothyroidism. *Recently treated urinary tract infection, reported w/o*
AXIS IV: Moderate. *closed head injury as youth.*
XIS V: Global assessment of function equals 50. *sub 10/29*

REASON FOR ADMISSION: The patient is a 37-year-old white female with a history of bipolar disorder, committed to IOP 1 North because she was unable to care for herself. She became delusional and noncompliant with medications. The patient was referred from a hospital in Rock Hill where she was visiting friends. The patient *was NE, sub 10/29* became paranoid and grandiose at admission with flight of ideas and pressured speech. She denied suicidal ideation or homicidal ideation on admission.

SIGNIFICANT RESULTS:

LABORATORIES: UDS negative. Urinalysis: pH was high at 7.5. Also, few bacteria present. Otherwise, UA was normal. CBC: Hematocrit was low at 35.6, otherwise normal. LFTs were normal. TSH, free T4 and triiodothyronine all normal. Basic metabolic panel drawn on 09/29/03, 10/08/03, 10/14/03, and 10/17/03: Bicarb was low at 20-21 in 3 of 4 tests. Otherwise, BMPs were normal.

MENTAL STATUS ON ADMISSION: The patient was unkempt, cooperative. Motor normal. Speech: Monotone and pressured. Mood: Irritable. Affect: Blunted. Thought content: Grandiose, bizarre, persecutory and paranoid. Thought process is illogical, disorganized.

EDICAL UNIVERSITY HOSPITAL AUTHORITY
Institute of Psychiatry
(843) 792-9888

67 President Street
PO Box 250861
Charleston, SC 29403-5712

INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY

MRN: 000947758

PATIENT: JOHNSON, CLAIR

Concentration: Distractible. Insight and judgment were poor.

PROCEDURES AND TREATMENT RENDERED: Ms. Johnson was initially hostile, demanding and entitled on the unit. She was agitated and uncooperative with staff and peers, with pressured speech and irritable mood. She repeatedly demanded Wellbutrin and Concerta and stated that she was "Pfizer, Johnson & Johnson, and Glaxo." She was started on Geodon and Ativan but repeatedly refused to take Geodon. On 10/08/03, after independent evaluations by attending physicians outside the treatment team (Drs. Myrick and Farrar), she was placed on a forced medication protocol with p.o. Abilify 15 mg q.d. and IM Geodon 20 mg if she refused p.o. Abilify. In addition, she was titrated to 600 mg p.o. b.i.d. of Trileptal and Topamax 100 mg p.o. i.a.m., 150 mg p.o. q.h.s. The patient was compliant with Abilify, Trileptal, and Topamax, and gradually exhibited less irritability and less disorganized thoughts. Her persecutorial delusions persisted but became less pronounced and bizarre with time. Her Ativan was reduced to p.r.n. status by discharge. At discharge, the patient denied suicidal ideation, homicidal ideation, auditory or visual hallucinations, and contracts for safety. She will follow up with Dr. John Roberts on 10/21/03.

PATIENTS CONDITION ON DISCHARGE: Stable.

DISCHARGE MEDICATIONS:

1. Abilify 15 mg p.o. q.d.
2. Trileptal 600 mg p.o. b.i.d.
3. Topamax 100 mg p.o. q.a.m., 150 mg p.o. q.h.s.
4. Ativan 2 mg p.o. q.h.s. p.r.n. insomnia.
5. Levothyroxine 0.05 mg q.a.m.
6. Ethinyl estradiol and norgestimate 1 tablet q.d.

FOLLOW-UP-APPOINTMENT: Dr. John Roberts. The phone number is 881-0455, fax number is 881-6878. Appointment date and time is 10/21/03 at 5 p.m.

EDICAL UNIVERSITY HOSPITAL AUTHORITY
Institute of Psychiatry
(843) 792-9888

67 President Street
PO Box 250861
Charleston, SC 29403-5712

INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY

MRN: 000947758

PATIENT: JOHNSON, CLAIR

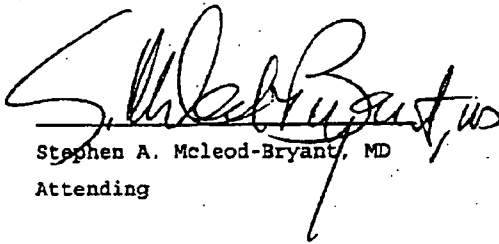
No activity restrictions. No food and meal instructions. No special instructions. The social worker is Betsy Hodges. Her number is 792-0100.

ADD: Parents and spouse expressed frustration with recent inability to get Ms. Johnson to adhere to treatment plan for long enough time to significantly recover. The potential role of health care provider & attorney was discussed with them.

Dictated by: Bryan K. Tolliver, MD

ZMB
10/2/03

Bryan K. Tolliver, MD


Stephen A. McLeod-Bryant, MD
Attending

979466 / 33265 /

JOB: 98549

DD: 10/21/03 04:42 PM

DT: 10/22/03 01:24 PM

cc: John M. Roberts, MD

881-6878

Additional CC:

For more information, call the Institute of Psychiatry at (843) 792-9888

  *IOPNOTE* Institute of Psychiatry GENERAL ATTENDING NOTE Page 1 of 2	STAMP PLATE AREA Patient Name <u>Johnson, Clair</u> MRN _____

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed

Condition ☐ Unstable ☒ Stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)

Patient secluded/restrained in past 24 hours ☐ Yes ☒ No

Chief Complaint _____

PI/EXAM Slept 3-0-3 hours and ate 50 % based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note, Temperature _____ Weight _____)

Blood pressure _____ Heart rate _____ Respiratory rate _____

☐ Orthostatic vital signs Sitting blood pressure _____ Sitting heart rate _____

Standing blood pressure _____ Standing heart rate _____

Narrative Description

Irritable, demanding, and delusional about getting

subliminal messages. Requiring prns for agitation.

Less argumentative this morning. C/O dry mouth and

increased appetite.

Appearance/Activity alert agitated

Speech hyperverbal

Mood/Affect irritable labile

Thought paranoid delusional

Cognition/Memory intact

Judgement/Insight poor/poor

Gait steady Tone normal

SOCIAL _____

TESTING Optic discs flat, no change in HA pattern since 2002 SCIMAP positive - , negative -

Radiology/Other MRI 2002 Baptist Hospital Columbia

DIAGNOSES/PLAN BPAD Manic PSA - long remission

Topamax 50mg bid

Seroquel 100mg qhs, repeat X1 if needed and not orthostatic

Pt is unable to participate in tx planning due to her agitation and psychosis. Will

pursue alternative consent from family for ECT and medications

ECT #1 yesterday 16sec EEG sz, ECT #2 in AM

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal

☐ obtain further information/medical records ☐ family meeting

Medical Diagnoses/Complications Migraine, hypothyroid, macular degeneration, heart murmur (Echo 2002 prior to last tx)

no complications

Consult considerations ECT

REASON FOR CONTINUED STAY stabilization of mania

stabilization of psychosis

Discharge planning _____ John Roberts (Mt. Pleasant)

Other _____ Floor time _____

Rendering Physician Signature [Signature] Pager ID 14488 Date 04/05/2005 Time _____ AM/PM

opattprognote Ben Weinstein, MD OTE 804239 Rev 7/03

  *IOPNOTE* Institute of Psychiatry GENERAL ATTENDING NOTE Page 1 of 2	STAMP PLATE AREA Patient Name <u>Johnson, Clair</u> MRN: _____

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
 Condition ☐ Unstable ☒ Stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
 Patient secluded/restrained in past 24 hours ☐ Yes ☒ No

Chief Complaint _____
 P/E/EXAM Slept 2 hours and ate 100 % based on unit staff report
☒ Vital signs reviewed as recorded in medical record (of note, Temperature _____
 Blood pressure _____ Heart rate _____ Respiratory rate _____ Weight _____
☐ Orthostatic vital signs _____ Sitting blood pressure _____ Sitting heart rate _____
 Standing blood pressure _____ Standing heart rate _____

Narrative Description <u>Hx ECT for mania responded after 5 Tx. Irritable,</u> <u>grandiose, paranoid, disorganized. Getting subliminal</u> <u>messages about her eyes.</u>	Appearance/Activity <u>alert</u> <u>afraid</u> Speech <u>hyperverbal</u> Mood/Affect <u>irritable</u> <u>labile</u> Thought <u>paranoid</u> <u>delusional</u> Cognition/Memory <u>intact</u> Judgement/Insight <u>poor/poor</u> Gait <u>steady</u> Tone <u>normal</u>

SOCIAL _____
 TESTING Optic discs flat, no change in HA pattern since 2002 SCIMAP positive, negative
 Radiology/Other MRI 2002 Baptist Hospital Columbia
 DIAGNOSES/PLAN BPAD Manic PSA - long remission
Topamax 100mg bid
Zyprexa 20mg qhs
Pt is unable to participate in tx planning due to her agitation and psychosis. Will
pursue alternative consent from family for ECT and medications
ECT #1 today

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
 Medical Diagnoses/Complications Migraine, hypothyroid, macular degeneration, heart murmur (Echo 2002 prior to last tx)
no complications

Consult considerations ECT
 REASON FOR CONTINUED STAY stabilization of mania
stabilization of psychosis

Discharge planning John Roberts (Mt. Pleasant) Floor time _____
 Other _____

Rendering Physician Signature [Signature] Pager ID 14488 Date 04/04/2005 Time AM/PM
 IOPNOTE Ben Weinstein, MD OTE 604239 Rev 7/03

Patient: JOHNSON, CLAIR

MRN: 947758

Encounter: 102952868

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MUSC1969 OF 2835

  *IOPNOTE* Institute of Psychiatry GENERAL ATTENDING NOTE Page 1 of 2	STAMP PLATE AREA Patient Name <u>Johnson, Clair</u> MRN _____

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
 Condition: ☐ Unstable ☒ Stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
 Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No

Chief Complaint: _____

PI/EXAM: Slept 7 hours and ate 100 % based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note, Temperature _____
 Blood pressure _____ Heart rate _____ Respiratory rate _____ Weight _____)

☐ Orthostatic vital signs: Sitting blood pressure _____ Sitting heart rate _____
 Standing blood pressure _____ Standing heart rate _____

Narrative Description <u>Pt is irritable, irrational, intrusive, demanding and</u> <u>entitled. Had episode of hand cramps last PM. No</u> <u>violence.</u>	Appearance/Activity <u>alert</u> <u>agitated</u> Speech <u>hyperverbal</u> Mood/Affect <u>irritable</u> <u>constricted</u> Thought <u>paranoid</u> <u>delusional</u> Cognition/Memory <u>intact</u> Judgement/Insight <u>poor/poor</u>

SOCIAL: _____ Gait: steady Tone: normal

TESTING: Optic discs flat, no change in HA pattern since 2002 SCMAP: positive, negative

Radiology/Other: MRI 2002 Baptist Hospital Columbia

DIAGNOSES/PLAN: BPAD Manic PSA - long remission

Topamax 50mg bid
Seroquel 100mg qhs prn, repeat X1 if needed and not orthostatic
Pt is unable to participate in tx planning due to her agitation and psychosis. Will
pursue alternative consent from family for ECT and medications.
ECT #2 today

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting

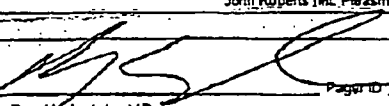
Medical Diagnoses/Complications: Migraine, hypothyroid, macular degeneration, heart murmur (Echo 2002 prior to last tx)
no complications

Consult considerations: ECT

REASON FOR CONTINUED STAY: stabilization of mania
stabilization of psychosis

Discharge planning: John Roberts (Mt. Pleasant)

Other: _____ Floor time: _____

Rendering Physician Signature:  _____
 Copat/prognosis: Ben Weinstein, MD

  "IOPNOTE" Institute of Psychiatry GENERAL ATTENDING NOTE Page 1 of 2	STAMP PLATE AREA Patient Name <u>Johnson, Clair</u> MRN _____

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
 Condition: ☐ Unstable ☒ Stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
 Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No

Chief Complaint: _____
 P/EXAM: Slept 5 hours and ate 60 % based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note, Temperature _____
 Blood pressure _____ Heart rate _____ Respiratory rate _____ Weight _____)
☐ Orthostatic vital signs: Sitting blood pressure _____ Sitting heart rate _____
 Standing blood pressure _____ Standing heart rate _____

Narrative Description <u>Pt is grandiose, delusional, and entitled. She believes that she is FDR's grand-daughter and that she has macular degeneration. Pt is somewhat less agitated. Frequent MNA. Parents have confirmed agreement with forced ECT.</u>	Appearance/Activity <u>alert</u> <u>anxious</u> Speech <u>hyperverbal</u> Mood/Affect <u>elevated</u> <u>congruent</u> Thought <u>grandiose delusions</u> <u>-SI -HI -AH</u> Cognition/Memory <u>intact</u> Judgement/Insight <u>poor/poor</u> Gait: <u>steady</u> Tone: <u>normal</u>

SOCIAL: _____
 TESTING: _____ SCIMAP: positive negative

Radiology/Other: _____
 DIAGNOSES/PLAN: BPAD Manic PSA - long remission

Topamax 100mg bid
Zyprexa 10/15 mg
Pt is unable to participate in tx planning due to her agitation and psychosis.
Husband and parents have consented for forced ECT and medications.
ECT #3 today

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
 Medical Diagnoses/Complications: Migraine, hypothyroid, macular degeneration, heart murmur (Echo 2002 prior to test tx)
no complications

Consult considerations: ECT
 REASON FOR CONTINUED STAY: stabilization of mania
stabilization of psychosis

Discharge planning: John Roberts (Mr. Pleasant)
 Other: _____ Floor time: _____
 Rendering Physician Signature: [Signature] Page ID 14488 Date 04/12/2005 Time _____ AM/PM
 lopattprognosis Ben Weinstein, MD OTE 804239 Rev. 7/03

  "IOPNOTE" Institute of Psychiatry GENERAL ATTENDING NOTE Page 1 of 2	STAMP PLATE AREA Patient Name <u>Johnson, Clair</u> MRN _____

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
 Condition: ☐ Unstable ☒ Stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
 Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No

Chief Complaint: _____
 PI/EXAM: Slept 7 hours and ate 80 % based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note, Temperature _____
 Blood pressure _____ Heart rate _____ Respiratory rate _____ Weight _____)

☐ Orthostatic vital signs: Sitting blood pressure _____ Sitting heart rate _____
 Standing blood pressure _____ Standing heart rate _____

Narrative Description <u>Sleep improved. Irritable this am. Paranoid about</u> <u>being a "guinea pig." Accused medical student of</u> <u>posing as a patient. c/o medications causing weight</u> <u>gain. Parents have confirmed agreement with forced</u> <u>ECT.</u>	Appearance/Activity <u>alert</u> <u>anxious</u> Speech <u>hyperverbal</u> Mood/Affect <u>elevated</u> <u>congruent</u> Thought <u>grandiose delusions</u> <u>-SI -HI -AH</u> Cognition/Memory <u>intact</u> Judgement/Insight <u>poor/poor</u> Gait: <u>steady</u> Tone: <u>normal</u>

SOCIAL: _____

TESTING: _____ SCIMAP: positive / negative

Radiology/Other: _____

DIAGNOSES/PLAN: BPD Manic PSA - long remission EDNOS

Topamax 100mg bid
Zyprexa 10/15 mg. consider Risperdal/Geodon
Pt is unable to participate in tx planning due to her agitation and psychosis.
Husband and parents have consented for forced ECT and medications.
ECT #4 tomorrow

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting

Medical Diagnoses/Complications: Migraine, hypothyroid, macular degeneration, heart murmur (Echo 2002 prior to last tx)
no complications

Consult considerations: ECT

REASON FOR CONTINUED STAY: stabilization of mania
stabilization of psychosis

Discharge planning: John Robbins MD (Parent)

Other: _____ Floor time: _____

Rendering Physician Signature: [Signature] Page ID 14488 Date 04/13/2005 Time _____ AM/PM
 IOP/PROG/NO: Ben Weinstein, MD OTE 804239 Rev. 7/03

  *IOPNOTE* Institute of Psychiatry GENERAL ATTENDING NOTE Page 1 of 2	STAMP PLATE AREA Patient Name <u>Johnson, Clair</u> MRN <u>947758</u>

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
 Condition: ☐ Unstable ☒ Stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
 Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No

Chief Complaint: _____
 P/E/EXAM: Slept 4+ hours and ate 60 % based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note, Temperature _____
 Blood pressure _____ Heart rate _____ Respiratory rate _____ Weight _____)

☐ Orthostatic vital signs: Sitting blood pressure _____ Sitting heart rate _____
 Standing blood pressure _____ Standing heart rate _____

Narrative Description <u>Sleep improved. Isolating in her room. Delusional -</u> <u>believes that there are webcams in her house spying</u> <u>on her and that her computer speaks Portuguese.</u> <u>Believes that a Pathologist has been giving her sugar</u> <u>pills. Continues to demand discharge.</u>	Appearance/Activity <u>alert</u> <u>anxious</u> Speech <u>hyperverbal</u> Mood/Affect <u>elevated</u> <u>congruent</u> Thought <u>grandiose delusions</u> <u>-SI +HI -AH</u> Cognition/Memory <u>intact</u> Judgement/Insight <u>poor/poor</u> Gait: <u>steady</u> Tone: <u>normal</u>

SOCIAL: _____
 TESTING: _____ SCIMAP: positive, negative

Radiology/Other: _____
 DIAGNOSES/PLAN: BPAD Manic PSA - long remission EDD NOS

Topamax 100mg bid
Geodon 80mg bid
PT is unable to participate in tx planning due to her agitation and psychosis.
Husband and parents have consented for forced ECT and medications.
ECT #5 today

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
 Medical Diagnoses/Complications: Migraine, hypothyroid, macular degeneration, heart murmur (Echo 2002 prior to last tx)
no complications

Consult considerations: ECT

REASON FOR CONTINUED STAY: stabilization of mania
stabilization of psychosis

Discharge planning: John Roberts (ML Pleasant)

Other: _____ Floor time: _____

Rendering Physician Signature  Pager ID 10488 Date 04/15/2005 Time _____ AM/PM
 Topattprognole Ben Weinstein, MD OTE 804239 Rev. 7/03

Patient: JOHNSON, CLAIR

MRN: 947758

Encounter: 102952868

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MUSC1958 OF 2835

  *IOPNOTE* Institute of Psychiatry GENERAL ATTENDING NOTE Page 1 of 2	STAMP PLATE AREA Patient Name <u>Johnson, Clair</u> MRN <u>947758</u>

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed

Condition: ☐ Unstable ☒ Stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)

Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No

Chief Complaint: _____

PI/EXAM: Slept 7 hours and ate 90 % based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note, Temperature _____ Weight _____)

Blood pressure _____ Heart rate _____ Respiratory rate _____

☐ Orthostatic vital signs: Sitting blood pressure _____ Sitting heart rate _____

Standing blood pressure _____ Standing heart rate _____

Narrative Description <u>Sleep improved. Doing better on the unit. Less overtly delusional. Calm on interview. Considering maintenance ECT as primary tx option. No side effects.</u>	Appearance/Activity <u>alert</u> <u>calm, cooperative</u> Speech <u>fluent</u> Mood/Affect <u>elevated</u> <u>congruent</u> Thought <u>circumstantial</u> <u>-SI -HI -AH</u> <u>+safety plan</u> Cognition/Memory <u>intact</u> Judgement/Insight <u>poor/poor</u> Call: <u>steady</u> Tone: <u>normal</u>

SOCIAL: _____

TESTING: _____ SCIMAP: positive, negative

Radiology/Other: _____

DIAGNOSES/PLAN: BPAD Manic PSA - long remission EDD NOS

Topamax 100mg bid

Geodon 80mg bid

ECT #8 today

Family to visit today. Will discuss disposition and follow-up options.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal

☐ obtain further information/medical records ☐ family meeting

Medical Diagnoses/Complications: Migraine, hypothyroid, macular degeneration, heart murmur (Echo 2002 prior to last tx)

no complications

Consult considerations: ECT

REASON FOR CONTINUED STAY: stabilization of mania

stabilization of psychosis

Discharge planning: Live with family John Roberts (MD, Psychiatrist)

Other: _____ Floor time: _____

Rendering Physician Signature [Signature] Pager ID 14488 Date 04/18/2005 Time _____ AM/PM

lopattprognosis Ben Weinstein, MD OTE 804239 Rev. 7/03

Patient: JOHNSON, CLAIR MRN: 947758 Encounter: 102952868 Page 75 of 81

MUSC1963 OF 2835

PIEDMONT HEALTHCARE SYSTEM
222 South Harlong Avenue
Rock Hill, South Carolina 29732
(803) 329-1234

PATIENT: JOHNSON, CLAIR
MR#: 000136439

DATE OF ADMISSION: 09/16/2003

DATE OF BIRTH: ~~09/16/2003~~

CHIEF COMPLAINT, IDENTIFYING INFORMATION: The patient is a 37-year-old married Caucasian female who is referred from the emergency room because of psychotic decompensation.

HISTORY OF PRESENT ILLNESS: This will be the first Piedmont Medical Center psychiatric admission for this patient who appears to have a long history of bipolar disorder. The patient is a poor historian because of her psychotic state. Most information was gathered through observation of the patient's behavior during the first few hours she was in the psychiatric unit as well as accounts from the emergency room as well as the psychiatric nurse evaluation also in the emergency room. Apparently the patient is not from the local area and came to visit a friend who is here in the Rock Hill. Her friend apparently was expecting her and was worried was nowhere to be found.

She eventually found the patient at the hotel and there were allegations that the patient started to threaten her. There were also reports that the patient felt that her friend was having an affair with her husband. Her friend knew of her mental illness and called the police. The police reported that the patient was found to be bizarre and talking to herself. She was starting to be very delusional when seen in the emergency room and unable to state information except that she believes that the devil had brought her to the hospital.

The patient's husband was apparently informed by the police of the patient's state and the patient's husband reported that the patient has a long history of psychiatric problems and has been noncompliant with treatment in the past. When she was admitted she was noted to be extremely manic and was very loud, animated. She had pressured speech and expansive affect. She was very irritable and at times would be verbally threatening the staff. At one point she tried to hit another staff member. This prompted the patient to be given p.r.n. medications for her safety as well as safety of the staff. She received IM Geodon 20 mg on the day of admission which somehow sedated her for a few hours. When she was back up, she continued to

FILE COPY

PATIENT: JOHNSON, CLAIR C
MR#: 000136439 ROOM#: 425-A
PHYSICIAN: Delfin F. Valdez, MD

HISTORY & PHYSICAL

Piedmont HealthCare System PCI *Live* (PCI: OE Database AMP)

DRAFT COPY

Run: 09/18/03-09:32 by Roberta Sargent RN

Page 1 of 4

MUSC2799 OF 2835

PIEDMONT HEALTHCARE SYSTEM
222 South Main Street
Rock Hill, South Carolina 29732
(803) 329-1234

be quite paranoid and had threatened legal action against the staff members. She was very suspicious and wanted the staff members including my license and had boasted that she had investigators working for her and that we cannot hide from her.

Information was also gathered from the patient's private psychiatrist, Dr. John Roberts from Mt. Pleasant, South Carolina. Dr. Roberts reported that he had last seen the patient about 2 weeks ago and during that time he had wanted her admitted to the hospital because the patient was becoming extremely manic but did not have any grounds for involuntary commitment as the patient refused to be admitted.

Because of the psychotic decompensation, even though the patient was somewhat compliant with medication, the patient was admitted for further inpatient psychiatric treatment.

PAST PSYCHIATRIC HISTORY: According to the patient's private psychiatrist, the patient has had a long history of bipolar disorder and was diagnosed when she was 15 years old. She has had multiple admissions to different psychiatric hospitals and most recently she was admitted to a hospital in Columbia in January 2003. After discharge she was referred to Dr. Roberts for outpatient treatment.

The patient has also been tried on several mood stabilizers and other medications in the past with complications or very minimal improvement. She broke out on lithium and had tried Tegretol and Neurontin in the past. She refused Depakote because of issues with weight gain. Lamictal was just too complicated for the patient to follow instructions. She has never been tried on Trileptal. She does take the Topamax as a mood stabilizer and also for migraine prophylaxis.

MEDICATIONS: Her last known medications included Geodon 80 mg twice a day, Topamax 100 mg tablet 1 tablet a.m. and 2 h.s., Wellbutrin SR 150 mg p.o. b.i.d., Ativan 1 mg in the morning and 2 mg at bedtime. The patient apparently has a history of frequent cycling despite medications. At times she would become extremely depressed and would be very withdrawn with increased appetite and increased sleep. She at times had been given Concerta in the past to help with her depression. I am not sure if the patient has any history of suicide attempt in the past.

PAST MEDICAL HISTORY: The patient has a history of hypothyroidism and is on Synthroid 0.05 mg once daily. She also has a history of vascular headaches and also a history of functional heart murmur.

FILE COPY

PATIENT: JOHNSON, CLAIR C
MR#: 000136439 ROOM#: 425-A
PHYSICIAN: Delfin F. Valite, MD

HISTORY & PHYSICAL

Piedmont HealthCare System PCI *Live* (PCI: OE Database AMP)

DRAFT COPY

Run: 09/18/03-09:32 by Roberta Sargent RN

Page 2 of 4

MUSC2800 OF 2835

PIEDMONT HEALTHCARE SYSTEM
222 South Herlong Avenue
Rock Hill, South Carolina 29732
(803) 329-1234

FAMILY HISTORY: This is not available at this time.

SUBSTANCE ABUSE HISTORY: Unable to assess at this time. The patient's urine drug screen was reportedly negative when this was taken in the emergency room.

PERSONAL, SOCIAL HISTORY: Very limited information is available at this time and we will probably wait until the patient's cognition improves. We will probably also get more information from the patient's husband or parents or even the patient's friend who lives here in Rock Hill. Briefly, we know that she is married to a psychiatrist and she apparently lives in Mt. Pleasant, South Carolina. She appears to be well-educated and very familiar with psychiatric terminology.

PHYSICAL EXAMINATION: This will be deferred to Dr. Das and he will probably come tomorrow to do a physical examination on the patient. Her vital signs are stable on admission.

MENTAL STATUS EVALUATION: The patient was seen wearing casual clothes and was well-groomed. She was alert and uncooperative much of the time. There is prominent psychomotor agitation. She had pressured speech and had flight of ideas. Her mood was irritable and her affect was expansive. She denies any auditory or visual hallucinations but she appears to be internally preoccupied. At times she would be seen talking to herself and would be gesturing or posturing at times. She also appeared to have paranoid delusions and at times can become quite grandiose. She denied any active suicidal or homicidal ideations but can become threatening at times. She has poor impulse control, poor insight and poor judgment. She appears to be of average intelligence.

ASSETS AND LIABILITIES: The patient's assets include her continued compliance with outpatient treatment despite her frequent decompensation. She also appears to be quite smart and may be doing financially well with good access to health care. Liabilities probably mostly involve her history of mental illness with recent decompensation despite compliance with medications.

INITIAL DIAGNOSTIC IMPRESSION:

- AXIS I. Bipolar disorder most recent episode manic severe with psychosis.
AXIS II. Deferred.
AXIS III. Hypothyroidism.
AXIS IV. None volunteered at this time.

FILE COPY

PATIENT: JOHNSON, CLAIR C
MR#: 000136439 ROOM#: 425-A
PHYSICIAN: Delfin F. Valles, MD

HISTORY & PHYSICAL

Piedmont HealthCare System PCI *Live* (PCI: OE Database AMP)

DRAFT COPY

Run: 09/18/03-09:32 by Robertá Sargent RN

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MUSC2801 OF 2835

PIEDMONT HEALTHCARE SYSTEM
222 South Harlong Avenue
Rock Hill, South Carolina 29732
(803) 329-1234

AXIS V. Global assessment of functioning 20-30 at this time.

INITIAL TREATMENT PLAN:

1. We will try to get more information from the patient's immediate family.
2. The patient is admitted on involuntary status.
3. Individual, group and milieu therapies.
4. The patient will be resumed on her Synthroid 0.05 mg p.o. q.d.
5. Physical examination will be done by Dr. Das and further medical management if needed will be per his discretion.
6. The patient will be resumed on Geodon probably at 40 mg twice a day for now as she had received dose of Geodon 20 mg IM. We will try dose of 80 mg twice a day and further adjustment will depend on her response. We will resume her Topamax and Ativan and ~~probably hold Welibutrin for now.~~
7. Family meeting with the social worker if feasible.

INITIAL DISCHARGE CRITERIA:

1. The patient will have significant improvement in mental status with the patient having a more neutral mood and absence of any psychotic symptoms.
2. The patient will be able to tolerate all medications well.
3. The patient will have proper disposition prior to discharge.

D: 09/17/2003 00:40 T: 09/17/2003 08:02
796453 MedQuist, Inc.

Delfin F. Valite, MD

Electronically Signed:
Report #: 0917-0069
: 796453

FILE COPY

PATIENT: JOHNSON, CLAIR, C
MR#: 000136439 ROOM#: 425-A
PHYSICIAN: Delfin F. Valite, MD

HISTORY & PHYSICAL

Piedmont HealthCare System PCI *Live* (PCI: OE Database AMP)

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INTERDISCIPLINARY ADMISSION
DATABASE
Intake Information

3/30/2005 8:34:56 AM Ellen
Admit date time team
3/30/2005 3:00 3N

☒ Inpt ☐ PHP ☒ Voluntary ☐ Committed

0000

947758 3/30/05
JOHNSON CLAIR
W/F
102952868
Acute Unit 1 North - ()

"Is the pt currently violent or agitated?"
"Does the pt have a history of violence?"

Patient Name Claire Johnson DOB [REDACTED] Age 38 Race C Sex F
Address [REDACTED] SC [REDACTED]
Phone: H: [REDACTED] W: [REDACTED] County [REDACTED]
Marital Status: ☐ S ☒ M ☐ D ☐ Sep ☐ W acute unit?
EMERGENCY

Contact Hope Craver Relationship father
Address saa
Phone: Home: saa Work: Agency
Lead Agency Pho
Custody/Guardianship self Re
Cust home phone Cust work phone



REFERRER

Name DR John Roberts Relationship psychiatrist
Referrer Agency County
Address
Phone Page Fax
MUSC Attending Phone
Current Physician Phone

DIAGNOSIS: bpad w/psychotic features

	INSURANCE I	INSURANCE II
Insurance Co	benefit administrators	
Insured	John F. Johnson-husband	
Employer		
Phone OK Verify?	☐ Yes ☐ No	☐ Yes ☐ No
Policy ID	251-31-3528	
Group		
Benefits phone	803-791-0236	
Patient's SS#		

Crisis Stabilization Authorized by County
Have you been in a psychiatric facility in the past three days? [REDACTED]

atient: JOHNSON, CLAIR

MRY: 947758

Encounter: 102952868

Page 1 of 2

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Presenting

CLINICAL INFORMATION

Johnson-Pt has been up all night in a manic state, very delusional. Pt believes she is being followed and persecuted. Is wanting to contact state attorney general. Pressured speech, irritable, tangential. Grandiose. Feels depressed. No HI or SI.

Self-harm Behavior?

☐ Yes ☐ No

Violent History?

☐ Yes ☒ No

height

weight

Any current legal involvement? none reported

Medications/dose/frequency

Past

Current zonagran 100 mg bid, topamax 100 bid, trileptal 600 mg bid, frovaprnl migraine,

Past Hospitalization, Placements and other Interventions

IOP-Sept-October 2003

GWB, IOP 11/2003

Outpatient Therapy non compliant

Present Therapist

Phone

Present Psychiatrist

Phone

Medical **Acute** hypothyroid, constipation, and migraine headaches
Conditions Chronic nkda

Goals/Objectives of Hospitalization:

crisis stabilization, safety precautions and medication management

DISCHARGE DISPOSITION Home ☒ Yes. Placement Arranged

Other

FOLLOW-UP APPOINTMENT(S)

Date

Time

Therapist

Psychiatrist

Other

590256207

CLAIR
LOS ANGELES
5/30/03

500000

Patient: JOHNSON, CLAIR

MRN: 947758

Encounter: 102952868

Page 2 of 2

MUSC1646 OF 2835

04/11/05 15:17 FAX

- INORTH

0001

***** MUSC MEDICAL RECORD FACE SHEET *****

Admit Date 3/30/05
 Medical Record # 000947758
 Episode Counter 005
 Discharge Date
 Race W
 Pat. Age at Admit 038
 Preadmit/Reg by
 Patient Name *** JOHNSON
 Pat. Address 1
 Patient City
 Patient State
 Patient Zip
 County Code 10
 Pat. Phone
 Fin. Class CF COMMRL/SE
 Employer Name
 Pat. Emp. Addr 1
 Pat. Emp. City
 Pat. Emp. State
 Pat. Emp. ZIP 00000 - D
 Patient Type Y
 Medical Serv PSY
 TAR Number CFB0503311044
 NOK Last Name CRAVER
 NOK Relationship 33
 NOK Bus. Phone
 Ref. Phys. Name ROBERTS, JOHN
 Ref. Phys. Phone (843) 792-0033
 Ref. Phys. Addr1 67 PRESIDENT ST
 Ref. Phys. Addr2 PO BOX 250861
 Ref. Phys. Addr3 CHARLESTON SC 29425
 Ref. Phys. Addr4
 Ref. Facility
 Complaint BPAD
 Procedure PSY-EVAL
 Primary Ins.Co. OT31
 Principal Diagnosis

Admission Time 17:35
 Source Code 807
 Pat Com. # 102952868
 Patient Sex F
 Birth Date
 Marital Status M
 Adm/Reg by scn.ipr
 CLAIR
 Advanced Directive? P
 AD on File at MUSC? P
 AD Info Provided? P
 Vip Code Desc
 Pat. SSN
 Refer. Name
 Pat. Emp. Phone

Room-Bed PH1N P101 J
 Attnd. Doc Name WEINSTEIN, BENJAMIN
 Admit. Doc Name HIOTT, DAVID
 Elig. Det. Date 3/30/05
 NOK First Name HOPE
 NOK Home Phone (843) 849-7796
 Family Doctor UNK., DR
 PCP Doc Name
 PCP Doc Phone
 PCP Address 1
 PCP Address 2
 PCP Address 3
 PCP Address 4
 E/R Referral Y

Secondary Ins.Co

Code Number

Secondary Diagnosis

Operation or Special Procedures

Attending

Date

Discharge Summary:

[] Date Dictated

Job #

Beeper #

OP Note:

[] Date Dictated

Job #

Beeper #

Patient: JOHNSON, CLAIR

MRN: 947758

Encounter: 102952868

Page 1 of 1

MUSC1648.OF 2835

MUSC Medical Center
INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY
Patient Name: JOHNSON, CLAIR
MRN: 000947758
Patcom: 102952868
Admitted: 03/30/2005
Discharged: 04/20/2005
Service:
Attending: BENJAMIN WEINSTEIN, MD

Referring:

CHIEF COMPLAINT: Grandiosity delusions. Noncompliance with meds.

HISTORY OF PRESENT ILLNESS: The patient is a 38-year-old white female with a history of mixed bipolar disorder with psychotic features brought to CMH ER by the police. She fled her psychiatrist's office earlier in the day before he could admit her. She then went to get her nails done, refused to pay, and the police were called. The psychiatrist was contacted. The police were told to take the patient to the hospital. She was brought on commitment papers. The patient has not been taking the medications. She believes doctors and lawyers are holding people hostage and the whole state of South Carolina are hostages as a result of Republicans and Democrats. Believes her brain is worth 2 million dollars and Verizon Wireless has hearing problems. She endorsed homicidal ideations toward doctors and lawyers. Denied SI, AVH, alcohol or drug use. Said she smoked cigarettes. She reports insomnia but denies sleeping difficulty. She has decreased appetite with weight loss, unknown amount, and she refused to be weighed on admission. She has a history of multiple hospitalizations to the Institute of Psychiatry, last in November 2003 for a similar episode.

PSYCHIATRIC HISTORY: Institute of Psychiatry November 2003, September 2003. GWB dates not known. ~~Dr. Roberts is her current outpatient psychiatrist.~~ She says she is currently (we are not sure of the doses here) on Zonagan, Geodon, hydrocodone, Trileptal, Wellbutrin, Topamax, Synthroid, vitamin B12, and folate. She has a history of Vioxx use. Endorses allergies of Haldol and lithium. We are not sure what these do to the patient. She is not able to tell us.

PAST MEDICAL HISTORY: Hypothyroidism. History of migraines and constipation.

PAST SURGICAL HISTORY: She has had multiple cosmetic surgeries, including breast reduction, nipple reconstruction, partial face lift. Also, she had a head injury, hit in the head with a baseball as a child.

FAMILY HISTORY: The patient is adopted, unknown for psychiatric or medical history.

SIGNIFICANT FINDINGS:

MENTAL STATUS EXAMINATION: She was unkempt, appeared older than stated age. Irritable, uncooperative, suspicious, poor eye contact. Loud, but says she is soft, with a normal rate. Blunted affect. Did not appear to be abnormal perceptions at this time. The patient was grandiose, persecutory, loose associations, disorganized, awake. Insight and judgment significantly impaired. Concentration: The patient was unable to pay attention. Memory: Unable to assess.

REVIEW OF SYSTEMS: The patient denied GI, GU, musculoskeletal, heme, neurologic, ENT complaints. Endorsed allergies to Haldol and lithium. Says she is heterosexual, not sexually active. Her last menstrual

MUSC1652 OF 2835

period was March 2005.

PHYSICAL EXAMINATION: Vital signs: 96.8, pulse 57, blood pressure 112/84. Generally within normal limits. Well-developed. Healing surgical scars on her face. Oropharynx is clear. The pupils are equal, round, and reactive to light. Neck is supple, no masses. No lymphadenopathy. Chest clear to auscultation. Cardiovascular: Regular rate and rhythm. Abdomen: Normoactive bowel sounds, no masses. GU deferred. Neuro: Cranial nerves 2 through 12 intact. No tremor, normal gait. Strength 5/5 x4. Musculoskeletal: Full range of motion. Skin: Warm and dry.

LABORATORY DATA: Sodium 139, potassium 4.1, chloride 112, bicarbonate 20, BUN 19, creatinine 1, glucose 80, calcium 8.8, magnesium 2.4, phosphorus 2.8, folate 21.9, vitamin B12 1188. White blood count 7.7, hemoglobin 12.1, hematocrit 37, platelets 287. Cholesterol was normal, 158, triglycerides 67, HDL 58, LDL 87, VLDL 13. Urine drug screen was negative. Total LFTs were within normal limits. Total bilirubin 0.3, AST 21, ALT 23, alk phos 66, total protein 6.8, albumin 4.1. Free T4 1.2, TSH 1.1.

PROCEDURES AND TREATMENT RENDERED: The patient was admitted to 1 North and started on a forced med protocol after an ECT protocol after consent was obtained from her parents and her husband, with whom she is now separating. The patient's was initially started on Zyprexa, required multiple Zyprexa injections as a result of refusing p.o. She reached Zyprexa 10 in the morning, 30 at bedtime, with good effect, though the patient endorsed considerable concern over weight gain. Seroquel was given to help her sleep, which she said caused her muscles to contract in her hands. This was observed on one occasion by a nurse, with the symptoms resolving within a few minutes of presentation. The patient never experienced again. However, as a result, the Seroquel was discontinued and labs were ordered and found the electrolytes were within normal limits. The patient received Visine eye drops as needed four times a day. She received 2 ECTs, the first was on 04/04, the second on 04/06. As a result of good behavior and improvement she was transferred to 3 North over the weekend. She refused meds, she refused the ECT, became irate, and very difficult to redirect. She was transferred back to 1 North where she received 5 more ECTs and was started on Geodon 80 mg p.o. b.i.d. with meals, which she tolerated, and seemed to like. The patient's psychiatrist, Dr. Roberts, was contacted and discussed B12, folate, and other medications. After discussion with the treatment team, because the folate was within normal limits and B12 was supratherapeutic, we decided not to issue these medications in the hospital. Had multiple visits with patient's family regarding patient's long-term care and concern that the upcoming divorce might be a significant stressor for the patient. The patient will be discharged on 04/20/2005 with followup with Dr. Roberts on 04/26/2005 at 3 p.m. She will be discharged on Topamax 100 mg p.o. b.i.d., which she received throughout the hospitalization, Geodon 80 mg p.o. b.i.d. with meals, and Synthroid 25 mcg p.o. daily. She was stabilized on these medications and received a nicotine patch for in-hospital use. She is court ordered for outpatient treatment. The court order extends for a period not to exceed 24 months.

DISCHARGE DIAGNOSES:

AXIS I: Bipolar with psychotic features. Nicotine dependence.
AXIS II: Deferred.
AXIS III: Hypothyroidism. History of migraines.
AXIS IV: Moderate.
AXIS V: 55.

DISCHARGE MEDICATIONS:

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1. Topamax 100 mg p.o. b.i.d.
2. Synthroid 25 mcg daily.
3. Geodon 80 mg p.o. b.i.d. with meals.

FOLLOW-UP APPOINTMENT: Followup with Dr. Roberts 04/26/2005 3 p.m.

Dictated by: Emily R. Goddard, MD

Emily R. Goddard, MD

BENJAMIN WEINSTEIN, MD
Attending

721710 / 33265 /
JOB: 203921
DD: 04/19/05 12:49 PM
DT: 04/20/05 07:47 AM

Additional CC: _____

MUSC1654 OF 2835

CLAIR
JOHNSON - phone
8-16 - 10

"I called Dr. STEUDE to get my records, and to see him as she had no memory of their past interactions... especially as he was the first psychiatrist she had seen."

\ she was told that she had outstanding bills they had tried to collect for two years, and, therefore, would not see her.

\ however, he would be able to send her records to her current treating physician.

Her friend Anna has been helping her find an atty to take her case and may have found one, Chavens Ravinell.

\ some attorneys have suggested the stress it would put her through may not be warranted, given the nature of the case.

\ she wonders if she should pursue it

Processed her feelings about the situation & explored options.

Maintain Lamictal 200 mg
Synthroid

CLAIR
JOHNSON
8-5-10

"I spent the weekend with Anna reviewing my medical records."

In upset that John signed the consent forms and continued to sign the consent forms even after they were separated.

Wonders if it is too late to pursue legal action or what the outcome might be.

I reiterated that there were important legal questions, that an attorney would need to answer.

∴ processed her feelings about the situation & explored options

CLAIR
JOHNSON

7-29-10

"Mark Hardy said he thought she did have
a case, but he couldn't take it on right
now."

Musc released her records - some 2000 pages
she hopes to get her friend Anna to help
review.

Deplin 7.5

Lamictal 200

SYNTHROID .15

Roberts 026

CLAIR
JOHNSON

7-21-10

"I'm fat... I've gained 3 pounds."

\ has been travelling, so she hasn't
been working out every day
\ has been eating more also

~~Is still waiting to hear from the atty about~~
~~whether she has a case regarding her~~
~~memory difficulties and the ECT she had.~~

processed her feelings about the situation
& explored options

Maintain meds

CLAIR
JOHNSON

7-13-10

"I'm tired ... I got about three hours of sleep last night."

\ was down & sleeping yesterday

\ didn't sleep last night

\ had to get up early to meet & atty. "Mr. Hardy" on ECT case ... but he wasn't very encouraging

CLAIR
JOHNSON

7-9-10

"Well, I have my appointment with the attorney next Tuesday."

Remains concerned that she has suffered memory loss from ECT and wonders if the consent to the procedure was properly obtained?

Mood remains stable & euthymic
sleep, appetite & energy good
not anhedonic, hopeless or suicidal

CLAIR
JOHNSON

7-5-10

"I'm in Charlotte & Anna."

Has an appt. w/ Mark Hardy, an Atty who
handles ECT cases.

- \ still concerned that ECT affected
her memory
- \ went to watch fireworks last night
and couldn't remember ever having
seen fireworks before
- \ went shopping in Charleston but
couldn't remember where King Street was
- \ went to Bob Ellis where she used to
shop frequently for shoes... two of
the salesmen remembered her and
hugged her... yet she had no
recollection of them.

CLAIR
JOHNSON
7-1-10

"I'm real pissed at Jim right now. I left him two screaming messages."

Jim MERRITT 919-239-7414

- \ an attorney who had gotten her out of the hospital before
- \ she asked him to come and stop the ECT but he did not
- \ which is why she is angry @ him now

She doubts she will ever need to be hospitalized again

- \ no longer suicidal
- \ mood irritable & dysphoric around situation, but not depressed
- \ sleep, appetite, & energy good
- \ not anhedonic, hopeless or suicidal
- \ maintains a good sense of humor

CLAIR
JOHNSON

6-22-10

"I'm still stunned and shocked at that text that John sent. How could he turn it around that he's been wronged by my illness?"

Apparently her efforts to have John increase the life insurance policy of which she is the beneficiary resulted in him informing her that if she persisted he would pursue legal action to stop all alimony.

∴ makes it difficult for her to achieve closure and move on.

CLAIRE
JOHNSON
6-7-10

"I'm taking adoxa for my rosacea and
now it's making me ill."

\ took it Q D x 2 mos

\ now Q O D

\ supposed to avoid eating for two
hours $\bar{p}$ dose

\ supposed to take dose H.S. ... but
tends to eat @ night so she
takes it in AM

\ on two occasions it
made her N & V 30 min

$\bar{p}$ dose

\ her had \$7000 of luggage so far from ^{Delaware}
Yesterday was 3 yr anniversary of divorce

hamletal 200

Fish Oil B10

Syntroid

had stopped taking Depkin $\therefore$ restart

Has had no ECT for 2 yrs but remains upset
that it had been done.

\ thinks she was bulimic @ the time

\ worries that the bulimia contributed
to her depression (did so sporadically
& wt never < 120, nor were electrolytes
ever out of balance).

CLAIR
JOHNSON

5-24-10

"Well, last Sunday had some crazy and drunk driver who has diabetes slam into me... I've never been so scared in all my life."

- waiting @ an intersection to make a left when the light turned yellow
- turned to clear intersection when a woman oncoming gunned her accelerator

- Clair slammed on her brakes... but her @ front bumper hit the woman's rear fender... spinning her car into a ditch.

- onlookers said the woman was drunk and was taken off in an ambulance

- Clair's @ headlight was broken and bumper damaged

- the police cited Clair 4 point ticket for failing to yield the right of way.

Has been going out @ friends from high school and has met some strong & influential women... however, has also been shopping @ Copelands (the most expensive store in the state), and bought \$4000 of clothes using parent's credit card (90% off so only paid \$400)

is frustrated that she can't spend as much
as she used to

\ upset that she will have to
be on a budget

\ finds it overwhelming to try &
understand her finances

\ not sure she trusts her brother Chip
to manage her trust once her
parents are gone

needs to take the initiative in
learning about her finances

CLAIRE
JOHANSON

5-10-10

"I saw John the night before I went to the storm eye institute."

- \ he has moved back into their house
- \ she spontaneously went to the house & knocked on the door
- \ he said he didn't want to see her ... but let her in anyway
- \ she stood in the foyer while he ranted & raved @ her
- \ she was speechless ... felt attacked

∴ perhaps now she can move on

Conc - rad dystrophy

- \ not as bad as prior dx
- \ progresses a lot slower
- \ a good sign it didn't show up till her 40's
- \ the day will come when she can't drive ... but can't say when

Roberts 036

CLAIR
JOHNSON
3-25-10

"I'm tired ... I just got back from D.C.
It was so much fun."

Mood stable & euthymic.

sleep, appetite & energy good
not anxious, hopeless or suicidal

Has been going to the gym 1-2 times a day
& working out 2 hrs @ a time

- working w/ a personal trainer
- now weighs 126 ... size 0-1

Has pulled out all her clothes to get rid
of those she can't wear

- however ... the entire upstairs of her
parent's house is littered w/ clothes

- since October she has been spending
many thousands of dollars on clothes
(\$900 for a pair of boots, \$300 for a leather jacket)

∴ parents concerned

? ~~hypomania~~

∴ processed her feelings & explored options
maintain needs

Flu 2 wks

CLAIR
JOHNSON

3-1-10

"I'm having trouble with Niman Marcus."

\ gave her a credit card ... which she tends
to over-use

\ although she has designer clothes & the
price tags still in them, she is angry
she can no longer spend in that fashion

Grieving Aunt Mont's death

Seeking closure on relationship & John

Liked Esther Bowie MD who did not think
she had the genetic eye problem

\ returns for further testing 3/26

Roberts 038

CLAIR
JOHANSSON

2.22.10

"The ophthalmologist said I had Central Arterial
Choroidal Dystrophy. He said it was a
rare genetic condition that he had only
seen one other time in 15 years. He
said there was nothing that could be
done for it and that she would be
blind by the time I was sixty."

∴ referred for second opinion to
Esther Boucie MD 792-8861
(secretary is Hope) @ Storm Eye Institute

Still fixated on the relationship - John
- urged her not to contact him as it
only upsets her

Synthroid .15
Lamictal 200 mg

CLAIR
JOHNSON

2-11-10

"Aunt Merv passed away."

Still upset w/ John, who is having his
accounting firm pay her bills

- ✓ they continue to deal w/ her father
instead of her ... which upsets her
- ✓ she is trying to take control of
her finances again*
- ✓ she does not want people in his
office knowing of her health
issues

*has run up \$300⁰⁰ on a Nieman Marcus card
she got (that her father does not know of)
? getting hypochondriac

CLAIR

JOHNSON - phone

10-26-09

" I've been seeing an attorney wednesday *
morning and I'm going to rip John
a new asshole.

*Ken Lester

Has been calling him for two years but
he hasn't responded ... so she went to
his office last week to see him ...
parking opposite the door & engine
running to keep AC on ... which also
means the headlights were on shining
into their building ... so John called
the police.

\ they came & were polite &
she left quietly

\ however, she thinks he owes her more \$

She has been working out several hours a
day for the past several months

\ weighs 123

\ muscles toned ... six pack

No coke past 9³⁰pm so sleep improving
On Chantix so cut cigarettes to 6/day

~~Mood may be getting hypomanic & irritable~~
sleep ok, appetite & energy ok
not anhedonic, hopeless or suicidal

CLAIR
JOHNSON

5-15-09

"Not much."

Has been working out daily
w/ Personal Trainer 3x/wk

Has lost 15 lbs.

plans to lose 35 more by Sept
trying to do metabolic diet

~~Fears she's lost her social skills & her
self-confidence & her self-esteem~~

Synthroid .15

Lamictal 200

Depkin 7.5

B 100

Mood stable & anergic

sleep, appetite & energy good
not anhedonic, hopeless or suicidal

Roberts 049

CLAIRE
JOHNSON

1-6-09

"Nothin... I cancelled out almost all my work outs last month... but I started up this month and I started back on my metabolic diet."

Upset & what she considers to be the effect ECT has had on her.

- feels she has no self-confidence
- feels she has no motivation

∴ processed her feelings and explored options

Mood stable & euthymic

sleep, appetite & energy OK

starting diet again

working out 3/week

not anhedonic, hopeless or suicidal

Having trouble seeing a positive future
tends to dwell on the negative &
it inhibits her

∴ processed her feelings about the situation
& explored options

Maintain meds

Flu & wks.

CLAIR
JOHANSON

2-18-08

"Been trying to work out. I went on Monday.
I just can't make myself do anything."

Wants to lose wt but hungry all the time - wt 149
not eating out or eating much
not gaining wt but not losing either
wonders if it's 2° hyperald and wants to stop it

ECT 9 Tokes x 2

hopes to extend further

Doesn't remember much of her past - just a blank

Low self-confidence - fears going places & meeting people

Taking Chantix 1mg BID but still smoking
has cut back to less than a pack a day

Rarely had H/A

Dwells on the marriage & the divorce

Mood dysphoric

sleep is good - sleeps @ night up in day
appetite & energy improving
less anhedonic - going to movies
not hopeless or suicidal

Roberts 057

CLAIR
JOHNSON

3-1-07

"~~No much~~... I don't really remember I
~~had a treatment this morning.~~"

- still having ECT q 2 wks
- subdural p tx

CLAIR
JOHNSON

1-18-07

"My dad drives me absolutely crazy."

Had ECT today ... next tx in 2 wks

wants to come back to his home

- feels she can't diet @ her parents

- but has some memory difficulties

∴ unsure she can drive & not get lost

unsure she could follow a diet

Father wants her to exercise w him

\ she feels he is overly controlling

∴ processed her feelings about the situation
& explored options.

Risperdal Consta IM 37.5 mg - no TD or EPS

CLAIR
JOHNSON

1-12-07

"Did you know John fired his attorney ... so they had to reschedule everything."

Had ECT yesterday 3 problem
plan to repeat next week
then @ 2 wks x 1 month
then @ 3-4 wks

Mood stable & euthymic

sleep OK @ Ambien ... but takes it
regularly and so, doesn't know if
it's necessary in trying sleeping
@ it.

appetite OK energy varies - lethargic today
not anhedonic, hopeless or suicidal
no mania or hypomania

~~Still notes difficulties in memory & concentration
can't drive is getting lost or forgetting
destination~~

Risperdal Consta - no TD or EPS - @ 2 wks

Lamictal 25mg II AM ∴ ↑ III AM no rash

SYNTHROID .15 mg

Ambien CR 12.5 mg

CLAIR
JOHNSON

1-4-07

"I did nothing inappropriate except go up with
my father and say I didn't want to get
the treatment's as often.... and they locked
me up."

Hospitalized @ MUSC - recurrence of Mania!

ECT 2-3 / wk then disch & now Q OK

waiting toward 1- / month

VIT B₁₂ 100 mg $\dot{\bar{I}}$

Topamax 85 mg $\dot{\bar{I}}$

Risperdal 4 mg $\dot{\bar{I}}$ HS

Lamictal 25mg $\dot{\bar{I}}$ QD x 1 wk then $\dot{\bar{I}}$

Synthroid 150 mg

Ambien 10 mg HS

Risperdal IM

Mood stable & euthymic

sleep OK $\dot{\bar{I}}$ Ambien

appetite OK - trying to diet again

energy OK

not anhedonic hopeless or suicidal

CLAIR
JOHNSON

12-8-06

"Are you going to fire me as a patient? I'm
working now."

Cut 4-6" off @ side of her hair
↓ sleep ↑ energy ↓ concentration
loud irritable impulsive (wants to buy
grandiose, paranoid, pressured speech, tangential
manic

Still taking meds

Synthroid .1 or .15

Ambien CR 12.5

Zonagan 100 mg

~~ECG - not abnormal - no significant changes - 11/25~~
~~next ECG 12/12/06~~

Mood labile

appetite OK but dieting - lost 10 lbs
not anhedonic, hopeless or suicidal

CLAIR
JOHNSON

11-15-06

"Not much."

Hospitalized 8 days ... ECT P.O.D.

Home 6 days ago ... memory difficulties

Mood stable & euthymic

initial insomnia despite Ambien 10 mg
then stays asleep 6 hrs

appetite OK ... starting diet

energy OK ... going to start working out
less anhedonic

not hopeless or suicidal

No mania or hypomania

Can't drive for 6 wks

CLARE
JOHNSON

5-12-06

Oh, not much."

ECT - the next best thing to it. I don't
feel they're "depressing" but can't
say for sure.

Mood seems stable & euthymic - subdued
sleep OK - some initial insomnia
appetite - OK - wants to lose but not
energy - OK - plans to use treadmill
some anhedonia.
not hopeless or suicidal

∴ processed her feelings about the situation
& explored options.

Sept. 21, 2007
[REDACTED]
[REDACTED]

Dr. Roberts,

We have scheduled the movers for next Thursday, Sept. 27th. We are seeking to put Clair's furniture in storage here in Mt. Pleasant. She will go home with us for some period of time - until she can function better on a daily basis. Clair is still sleeping most of the day! She will continue to see you and Dr. Foust in Charleston. We think that is very important.

We think Clair is going through a grieving process. She says the divorce is all her fault. She is very sorry she is divorced. She does not want to be divorced.

Clair wants to see John. She wanted to lose weight before she saw John, but now she wants to see him soon.

Clair cannot remember much about her married years - how bad it was or how good it was. She doesn't remember some of the trips she and John took. Will she likely regain her memory?

Clair did not cycle up in the spring of this year. Is she likely to cycle up in the fall? She seems to remain very depressed at this time. What can we expect in the next 30-90 days?

We will appreciate any help or suggestions you can give to us to help Clair to recover.

Please call us or write or E-mail: LCRAVER@SC.RR.CO

803 781-8078 home

803 546-9366 cell

Clair's phone only until next Friday.
849-7798

Clair's cell 843 906-6411

Thank you for your help.

Sincerely, Sandra & Hope Craver

Roberts 425

EXHIBIT B

DATES SEEN BY DR. ROBERTS	DATES OF ECT	Wellbutrin in Dr. Roberts' notes
08/13/97		
08/18/97		
02/13/02		Wellbutrin SR 200 BID X 1 WK
01/23/03		Wellbutrin SR 150 BID X 4 WKS
01/27/03		Wellbutrin SR 100 am & pm
01/30/03		on Wellbutrin SR 100 X 4 WKS
02/06/03		Wellbutrin SR 300 Mg
02/13/03		
02/20/03		Wellbutrin SR 100
03/06/03		
03/17/03		Wellbutrin SR 100 mg
03/31/03		
04/10/03		on Wellbutrin SR 200 daily; increase 150 twice/day
04/17/03		Wellbutrin SR 200 twice/day
04/29/03		Wellbutrin SR 200 twice/day
05/13/03		
05/20/03		Wellbutrin SR 200 twice/day
05/27/03		
06/12/03		
07/02/03		
07/15/03		
07/22/03		
07/28/03		
07/31/03		
08/04/03		wonders if migraines worse w/ Wellbutrin, so taking 100 mg 4 x day
08/18/03		
09/08/03		Wellbutrin SR 200 twice/day
09/12/03		noted taking Wellbutrin SR 200 twice/day
10/21/03		Hospitalized and removed from Wellbutrin
10/28/03		"admits to taking Wellbutrin...urged to stop".
11/04/03		Clair taking Wellbutrin "against advice". May drive cycle, not good idea at this time.

11/17/03		noted taking Wellbutrin SR 200 twice/day "on her own"
	12/10/03	
	12/12/03	
	12/15/03	
	12/17/03	
	12/19/03	
12/24/03		
01/02/04		
01/09/04		
01/16/04		
01/23/04		Roberts prescribes Wellbutrin again - XL 150 MG
02/02/04		Wellbutrin XL 300
02/12/04		
02/18/04		
02/26/04		
03/03/04		
03/10/04		Wellbutrin XL 450
03/24/04		
03/31/04		
04/07/04		Wellbutrin XL 150
04/13/04		
04/20/04		
04/28/04		
05/06/04		Wellbutrin XL 300 & 150
05/18/04		
05/27/04		Wellbutrin XL 450
06/07/04		
06/16/04		Wellbutrin XL 300 & Wellbutrin XL 150 mg
06/28/04		Wellbutrin XL 450
07/07/04		
07/16/04		Wellbutrin XL 150; Wellbutrin XL 300
07/26/04		
08/05/04		

08/12/04		Wellbutrin XL 150 mg & Wellbutrin XL 300 MG
08/19/04		
08/27/04		
09/01/04		wellbutrin XL 450
09/13/04		
09/20/04		
09/27/04		
10/04/04		
10/12/04		
10/19/04		
10/26/04		
11/02/04		
11/09/04		
11/16/04		
11/30/04		Wellbutrin XL 150 mg & Wellbutrin XL 300 mg
12/02/04		
12/06/04		
12/14/04		
12/21/04		
12/27/04		
01/04/05		
01/10/05		
01/18/05		
01/25/05		
02/11/05		
02/23/05		
03/08/05		Wellbutrin XL 300 mg; Wellbutrin XL 150 mg
03/18/05		
	04/04/05	
	04/06/05	
	04/12/05	
	04/14/05	
	04/15/05	

	04/18/05	
	04/20/05	
05/03/05		Wellbutrin XL 150 every day
05/11/05		Discontinues Wellbutrin; "stop for now"
05/16/05		
05/23/05		
05/31/05		
06/08/05		
06/14/05		
06/23/05		Wellbutrin XL 150
06/30/05		
07/14/05		Wellbutrin XL 300 mg
07/25/05		
08/04/05		
08/15/05		
08/22/05		
08/30/05		
09/13/05		
09/26/05		
10/06/05		
	10/19/05	
	10/21/05	
	10/24/05	
	10/26/05	
	10/28/05	
	10/31/05	
	11/07/05	
11/09/05		Wellbutrin SR 100 X 2 days
	11/15/05	
11/18/05		
	11/23/05	
	11/28/05	

	11/30/05	Noted In MUSC IOP Discharge Summary - Wellbutrin was added to PT's Med Regimen since IOP discharge in November. Dr. Roberts advised discontinuing Wellbutrin secondary to her mania.
12/08/05	12/08/05	
	12/15/05	
12/21/05		
	12/22/05	
12/28/05		
	12/29/05	
01/04/06		
	01/13/06	
01/16/06		
01/19/06		"mood has flipped in past 72 hours to manic, probably wellbutrin. Discontinue wellbutrin".
01/23/06		
	01/24/06	
	01/27/06	
	01/30/06	
02/01/06		
	02/03/06	
02/09/06		
	02/10/06	
	02/16/06	
02/22/06		
	02/23/06	
03/06/06		noted wants strattera or welbutrin, but not good idea as it would drive cycle.
	03/07/06	
	03/10/06	
	03/13/06	
03/15/06		
	03/16/06	
	03/21/06	

03/23/06		
	03/28/06	
03/30/06		
	04/04/06	
04/06/06		
	04/12/06	
04/17/06		
	04/18/06	
	04/25/06	
04/26/06		
	05/02/06	
05/04/06		
	05/09/06	
05/12/06		
	05/16/06	
05/17/06		
05/24/06		
	05/25/06	
06/06/06		
	06/08/06	
	06/22/06	
06/23/06		
07/12/06		
	07/13/06	
07/26/06		
	08/01/06	
08/02/06		
08/15/06		
	08/22/06	
08/23/06		
09/06/06		
	09/08/06	
	09/21/06	

09/22/06		
10/04/06		
	10/05/06	
10/18/06		
	10/19/06	
10/26/06		
	10/31/06	
	11/02/06	
	11/06/06	
	11/08/06	
11/15/06		
	11/16/06	
	11/28/06	
12/08/06		
	12/13/06	
	12/15/06	
	12/18/06	
	12/27/06	
	01/03/07	
01/04/07		
	01/11/07	
01/12/07		
01/18/07	01/18/07	
02/01/07	02/01/07	
02/15/07	02/15/07	
03/01/07	03/01/07	
03/14/07		
	03/15/07	
03/28/07		
	03/29/07	
04/18/07		
	04/26/07	
05/10/07		

05/23/07		
	05/24/07	
06/06/07		
06/20/07		
	06/21/07	
07/05/07		
	07/19/07	
07/20/07		
08/01/07		
08/09/07		
08/16/07		
08/29/07		
	08/30/07	
09/12/07		
	10/11/07	
10/25/07		
11/08/07		
	11/27/07	
01/03/08		
	01/17/08	
02/13/08		
	03/26/08	
04/23/08		
	06/26/08	
07/16/08		
10/07/08		
12/19/08		
01/06/09		
01/22/09		
05/15/09		
07/28/09		
08/31/09		
10/26/09		

0190

11/03/09		
11/11/09		
11/18/09		
01/20/10		
01/25/10		
02/11/10		
02/22/10		
03/01/10		
03/25/10		
05/10/10		
05/11/10		
05/24/10		
06/07/10		
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06/22/10		
07/01/10		
07/05/10		
07/09/10		
07/13/10		
07/21/10		
07/29/10		
08/05/10		
08/16/10		

STATE OF SOUTH CAROLINA	)	
	)	COURT OF COMMON PLEAS
COUNTY OF CHARLESTON	)	
Clair Craver Johnson,	)	
	)	
v.	)	Case No. 11-CP-10-8318
	)	
Medical University of South Carolina	)	
-and-	)	
Clair Carver Johnson	)	
	)	
v.	)	Case No. 12-CP-10-2867
	)	
John Roberts, M.D.	)	

TRANSCRIPT OF HEARING

The within Hearing in the above-captioned matter was held on January 9, 2014, before The Honorable R. Markley Dennis, Jr. in Courtroom 3A of the Charleston County Courthouse, 100 Broad Street, Charleston, South Carolina; attended by counsel as follows:

APPEARANCES:

Cravens Ravenel, Esq.
Appearing for Plaintiff Clair Craver Johnson

Perry Buckner, Esq.
Appearing for John Roberts, M.D.

William Early, Esq.
Appearing for Medical University of South Carolina

Deborah Garrison
Circuit Court Reporter – 13th Judicial Circuit
P O Box 27145
Greenville, South Carolina 296616
dgarrison@sccourts.org

Clair Johnson v MUSC and John Roberts, M.D.
Case No. 111-CP-10-8318 and 12-CP-10-2867
Hearing of January 9, 2014
Before The Honorable R. Markley Dennis, Jr.

2

1

2

THE COURT: The next one is Johnson
versus the Medical University.

3

4

MR. EARLY: Good morning, Your Honor.

5

THE COURT: Good morning, Mr. Early.

6

How are you?

7

MR. EARLY: Fine, sir.

8

THE COURT: Mr. Buckner, how are you?

9

MR. BUCKNER: Good morning, Your Honor.

10

THE COURT: Mr. Ravenel, good morning

11

to you sir, as well.

12

Gentlemen, I thank you all. I've had --

13

in fact, I've -- yesterday afternoon I had an

14

opportunity after we concluded to review your

15

memoranda and attachments. Thank you very

16

much. Certainly they are incorporated fully

17

for purposes of review. You may certainly rely

18

on the positions stated therein; but that

19

doesn't -- I am not restricting your arguments.

20

Please argue the case fully, as you deem

21

necessary. But I am familiar with what's there

22

and have had a chance to read some of the law

23

about continuing treatment and other things

24

that are significant in this particular case.

25

Okay. I'll be happy to hear from --

Clair Johnson v MUSC and John Roberts, M.D.

Case No. 111-CP-10-8318 and 12-CP-10-2867

Hearing of January 9, 2014

Before The Honorable R. Markley Dennis, Jr.

3

1 identify yourselves and the parties that you
2 are representing. Mr. Buckner?

3 MR. BUCKNER: Thank you, Your Honor. My
4 name is Perry Buckner and I represent Dr. John
5 Roberts in this action.

6 MR. EARLY: Will Early, representing
7 the Medical University of South Carolina.

8 THE COURT: And Mr. Ravenel?

9 MR. RAVENEL: Cravens Ravenel. I
10 represent the plaintiff in this matter.

11 MR. BUCKNER: Your Honor, some of our
12 positions, Mr. Early's and
13 my position primarily is just the timeliness of
14 the plaintiff's complaint under both the
15 statute of repose and the statute of
16 limitations under Section 15-3-545.

17 Your Honor, the plaintiff's expert has
18 submitted his affidavit and we've taken his
19 deposition. Actually the plaintiff's own
20 Complaint alleges malpractice as to my client,
21 Dr. John Roberts, beginning in 2002; also,
22 again in 2003. It's in the Complaint. It
23 wasn't filed until the -- the notice of intent
24 -- until November of 2011.

25 THE COURT: On its face, it appears to

Clair Johnson v MUSC and John Roberts, M.D.

Case No. 111-CP-10-8318 and 12-CP-10-2867

Hearing of January 9, 2014

Before The Honorable R. Markley Dennis, Jr.

4

1 be a slam-dunk. We know that. But then we get
2 into 'what about her mental condition and
3 whether or not that tolls the statute.'

4 MR. BUCKNER: Your Honor, ---

5 THE COURT: And, if so, how long does
6 it do that?

7 MR. BUCKNER: Your Honor, we take the
8 position that we believe under 15-3-545(a) that
9 it can only be tolled by its own provisions
10 with a minority tolling provision. It actually
11 says, "This statute or other statute or repose
12 may only be tolled under the provisions of this
13 section."

14 The disability tolling statute and it's
15 provisions, or anything of the like, is not
16 found there.

17 THE COURT: So your position is that
18 case basically dealt with that six years is the
19 max.

20 MR. BUCKNER: Both the Langley case and
21 the Harrison case address exactly that and say
22 'although there are sometimes harsh results,
23 the Legislature's sole purpose and intent was
24 to establish this limit and absolute right of
25 six years.' His own expert and the pleadings

1 say that our guy committed malpractice in 2002,
2 again in 2003, and the continuous treatment --
3 continuous tort rule are not adopted in South
4 Carolina. They don't restart the clock. And,
5 Your Honor, we also think that the statute of
6 limitations similarly works because she states
7 that she was on notice of this claim before her
8 last ECT treatment, which was in June of 2008.
9 Even then she didn't file within three years of
10 that date.

11 Now, my friend, Mr. Ravenel has taken the
12 position that he had an additional five years
13 from that last ---

14 THE COURT: Yeah, I read that.

15 MR. BUCKNER: The reason that is
16 important in this case is because his own
17 expert affidavit says that in June of 2010 she
18 regained her mental capacity. The second part
19 of that disability statute says that you can
20 never file it within more than one year. In
21 June of 2011, she didn't file. So we don't
22 think the disability tolling statute plays in
23 at all.

24 THE COURT: Well, I'll let you respond
25 to Mr. Ravenel. Go ahead, Mr. Ravenel. You

1 can respond to the doctors at this time. And I
2 realize that there may be some overlapping
3 here, for sure.

4 MR. BUCKNER: Thank you, Your Honor.

5 THE COURT: Be happy to hear from you.
6 Tell me why those cases just don't say what I
7 think that they say.

8 MR. RAVENEL: My observation about
9 those cases and their applications to the facts
10 of this case are -- it's an unusual case in
11 that this lady received electro-convulsive
12 shock therapy eighty-six times over a several
13 years period of time -- 2003 to 2008. Each
14 time she received that, it was a blow to her
15 head, a tort. Each one, ---

16 THE COURT: I hear ---

17 MR. RAVENEL: --- standing alone.

18 THE COURT: I hear you. I hear you.
19 That's why I read it and I reread it, because I
20 thought 'gracious, that is just seemingly' -- I
21 mean, the logic and rationale of several cases
22 that talked it is that people ought not to
23 worry about suing their physician while they're
24 being treated. They ought to have the
25 opportunity to -- in fairness to a physician,

1 you may feel bad at first but ultimately over
2 the length of the treatment it may change
3 everything.

4 But clearly our court had the opportunity
5 to do what other states have done, which would
6 have enabled her to file this lawsuit without
7 any problems.

8 But the problem is, as I read them, they
9 said precisely that the legislature, basically,
10 sets the parameters. That is what they did.

11 MR. RAVENEL: No question about it, Your
12 Honor. And if we were relying on the
13 continuous treatment rule, ---

14 THE COURT: I know, but you have ---

15 MR. RAVENEL: It's not available to us.

16 THE COURT: But you have to do that in
17 order to get here.

18 MR. RAVENEL: No, sir, I disagree with
19 you.

20 THE COURT: All right. Why?

21 MR. RAVENEL: The reason I disagree with
22 you is this, is that the statutes also have a
23 provision in them that says that if you are
24 incapable of understanding that you have a
25 claim then ---

1 THE COURT: I agree with that except
2 for the fact that she is clear, at best, for
3 you in 2010. Then it says it is one year. You
4 didn't meet that one either.

5 MR. RAVENEL: But, Your Honor, there's a
6 statute of repose that applies, that gives you
7 five ---

8 THE COURT: I understand ---

9 MR. RAVENEL: --- years from the ---

10 THE COURT: No.

11 MR. RAVENEL: The last ECT was in the
12 year 2008, 2007, and this was brought before
13 that five-year statute had run.

14 THE COURT: Yeah, but the problem that
15 you have is that the language which said all of
16 that, taking all of that, ---

17 MR. RAVENEL: I'm sorry?

18 THE COURT: Taking all of that as being
19 correct, they place the limit of six years.

20 MR. RAVENEL: Right, six years. But,
21 Your Honor, each of these is an individual
22 toll.

23 THE COURT: They're not. Therein lies
24 the problem. They began ---

25 MR. RAVENEL: So the statute of

1 limitations ran before ---

2 THE COURT: Your position is that the
3 six years is it?

4 MR. BUCKNER: Our position is that the
5 six years starts from the first allegation of
6 medical negligence.

7 THE COURT: I understand. But what
8 about -- what about the fact that her -- and
9 the six years is not affected by the fact --
10 let's take the argument that in 2010 was the
11 first time that she could really, fairly
12 analyze it. You don't think that she has six
13 years from that date?

14 MR. BUCKNER: Absolutely not. The
15 statute of repose specifically says that it can
16 only be tolled as set forth in this section.
17 There are no disability provisions. The
18 statute of repose started in '02, so it
19 probably expired in '08 or '09. To the extent
20 that he would have had some relief under this
21 tolling statute, he didn't file it within a
22 year of the ending of her incapacity. That,
23 again, has no bearing on the statute of repose.
24 That's just for the purposes of the statute of
25 limitations.

1 MR. RAVENEL: Your Honor, it seems rather
2 unfair, factually, ---

3 THE COURT: Oh, I ---

4 MR. RAVENEL: --- or emotionally, on my
5 part, to say that this lady who is receiving a
6 treatment which causes her to be unable to
7 function ---

8 THE COURT: Let me say this to you in
9 that regard. I think that you're right. I
10 agree with you, as a human being. I think it's
11 a sad state.

12 However, having said that, I can't
13 legislate, nor can I overturn precedent. That
14 will be their decision. Maybe they will
15 clarify it. I think that they've had the
16 opportunity to clarify this six-year
17 limitation, which they seemed to -- really that
18 seemed to be the driving force of it, when they
19 related it back.

20 The Legislature has the right to set the
21 exposure, so to speak. They set the exposure
22 -- six years. I just -- it says what it says.

23 Now, whether they want to refine that?
24 They may well do that. But right now I'm going
25 to apply the law as I see it. You've framed

1 the issue nicely. I think you've set it forth
2 clearly and succinctly in your memo.

3 There is no question that there are some
4 questions about this lady's ability to perceive
5 and understand.

6 As I read those cases, I would agree with
7 you, Mr. Buckner, that she even comply with the
8 one-year situation for that statute.

9 But really this case, it seems to be
10 governed by the repose situation. I just --
11 I mean, they -- they easily could have put in
12 that section 'but with the exception of mental
13 deficiency, mental incompetency or mental
14 challenges.' They didn't. I don't know why,
15 but they didn't.

16 The easiest thing to deal with that one,
17 obviously, is -- and where this is clearly an
18 example of continuing treatment, that's how
19 other states deal with it; and they don't have
20 to worry about that. As you stated, each time
21 that she received one, it's another tort, in
22 theory. But that drops you right squarely in
23 the continuing treatment problem.

24 It's not a matter of -- if she had
25 stopped and didn't have treatment, maybe yes.

1 But I don't think that you can get around that.

2 I am going to -- yes, sir?

3 MR. RAVENEL: I understand what you're
4 saying, Your Honor, and I don't want to belabor
5 it because you obviously have made your
6 decision. But what I want to do is make as a
7 part of the record -- I want to put in as part
8 of this record the testimony of various
9 witnesses that I would be relying on.

10 THE COURT: Sure.

11 MR. RAVENEL: I do think that, as I
12 understand the statute that we're discussing,
13 it does not -- let me see if I can find it, if
14 you'll give me just one minute. In the ---

15 THE COURT: Let me just help you here.
16 Y'all have obviously deposed people in this.
17 Everybody is relying on the testimony of every
18 witness that has been deposed, I assume.

19 MR. RAVENEL: Yes, sir.

20 THE COURT: So all of the depositions
21 are incorporated fully for purposes of review.
22 You won't have to make that the record. Y'all
23 can select which parts or portions of it for
24 the record. But because both sides have to
25 rely on the testimony. I mean, they set the

1 factual situation in motion. I mean, you're
2 not trying to exclude any testimony, are you?

3 MR. EARLY: No, Your Honor. In fact, I
4 told Mr. Ravenel we're happy to include those
5 into the record. We'd be happy to file them.

6 THE COURT: Just for the purpose of
7 this proceeding, any side is entitled to rely
8 on any portion of any deposition testimony
9 taken prior to this hearing and make that a
10 part of the record of this proceeding without
11 citing it to me today. I understand it. I'm
12 relying on it as well. I mean, it is what it
13 is. Therein lies the issue. I don't think
14 that it could be framed any clearer. It's,
15 okay, deal with it. Answer the question,
16 please. I'll be happy to receive the answer.
17 If they reverse me, okay.

18 MR. RAVENEL: One final observation.

19 THE COURT: Sure.

20 MR. RAVENEL: Desperately grasping.

21 THE COURT: I understand.

22 MR. RAVENEL: In the case that is relied
23 on by counsel, Harrison v Benalockwa
24 (phonetic), 580 SE 2nd 109 (phonetic), footnote
25 five, it says "We know the Court of Appeals

1 addressed this issue."

2 THE COURT: --- I read that, too.

3 MR. RAVENEL: All right. And it
4 says it reflects a clear legislative intent of
5 tort actions against the State by a plaintiff
6 who is laboring under disability. We disagree
7 with the Court of Appeals interpretation. The
8 express language allows an action to be
9 extended by five years, thus an insane
10 plaintiff, as in my case, would apparently have
11 seven years from the negligence action under
12 the tort claims act.

13 We know, however, that if the claim were
14 for medical malpractice there's a six-year
15 statute of repose. Consequently it is unclear
16 how this statute would interact with the seven
17 years allowed under 15-78-110.

18 THE COURT: I don't concur. That is
19 precisely why I say we've framed the issue,
20 'now answer the question.' But in this
21 particular case you took the seven years, which
22 is -- frankly, in theory, the last treatment
23 was 2008 and she was clear in 2010. Correct?

24 MR. RAVENEL: She was aware of it in
25 2010.

1 THE COURT: But six years would have
2 run in 2008 as to one, and 2009 as to the
3 other. So we now have -- you really have had
4 seven years. That's covered.

5 MR. RAVENEL: You mean from the
6 beginning of the procedures.

7 THE COURT: She's totally had it.
8 Again, the bottom line is that they keep
9 talking about it. We are not even sure how
10 this is going to fall. I don't know how
11 you're going to reconcile that with what the
12 legislature set six years -- because really --
13 and I'm paraphrasing. They set the exposure
14 and we're going to honor that for tort suits.

15 MR. RAVENEL: In other words, we've
16 adopted the continuous treatment rule for the
17 purpose of allowing the statute of limitations
18 to run, or not ---

19 THE COURT: No. Really and truly, what
20 they said to me was 'we understand all these
21 things.' They acknowledge the mental problems.
22 They acknowledge the tolling situation. But
23 they still make -- that's why it is clear to
24 me. They could have easily have said, 'Well,
25 wait a minute. We're not going to toll this.'

1 In this case where there wasn't any mental
2 deficiency, that's fine. Six years. But it
3 will have to be determined by those statutes
4 being applied.' It may extend it seven, eight,
5 nine years. Who knows? For instance, if the
6 six years ran and they were not clear for
7 another six years, as you technically read it,
8 they'd have one year from the time they became
9 aware.

10 Well, they didn't do that. They said the
11 six-year exposure is it. As I read it.

12 Really, continuing treatment resolves the
13 problem. But -- anyway, it's an interesting
14 theory, it's an interesting problem. I promise
15 you if they decide to uphold this, then fine.
16 We'll apply it right on. If they don't, then
17 you've hit a lick for people who are mentally
18 challenged, and good for you. So thank you,
19 sir.

20 Go ahead and prepare Orders relying on
21 your briefs. The same would apply as well, Mr.
22 Early, as to yours. I think there's a -- I am
23 using it -- there is no reason -- you had some
24 other issues.

25 MR. EARLY: For the record, Your Honor,

1 the only other issue that I had was that he was
2 trying to -- he filed a notice of intent
3 against us. I don't think it tolls the
4 statute. I think he will concede that. There
5 was an insufficiency for dismissing that -- for
6 affidavit. Going by the state that he filed
7 the Complaint, I will withdraw that.

8 THE COURT: Okay.

9 MR. EARLY: The Order would be the
10 same.

11 THE COURT: One Order will be
12 sufficient. Thank you all very much.

13 (HEARING CONCLUDED)
14
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Clair Johnson v MUSC and John Roberts, M.D.

18

Case No. 111-CP-10-8318 and 12-CP-10-2867

Hearing of January 9, 2014

Before The Honorable R. Markley Dennis, Jr.

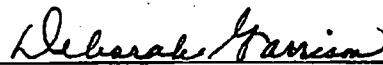
STATE OF SOUTH CAROLINA)

) CERTIFICATE

COUNTY OF CHARLESTON)

I, the undersigned Deborah Garrison, Circuit Court Reporter for the 9th Judicial Circuit, hereby certify that the foregoing is a complete and accurate transcript of the hearing held in the within action heard on January 8, 2014 before The Honorable R. Markley Dennis, Jr.;

I further certify that I am neither kin nor counsel to any of the parties and have no interest in the outcome of this action.



Deborah Garrison

Charleston, South Carolina
September 7, 2015

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

JOHN ROBERTS, M.D.,

DEFENDANT.

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

MEDICAL UNIVERSITY OF SOUTH
CAROLINA,

DEFENDANT.

IN THE COURT OF COMMON PLEAS

NINTH JUDICIAL CIRCUIT

CASE NO. 2012-CP-10-2867

FILED
2014 FEB - 4 PM 12:34
JULIE J. ARMSTRONG
CLERK OF COURT
BY L

IN THE COURT OF COMMON PLEAS

NINTH JUDICIAL CIRCUIT

CASE NO. 2011-CP-10-8318

**ORDER GRANTING SUMMARY
JUDGMENT IN FAVOR OF
DEFENDANTS**

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

rmc

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

FACTS AND PROCEDURAL HISTORY

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

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

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

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

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

STANDARD OF REVIEW

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

LAW/ANALYSIS

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

Medical malpractice claims are subject to a three-year statute of limitations and a six-year statute of repose. S.C. Code Ann. § 15-3545(A). Specifically, section 15-3-545 of the South Carolina Code provides:

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

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

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

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

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

any reason because to do so would upset the economic balance struck by the legislative body.”

Langley, 313 S.C. at 404, 438 S.E.2d at 243 (citation omitted).

a. Plaintiff's Complaint against MUSC

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

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

b. Plaintiff's Complaint against Dr. Roberts

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

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

A: 2/13/02 is a start.

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

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

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

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

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

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

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

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

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

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

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

(1) within the age of eighteen years; or

(2) insane;

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

(a) more than five years by any such disability, except infancy; nor

(b) in any case longer than one year after the disability ceases.

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

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

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

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

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

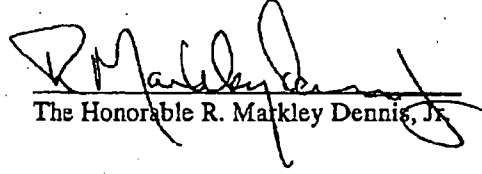
attributed that *at the time* to ECT. (See Deposition of Plaintiff, p. 81, l. 20 – p. 82, l. 21). She reiterated later in her deposition that it was during her maintenance ECT (2005-2008) that she first started believing that she was suffering from memory problems as a result of ECT. (See Deposition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

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

CONCLUSION

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

AND IT IS SO ORDERED.


The Honorable R. Markley Dennis, Jr.

January 23, 2014
Charleston, South Carolina

emo8/12

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS IN
THE NINTH JUDICIAL CIRCUIT

Clair Craver Johnson,)
)
Plaintiff,)

CASE NOS.: 2012-CP-10-2867
AND 2011-CP-10-8318

v.)
)
John Roberts, M.D.,)
)
Defendant.)

**PLAINTIFF'S RULE 59(e) MOTION
FOR RECONSIDERATION**

Clair Craver Johnson,)
)
Plaintiff,)
v.)
)
Medical University of South Carolina,)
)
Defendant.)
_____)

2014 FEB 25 PM 1:40
JULIE J. ARMSITRONG
CLERK OF COURT
BY _____

Plaintiff moves the court pursuant to Rule 59(e), SCRCP in the above styled actions for reconsideration of its order granting summary judgment in favor of the defendants. This Rule 59(e) motion is based upon the contention of defendants, relied upon by the court, that the six-year statute of repose governing medical malpractice actions and the tolling of claims due to insanity under the disability statute contained in §15-3-40 S.C. Code have expired and the claims in both actions are time barred.

Defendants and the court failed to consider in their analysis that defendants misled the plaintiff and are equitably estopped from raising this limitation of action defense by representing to the plaintiff that plaintiff's loss of both anterograde and retrograde memory would be and was transient when the medical community was aware of studies revealing that her loss was likely permanent. See attached Electroconvulsive Shock Therapy (ECT) consent form (Exhibit 1) and

deposition and the affidavit of Harold Bursztajn, M.D. (Exhibits 2 and 3) describing Clair Johnson's failure to "regain the mental capacity to understand and appreciate the harm she suffered as a result of ECT until June 2010." See Harvey v. South Carolina Department of Corrections, 338 S.C. 500, 527 S.E.2d 765 (Ct. App. 2000) at 770, "a defendant will be estopped from asserting a statute of limitation defense when the delay that otherwise would give operation to the statute had been induced by the defendant's conduct."

Defendants and the court failed to consider that the plaintiff's confused mental state, as it existed, was in no small part the direct result of the Medical University of South Carolina's use of bilateral ECT on Clair Johnson¹ (Exhibit 4) on eighty-six (86) occasions from December 10, 2003 to December 19, 2003 and then following a gap in the time from December 19, 2003 to April 4, 2005 continuously from April 4, 2005 to June 26, 2008 was not correctly described as "insanity" but instead was mental confusion resulting from damage to and repression of her memory caused by use of shock "therapy" that was superimposed on her mania and as such plaintiff can assert the discovery rule contained in S.C. Code Ann. § 15-3-535 (Supp. 1999); Moriarty v. Garder Sanctuary, 341 S.C. 320, 534 S.E.2d 672 (2000). In Moriarty, a priest's sexual molestation of a 4½ -year old child was repressed until the child reached age 26.

§ 15-3-535 provides:

Except as to actions initiated under Section 15-3-545, all actions initiated under § 15-3-530(5) must be commenced within three years after the person knew or by the exercise of reasonable diligence should have known that he had a cause of action.

In Moriarty, the court held that the discovery rule may toll a statute of limitations during the period a victim psychologically represses her memory of sexual abuse.

The Moriarty court further said:

¹ See Roberts involvement in consultation and referral with the Medical University of South Carolina for the use of ECT as treatment for plaintiff in attached Medical University of South Carolina's medical records.

Moriarty could have brought her lawsuit under two other statutes of limitations if she had done so in a timely manner: the six-year limit of S.C. Code Ann. § 15-3-530(5) . . . and the age of majority statute contained in Section 15-3-40

The ultimate question remains . . . may a plaintiff assert Section 15-3-535 in a repressed memory case in order to maintain a timely cause of action?

The Moriarty court held that the important date under the discovery rule is the date the plaintiff discovers the injury not the date of the discovery of the wrongdoer. Moriarty, 529.

Clair Craver's state of confusion resulting from repeated ECT prevented her from knowing she had an injury. The loss itself prevented her from appreciating the existence of the loss. She was a shadow of her former self and the fact that she was a shadow she could not appreciate the loss of her ability to function independently. Repressed memory suggests a subconscious act while ECT at the levels given to Clair forces the brain to forget for some period the conduct that resulted in memory loss and destruction of major portions of the recipients life and the argument in Moriarty applies equally to Clair C. Johnson, the plaintiff herein.

Plaintiff's potential for memory impairment from ECT was recognized as a risk by the Medical University of South Carolina and the medical community in general. See the Medical University of South Carolina Institute of Psychiatry ECT consent form attached as Exhibit 1 and the article in 2003 Neuropsychopharmacology, "The Cognitive Effects of Electroconvulsive Therapy in Community Settings." (Exhibit 5) and the recognition by the Medical University of South Carolina and Dr. John Roberts' that the plaintiff would likely have post-ECT poor memory function, the degree of which was likely related to the number of treatments and their type and that use of the "bilateral ECT" to which the plaintiff was subjected was likely to result in longer term and more serious impairment of an ECT patients mental processes equitably estop the Medical University of South Carolina and Dr. John Roberts from relying upon the

predictable consequences of their actions to time bar plaintiff from asserting a claim.

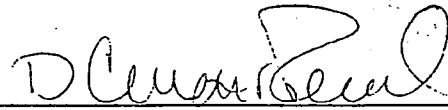
SUMMARY

The Medical University of South Carolina and Dr. John Roberts knowingly exposed the plaintiff to the most destructive form of ECT now assert the delay resulting from her memory impairment as a time bar to a claim for damage to her memory.

Any public policy served by South Carolina Limitation of Action Statutes is not served by rewarding the defendants for successfully damaging the mental processes of the plaintiff so that her loss of memory resulted in a delay in her appreciation of the nature of her loss and the availability of a claim for personal injuries. Dr. Roberts and the Medical University of South Carolina combined in efforts to treat Clair by applying bilateral electroconvulsive therapy to the brain of the plaintiff on eighty-six (86) occasions between December 10, 2003 and June 26, 2008 all the while knowing that bilateral ECT was the most likely of the available electrical shock "therapies" to result in permanent damage to plaintiff's brain's ability to function. Dr. Roberts was both aware of the extended use of ECT and is listed as referring physician for his consent to administration of ECT to the plaintiff, Clair Johnson. See Plaintiff's memorandum in opposition to Defendants' motion with exhibits. Particular notice is called to Exhibit A of MUSC 2508 of 2835 where the following appears. "Pt feels nothing is wrong, Dr. Roberts...wants to be involved in Pt's care."

To bar plaintiff from an opportunity to present her claim to a jury of her peers would be a travesty.

(Signature page follows)



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Attorneys for Plaintiff

February 14, 2014
Columbia, South Carolina

EXHIBIT 1



IOPCONSENT

Institute of Psychiatry
ECT CONSENT FORM

Page 1 of 4

STAMP PLATE AREA

JOHNSON, CLAIR
000947758 08/25/66 F W
01/17/08 09:15AM ECT
ECT PROCEDURE
V# 234645869 A# 4444712 M110
PSYCH 1 SOUTH PET

Patient Name _____
MRN _____

Consent for ECT series _____ Consent for maintenance ECT ☒

Name of Attending Physician: Dr. Faust

Name of Patient: Debra Schwartz

My doctor has recommended that I receive treatment with Electroconvulsive Therapy (ECT). The nature of this treatment, including the risks and benefits that I may experience, have been fully described to me by Dr. Faust and I give my consent to be treated with ECT.

I will receive ECT to treat my psychiatric condition. I understand that there may be other alternative treatments for my condition which may include medications and psychotherapy. Whether ECT or an alternative treatment is most appropriate for me depends on my prior experience with these treatments, the nature of my psychiatric condition, and other considerations. Why ECT has been recommended for my specific case has been explained to me.

ECT involves a series of treatments. To receive each treatment, I will be brought to a specially equipped room in this facility. The treatments are usually given in the morning before breakfast. Because the treatments involve general anesthesia, I will have had nothing to drink or eat for at least six hours before each treatment. When I come to the treatment room, an intravenous line will be placed so that I can be given medications. Generally, I will receive a medication to reduce oral secretions and to decrease heartbeat irregularities before each treatment. I will also be given an anesthetic drug that will quickly put me to sleep. I will be given another drug that will relax my muscles. Because I will be asleep, I will not experience pain or discomfort during the procedure. I will not feel the electrical current, and when I wake up, I will have no memory of the treatment.

To prepare for the treatments, monitoring sensors will be placed on my head and chest. A blood pressure cuff will be placed on one or two of my limbs. This is done to monitor my brain waves, my heart, and my blood pressure. These recordings involve no pain or discomfort. After I am asleep, a small, carefully controlled amount of electricity will be passed between two electrodes that have been placed on my head. Depending on where the electrodes are placed, I may receive either bilateral ECT, bifrontal ECT, or unilateral ECT. In bilateral ECT, one electrode is placed on the left side of the head, the other on the right side. In bifrontal ECT, one electrode is placed on the forehead above the outer edge of the right eye, and one on the forehead above the outer edge of the left eye. In unilateral ECT, both electrodes are placed on the same side of the head, usually on the right side. When the current is passed, a generalized seizure is produced in the brain. Because I will have been given a medication to relax my muscles, muscular contractions in my body that would ordinarily accompany a seizure will be considerably softened. The seizure usually lasts for approximately one minute. Within a few minutes, the anesthetic drug will wear off and I will awaken. During the procedure, my heart rate, blood pressure, and other functions will be monitored. I will be given oxygen to breathe. After waking up from the anesthesia, I will be brought to a recovery room, where I will be observed until it is time to leave the ECT area.

ectconsent

CTE 700065 Rev. 4/04

atient: JOHNSON, CLAIR

MRN: 947758

Encounter: 234645869

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IOPCONSENT

Institute of Psychiatry
ECT CONSENT FORM

Page 2 of 4

STAMP PLATE AREA

Patient Name _____

MRN _____

The number of treatments that I receive cannot be predicted ahead of time. The number of treatments will depend on my psychiatric condition, how quickly I respond to the treatment, and the medical judgment of my psychiatrist. Typically, six to twelve treatments are given. However, some patients respond slowly, and more treatments may be required. Treatments are usually given three times a week, but the frequency of treatment may also vary depending on my needs.

The potential benefit of ECT for me is that it may lead to improvement in my psychiatric condition. ECT has been shown to be a highly effective treatment for a number of conditions. However, not all patients respond equally well. As with all forms of medical treatment, some patients recover quickly; others recover only to relapse again and require further treatment; while still others fail to respond at all. Very rarely, a switch into a manic phase of manic-depressive illness can occur.

Like other medical procedures, ECT involves some risks. When I awaken after each treatment, I may experience confusion. The confusion usually goes away within an hour. Shortly after the treatment, I may have a headache, muscle soreness, or nausea. These side effects usually respond to simple treatment. More serious medical complications with ECT are rare. With modern ECT techniques, dislocations or bone fracture, and dental complications very rarely occur. As with any procedure performed under general anesthesia, there is a remote possibility of death. It is estimated that a fatality associated with ECT occurs in approximately one per 10,000 patients treated. While also rare, the most common medical complications with ECT are irregularities in heart rate and rhythm. Very rarely, myocardial infarction (heart attack) or stroke can occur.

To reduce the risk of medical complications, I will receive a careful medical evaluation prior to starting ECT. However, in spite of precautions, there is a chance that I will experience a medical complication. Should this occur, I understand that medical care and treatment will be instituted immediately and that facilities to handle emergencies are available. I understand, however, that neither the institution nor the treatment physicians are required to provide long-term medical treatment. I shall be responsible for the cost of such treatment whether personally or through medical insurance or other medical coverage. I understand that no compensation will be paid for lost wages or other consequential damages.

A common side effect of ECT is poor memory functioning. The degree of disruption of memory is likely to be related to the number of treatments given and their type. A smaller number of treatments is likely to produce less memory impairment than a larger number of treatments. Right unilateral ECT (electrodes on the right side) is likely to produce milder and shorter-lived memory impairment than bilateral ECT (one electrode on each side of the head). Bifrontal ECT (with the electrodes on the forehead) may cause memory problems more like unilateral ECT than bilateral ECT, although since it has not been used as much as the other two electrode placements, this has not yet been proven. The memory difficulties with ECT have a characteristic pattern. Shortly following a treatment, the problems with memory are most pronounced. As time from treatment increases, memory functioning improves. Shortly after the course of ECT, I may experience difficulties remembering events that happened before and while I received ECT. This spottiness in memory for past events may extend back to several months before I received ECT, and in rare instances, to one or two years. Many of these memories will return during the first several months following the ECT course. However, I may be left with some permanent gaps in memory, particularly for events that occurred close in time to the ECT course.

ectconsent

OTE 700065 Rev. 4/04

atient: JOHNSON, CLAIR

MRN: 947758

Encounter: 234645869

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"TOPCONSENT"

Institute of Psychiatry
ECT CONSENT FORM
Page 3 of 4

STAMP PLATE AREA

Patient Name _____
MRN _____

In addition, for a short period following ECT, I may experience difficulty in learning and remembering new information. This difficulty in forming new memories should be temporary and will most likely subside within several weeks following the ECT course.

Individuals vary considerably in the extent to which they experience confusion and memory problems during and shortly following treatment with ECT. However, in part because psychiatric conditions themselves produce impairments in learning and memory, many patients actually report that their learning and memory functioning is improved after ECT compared to their functioning prior to the treatment course. A small minority of patients report severe problems in memory that remain for months or even years. The reasons for these rare reports of long lasting impairment are not fully understood.

Because of the effects on my memory, it is important that I not make any important personal or business decisions during the ECT course or immediately following the course. This may mean postponing decisions regarding financial or family matters. After the treatment course, I will begin a "convalescence period," usually one to three weeks, but which varies from patient to patient. During this period, I should refrain from driving, transacting business, or other activities for which impairment of memory may be problematic. Alcoholic beverages are also prohibited during this period.

I understand that I should feel free to ask questions about ECT at this time or at any time during the ECT course or thereafter by calling 792-9888 (local) or 1-800-424-6872 (out-of-area) and requesting to speak with the doctor or any other member of the ECT team. I also understand that my decision to agree to ECT is being made on a voluntary basis, and that I may withdraw my consent and have the treatment stopped at any time.

I consent to the administration of such anesthetics as may be considered necessary or advisable by the person responsible. Prior to the procedure I will have the opportunity to discuss my plan of anesthesia care in detail with the Anesthesia care provider of such service with the exception of: none

State exception or write "none."

The nature, proposed and possible consequences of the anesthesia/moderate sedation, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me. No guarantees or assurances have been made or given by anyone as to the results that may be obtained.

ectconsent

OTE 700065 Rev. 4/04

atient: JOHNSON, CLAIR

MRN: 947758

Encounter: 234645869

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MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA



"TOPCONSENT"

Institute of Psychiatry
ECT CONSENT FORM
Page 4 of 4

C9

STAMP PLATE AREA

JOHNSON, CLAIR
000947758 08/25/55 P W
01/17/08 09:15AM ECT
ECT PROCEDURE
V# 234645869 A# 4444712 M110
PSYCH 1 SOUTH PET

Patient Name _____
MRN _____

I, THE UNDERSIGNED, HAVE HAD THIS FORM EXPLAINED TO ME AND FULLY UNDERSTAND THE CONTENTS
OF THIS AUTHORIZATION.

X Clair C. Johnson
Signature of Patient

Date 1/18/08

When patient is incompetent to affix signature:
Signature of person authorized
to consent for patient _____

Address _____

Authority to consent: _____

OK
Signature of Witness

Address 5 N. E. L. MUSC IOP

Physician obtaining consent: _____

Pager ID: 14024 Date: 1/17/08 Time: 09:35 AM/PM

ectconsent

OTE 700085 Rev. 4/04

atient: JOHNSON, CLAIR

MRN: 947758

Encounter: 234645869

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0230

EXHIBIT 2

STATE OF MASSACHUSETTS)
)
COUNTY OF MIDDLESEX)

AFFIDAVIT

1. I, Harold J. Burstztajn, M.D., am a physician currently licensed by the states of Massachusetts and New Hampshire. I am board-certified in psychiatry by the American Board of Psychiatry and Neurology. I serve as an Associate Clinical Professor of Psychiatry, Co-Founder of the Program in Psychiatry and the Law, and Principal Mentor for students at Harvard Medical School. A copy of my current curriculum vitae is attached hereto as Exhibit A.

2. This affidavit is provided pursuant to S. C. Code Ann. §§15-36-100 and 15-79-125.

3. Based upon my medical education, knowledge, training and experience, I am familiar with the generally accepted principles and standards of care in the diagnosis and treatment of Bipolar Disorder with psychotic features and a history of head trauma, for which Clair Craver Johnson was being treated.

4. I have, to date, reviewed records of Clair Craver Johnson's education, certain observations by the parents of Clair Craver Johnson over a significant period of time, court records, hospital and physicians' and psychologists' records, all documenting Clair Craver Johnson's emotional condition and the treatment of Clair Craver Johnson by the Medical University of South Carolina hospital and by John Roberts, M.D. and Milton Faust, M.D.

5. I interviewed Clair Craver Johnson in my office for 4 ¾ hours after reviewing the referenced materials.

6. After reviewing the described records and meeting with Clair Craver Johnson, and relying upon my education, knowledge, training and experience, I am of the opinion that based upon a reasonable degree of medical certainty, more likely than not, the treatment provided by

the Medical College of South Carolina hospital, John Roberts, M.D., and Milton Faust, M.D., did not meet the standard of care imposed upon hospitals and physicians under like circumstances. I am of the opinion that the Medical University of South Carolina failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with electroconvulsive therapy (ECT) (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; that Dr. Roberts failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, by failing to conduct an adequate psychopharmacological assessment of alternate medication choices, by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; and that Dr. Faust failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, and by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence.

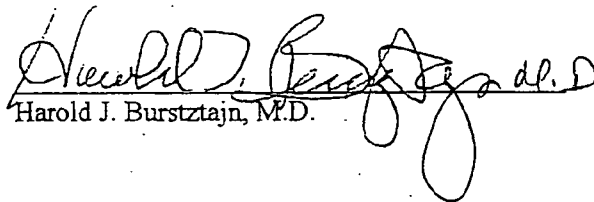
7. I am likewise of the opinion that based upon a reasonable degree of medical certainty, more likely than not, as a direct and proximate result of the negligent acts or omissions on the part of the Medical University of South Carolina, John Roberts, M.D., and Milton Faust, M.D., Clair Craver Johnson sustained the following injuries: prolonged and, to a degree, permanent exacerbation of cognitive impairments, including memory loss; impaired capacity to participate in her divorce proceedings; impairments in the post-traumatic spectrum resulting from the physically and emotionally traumatic experience of extended involuntary treatment with ECT, which produced feelings of helplessness, terror, and personal violation; a prolonged period of confusion and demoralization, resulting in a loss of access to a significant segment of her life experience and a loss of continuity of autobiographical memory; diminished trust in mental-health care providers; diminished hope for the future; and loss of the potential benefits of appropriate treatment with psychotherapy, medications, and a meaningful informed-consent process. Had Clair Craver Johnson been properly diagnosed and treated, I am of the opinion that to a reasonable degree of medical certainty, Ms. Johnson more likely than not would not have sustained the injuries described above and her emotional issues would have been managed so as to allow her to function as a productive individual.

8. Further, I am of the opinion that to a reasonable degree of medical certainty, more likely than not, Clair Craver Johnson did not regain the mental capacity to understand and appreciate the harm she suffered as a consequence of the negligent acts or omissions specified above, particularly the extended involuntary treatment with ECT, until she sought help in reviewing her medical records in June 2010, two years after ECT was concluded. Her capacity to comprehend what was going on in her life, already diminished by mental illness, was further diminished by the physical and emotional trauma and cognitive impairments associated with an

extended period of ECT, which foreseeably resulted in prolonged confusion and demoralization. She recovered the ability to process her experiences during those years only by reestablishing ties with a supportive community that helped her recreate her autobiographical memory.

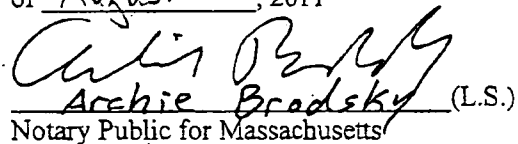
9. This affidavit does not include all of my opinions and I reserve the right to modify and/or formulate additional new opinions should additional, pertinent records be submitted for my review.

Further affiant sayeth not.


Harold J. Burstztajn, M.D.

Sworn to before me this 10th day

of August, 2011


Archie Bradsky (L.S.)
Notary Public for Massachusetts

My Commission expires: June 22, 2012

EXHIBIT 3

STATE OF SOUTH CAROLINA
IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON NINTH JUDICIAL
CIRCUIT

CLAIR CRAVER JOHNSON,
Plaintiff

vs. CASE NO. 2012-CP-10-2867

JOHN ROBERTS, M.D.,
Defendant

CLAIR CRAVER JOHNSON,
Plaintiff

vs. CASE NO. 2011-CP-10-8318

MEDICAL UNIVERSITY OF
SOUTH CAROLINA,
Defendant

TELECONFERENCE DEPOSITION
OF
HAROLD B. BURSZTAJN, M.D.

Harvard University Science Building
One Oxford Street
Cambridge, Massachusetts 02138

July 26, 2013
11:00 a.m.

REPORTER: Carol A. Fierimonte, CLNR

A. WILLIAM ROBERTS, JR., & ASSOCIATES (800) 743-DEPO
scheduledepo.com

Page 2

1 APPEARANCES:

2 BAKER, RAVENEL & BENDER, LLP
3 By: D. Cravens Ravenel, Esquire
4 3710 Landmark Drive, Suite 400
5 Columbia, South Carolina 29204
6 (803) 799-9091
7 Cravenel@hrblegal.com
8 On behalf of the Plaintiff

9

10 YOUNG, CLEMENT, RIVERS, LLP
11 By: James E. Scott, IV, Esquire
12 25 Calhoun Street, Suite 400
13 Charleston, South Carolina 29401
14 On behalf of the Defendant, Doctor Roberts

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10 PIERCE HERNS SLOAN & WILSON, LLC
11 By: William P. Early, Esquire
12 321 East Bay Street
13 The Blake House
14 Charleston, South Carolina 29401
15 (843) 722-7733
16 On behalf of the Defendant, Medical
17 University of South Carolina

Page 4

1 PROCEEDINGS

2 July 26, 2013

3 HAROLD BURSZTAJN, M.D.,

4 having first shown proper identification

5 and having been duly sworn, was examined

6 and testified as follows:

7 DIRECT EXAMINATION

8 BY MR. EARLY:

9 Q. Doctor Bursztajn, we met off the record a

10 minute ago. My name is William Early. I

11 am a lawyer down here in Charleston, South

12 Carolina. I am going to be taking your

13 deposition today along with my colleague,

14 Jim Scott. I represent the Medical

15 University of South Carolina. Mr. Scott

16 seated to my left represents Doctor

17 Roberts. And you have been identified as

18 an expert for the plaintiff, Clair Johnson

19 in this case and my goal is to find out

20 your opinions today and what you may

21 testify about at trial.

22 Is that your understanding of

23 your role in this case?

24 A. Yes.

25 Q. All right. Because your name is somewhat

Page 3

1 INDEX

2 WITNESS DIRECT CROSS REDIRECT RECROSS

3 HAROLD BURSZTAJN, M.D.

4 By Mr. Early 4

5

6

7

8

9

10 EXHIBITS

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13 Exhibit 2	Notes for Deposition Preparation	27

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Page 5

1 unfamiliar, could you please spell it for

2 the record? Tell me your full name and

3 spell your last name, if you would.

4 A. It is Harold J., and then Bursztajn,

5 B-U-R-S-Z-T-A-J-N.

6 Q. And Doctor Bursztajn, where are you

7 currently located right now?

8 A. We are in the basement of the Harvard

9 University Science Center in the Media

10 Services Center, B-4.

11 Q. All right. And tell me your, your

12 business or physical address where you get

13 your mail.

14 A. It is at my home office which is at 96

15 Larchwood, that is spelled

16 L-A-R-C-H-W-O-O-D, Larchwood as the tree,

17 Drive in Cambridge, Massachusetts. And

18 our zip code is 02138.

19 Q. And your date of birth, sir?

20 A. November 18, 1950.

21 Q. And are you married?

22 A. Divorced.

23 Q. Okay. How long have you been divorced?

24 A. Oh, gosh, it's been now over six years.

25 Q. Okay. And what was your wife's name?

Page 6 1 A. Patricia Illingworth, 2 I-L-L-I-N-G-W-O-R-T-H. 3 Q. And you are currently -- are you employed 4 by Harvard or are you employed by yourself 5 or by whom are you currently employed? 6 A. I am self-employed. 7 Q. And how long have you been self-employed 8 as opposed to employed by an entity such 9 as a university? 10 A. Since 1982. 11 Q. All right. So you have not been employed 12 by anyone other than yourself since 1982? 13 A. I have not received a salary from anyone 14 since 1982. My function at the 15 university, I donate my time. 16 Q. Okay. I am getting to that in a second. 17 What have you been doing since 1982 as a 18 self-employed, I will assume, 19 psychiatrist? 20 A. Yes. I have been in clinical and forensic 21 psychiatric practice. 22 Q. And if you could just tell me what that 23 entails, what your, what your job duties 24 as a clinical and forensic psychiatrist 25 since 1982, what your job duties are.	Page 7 1 A. From 1982 to 1986, I saw patients 2 primarily on an inpatient setting. Since 3 then, I see patients in my home office. I 4 also consult to other clinicians, give 5 second opinions, third opinions on 6 patients who have not responded well to 7 treatment, risk management issues. I also 8 do the same for institutions. I also 9 engage in risk management consultation and 10 forensic consultation which includes 11 consulting to attorneys, to judges, and to 12 institutions around issues where 13 psychiatry and the law meet. 14 Q. I am just curious, what kind of consulting 15 would you do for a judge or have you done 16 for a judge? 17 A. I have been asked to give talks to judges 18 about standards for what constitutes 19 forensic psychiatric methodology, what are 20 the standards for opinion formulation and 21 analysis. 22 Q. Have you ever given such a talk to any 23 judges in South Carolina? 24 A. I gave one talk to federal judges which I 25 believe included judges from South
Page 8 1 Carolina, but it wasn't in South Carolina. 2 It was in -- it may have been in 3 Tennessee. It was the Southeast Circuit. 4 And there I talked about standards for 5 forensic psychiatric autopsy and I used as 6 an illustration one particular case where 7 I consulted to a Discovery Channel program 8 on doing a forensic psychiatric autopsy. 9 Q. I am sorry. Did you say autopsy? 10 A. Autopsy, yes. 11 Q. Okay. 12 A. Forensic psychiatric autopsy is an autopsy 13 where you cannot go ahead and -- you 14 cannot actually examine the person but you 15 have to do a reconstruction. The reason 16 why you can't examine the person, either 17 the person has been recently dead or the 18 person has been long dead and you are 19 trying to put the pieces together to see 20 how best they fit. 21 Q. Okay. Do you -- I know you said it was a 22 Southeastern Circuit. Do you remember 23 where in Tennessee and when that talk was? 24 A. I don't. It was probably somewhere in the 25 past 15 years. But it was an annual	Page 9 1 meeting. 2 Q. Doctor Bursztajn, since 1986, I am 3 interested how many patients do you see on 4 average in a week or a month or how ever 5 you want to quantify it? 6 A. My clinical practice constitutes on the 7 average 20 hours of patients and that can 8 be anywhere from eight, eight patients to 9 15 patients a week. It just depends. 10 Q. And how many of those patients are you 11 seeing for expert witness or forensic 12 work? 13 A. None. When I do a forensic psychiatric 14 evaluation, they are not my patients any 15 longer. There is no doctor/patient 16 relationship so I wouldn't count them as 17 being clinical in that sense. Clinical is 18 only when you have a doctor/patient -- in 19 my vocabulary, a doctor/patient 20 relationship. 21 Q. All right. And do you charge those 22 patients that you see, Doctor? 23 A. I do. 24 Q. All right. Do you charge them, I mean do 25 you submit that to their insurance or do

Page 10

1 you charge them specifically or both?
2 A. It is almost exclusively private pay.
3 Q. All right. Okay. What do you charge them
4 per hour?
5 A. It depends. For an initial evaluation, it
6 is \$675 for an hour and 15 minutes. If I
7 am seeing a patient on a standard, yes, an
8 established patient on a treatment basis,
9 it is \$200 for 45 minutes or it is \$100
10 for 15 minutes or less.
11 Q. All right. Is this psychotherapy work or
12 what type of work are you doing with them?
13 A. It is psychiatric work which includes both
14 psychotherapy and psychopharmacology, as
15 well as an ongoing evaluation.
16 Q. Okay.
17 MR. RAVENEL: Will, let me
18 interrupt. Something is going on. We are
19 getting a lot of background right now.
20 Somebody is talking in the background.
21 MR. EARLY: Okay. Nobody else
22 is in the room.
23 MR. RAVENEL: It may be on our
24 end. Let me go see if I can get the
25 technician to check it.

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1 A. I do. And what I did was I brought with
2 me an updated C.V. which includes one more
3 publication, something which was in press
4 which has now been published, because it
5 hasn't gotten up in the web yet, but it
6 has gotten up on the PDF.
7 Q. Okay.
8 A. So I have a copy of that.
9 MR. EARLY: Why don't we do this?
10 For housekeeping, if we could go ahead and
11 mark what you brought, your current C.V.
12 that includes that publication that you
13 just referenced as Exhibit 1 or A.
14 THE WITNESS: Yes.
15 MR. EARLY: Or whatever is
16 easiest.
17 (Document marked as Exhibit 1
18 for identification.)
19 Q. And just for the record, Doctor Bursztajn,
20 what publication are you referencing that
21 is included on that C.V. which is Exhibit
22 1 that is not on the one that I have?
23 A. Let me take a look and just make sure.
24 Let's see. It looks like my office is
25 ahead of me. They actually did get it up

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1 MR. EARLY: I will too. There
2 is an ice machine that is making a lot of
3 noise.
4 MR. RAVENEL: All right.
5 (Brief recess.)
6 MR. EARLY: Back on the record,
7 please. If you hear something again, just
8 stop me and let me know. I will go get
9 whomever. Madam Court Reporter, can you
10 read back the last question or his
11 response? I forgot where I was.
12 (Record read back as requested.)
13 MR. EARLY: All right. Thank
14 you.
15 Q. Doctor Bursztajn, do you regularly
16 prescribe your patients drugs?
17 A. I do prescribe medications to patients on
18 a regular basis, yes.
19 Q. All right. I have a C.V. of yours and I
20 don't know the date of it. I think I have
21 got -- actually, what I have got has got a
22 URL or a website looking thing on the top
23 and the bottom. I had a notebook
24 overnighted to you guys yesterday. Do you
25 have that?

Page 13

1 on the web. I thought they didn't, but it
2 is the same one.
3 Q. Just so I know, which one was that that
4 was recently added?
5 A. Number 81 on the publications list, the
6 Journal of the Royal Society of
7 Medicine.
8 Q. The Vulnerabilities --
9 A. Mm-hmm, yes.
10 Q. Okay. Other than -- so what I have there
11 in the notebook and what is Exhibit 1 is
12 the most current, up-to-date C.V.?
13 A. Yes.
14 Q. All right. If we could just flip through
15 it real quickly, there were a couple of
16 things I wanted to ask, Doctor Bursztajn.
17 A. Okay.
18 Q. Your current position, I know you said you
19 were not paid by anyone but you donate
20 time. Can you tell me what you mean by
21 that?
22 A. I am an Associate Clinical Professor of
23 Psychiatry at the Beth Israel Department
24 of Psychiatry and the Massachusetts Mental
25 Health Center at Harvard Medical School.

Page 14	Page 15
1 Q. And what is your -- what does that mean? 2 What do you do there? 3 A. I teach, I mentor, I consult, I help 4 people to -- students and faculty as best 5 as I can. 6 Q. How much of your time do you donate doing 7 that per week or per month? 8 A. It varies. Anywhere between four hours to 9 eight hours of time per week. 10 Q. And you receive no remuneration for that 11 time donation? 12 A. I have donated my time since 1982 to the 13 medical school. 14 Q. Okay. And prior to 1982, what was your 15 role at Harvard? 16 A. Well, beginning in 1972, I came there as a 17 student, then I received a fellowship, 18 then I was first an instructor in 19 pediatrics, then internal medicine, then I 20 was in residency training. I became an 21 instructor in psychiatry and when I -- I 22 was the Chief Resident in psychiatry, the 23 program in psychiatry and the law and one 24 of the founders of the Harvard Medical 25 School program in psychiatry and the law	1 at the Massachusetts Mental Health Center 2 in 1982. 3 Q. And Doctor Bursztajn, just because I am 4 not familiar with that, is that a degree a 5 student gets in medical school or a sub 6 degree or is that a B.S. degree at 7 Harvard? What is Forensic Psychiatry in 8 the Law? 9 A. It is the program, Forensic Psychiatry in 10 the Law is a program which is risk 11 management consultation and research at 12 the interface of psychiatry and the law. 13 And we have students at all levels ranging 14 from undergraduate medical students to 15 residents to postgraduate to senior 16 faculty who wish to go ahead and continue 17 to learn. It is an ongoing workshop for 18 exploring difficult clinical risk 19 management and forensic problems at the 20 interface of psychiatry, ethics and the 21 law. 22 Q. All right. Well, how many different 23 classes are offered in that program, if 24 you will? 25 A. Well, we don't have -- it is a weekly
Page 16	Page 17
1 seminar which meets on a weekly basis and 2 then participants are encouraged to keep 3 in contact with each other throughout for 4 ongoing consultation and research 5 collaborations. 6 Q. All right. And how many -- do you teach 7 that every week? 8 A. Every week, except in July and August we 9 don't have formal meetings because too 10 many people are away. But from September 11 through, through July, usually July 7th, 12 the first week in July, we do meet on a 13 weekly basis. 14 Q. All right. Do you use a presentation 15 program such as PowerPoint to aid your 16 lectures and seminars? 17 A. As well as possible but occasionally I do 18 succumb to those, yes. 19 Q. Okay. Do you have copies of those dating 20 back in your hard drive somewhere? 21 A. I don't. Generally speaking, what happens 22 is the presentations, any specific 23 presentations which get to the point of 24 being a PowerPoint eventually became a 25 paper, and when the paper is published	1 there is no more need for the PowerPoint 2 per se. I find myself, although I must 3 say I do use PowerPoint occasionally, 4 especially for photographs, the regular 5 use of PowerPoints discourages discussion 6 and exploration and learning in a complex 7 fashion. I mean a PowerPoint can be 8 useful but it is not -- it is an aid to 9 teaching. It is not a substitute for 10 teaching. 11 Q. All right. Is the section of your C.V. 12 titled Presentations, would those be the 13 lectures or the titles of these lectures 14 that you have given in this Psychiatry in 15 the Law seminars and classes? 16 A. No. Because I don't -- those are outside 17 of there. Those are presentations in a 18 variety of different institutions ranging 19 from Grand Rounds at hospital and surgery, 20 for example, or plastic surgery, to 21 teaching at various, various institutions 22 across the country. So no, those are 23 outside of there. 24 Q. Okay. Well, do you have a list of any of 25 those presentations you offer in that

Page 18 1 class memorialized anywhere? 2 A. No. 3 Q. All right. Looking at your C.V., Doctor 4 Bursztajn -- 5 A. Yes. 6 Q. You have a, beginning on about page three 7 or four, the bottom, it is titled 8 Bibliography. 9 A. Yes. I think that is on page number six 10 in my -- I see. You are using -- let me 11 use this one. I see. 12 Q. I apologize. I see it now. 13 A. Yes, okay. 14 Q. What is the significance of that section? 15 Were those things that you penned with 16 others? 17 A. There are a variety of articles which have 18 been published in peer-reviewed journals, 19 blindly peer-reviewed journals since my 20 first article in 1977 through today. 21 Q. All right. And these are in chronological 22 order? 23 A. Yes. 24 Q. Obviously. 25 A. Yes.	Page 19 1 Q. All right. Do any of these articles under 2 your section of Bibliography have any 3 bearing on the opinions that you are 4 rendering in this case? 5 A. Well, the totality of my work does 6 specifically deal with the issues of 7 clinical decision making and informed 8 consent and dealing with complex patients 9 where there is an issue of involuntary 10 treatment, where there was an issue of 11 risks and benefits to be considered in 12 psychiatry, and where there was an issue 13 of informed consent process. We can go 14 through these specifically, but there is 15 -- the bulk of these articles do focus 16 very much on the issues which I believe 17 are at the heart of the matter in this 18 particular case. Would you like me to go 19 through them individually? 20 Q. Well, there are 70 something of them. 21 A. Pick any one of them. 22 Q. I don't know if we have time to go through 23 each one, and I was hoping to get a little 24 smaller answer than that. But how about 25 with regards to ECT specifically,
Page 20 1 Electroconvulsive Therapy, have you 2 offered any peer-reviewed articles dealing 3 specifically with Electroconvulsive 4 Therapy? 5 A. Looking through my articles here, let's 6 see here, the issues relevant to ECT 7 therapy are discussed, even if the word 8 ECT is not mentioned, in a variety of 9 these articles. 10 For example, looking at this 11 here, number nine, number ten, number 12, 12 number 13, number 16, number 19, number 13 20, number 22, number 23 and number 24, 14 number 33, number 38, number 41, number 15 42, number 43, number 55, number 60, 16 number 62, number 65, 66, number 68, 17 number 76, number 78, number 80. And 18 then in terms of books that I have written 19 and that is on page 15, numbers two 20 through five. 21 Q. Okay, Doctor. My question was did you 22 have any of those articles, and you have 23 expanded to books, dealing with 24 Electroconvulsive Therapy. And the ones 25 that you just told me that I have circled	Page 21 1 are dealing with Electroconvulsive Therapy 2 or are they a -- tell me what you meant by 3 that. 4 A. I meant by that that they deal with a 5 variety of issues in the treatment of 6 patients who are depressed and who are 7 potential candidates for Electroconvulsive 8 Therapy and where there is an issue of 9 diminished capacity and where there is 10 also an issue of the treatment being 11 involuntary. None of these articles is 12 exclusively about ECT. None of these 13 books is exclusively about ECT. 14 Q. Have you ever authored a book, article or 15 treatise Involving Electroconvulsive 16 Therapy specifically? 17 A. Not exclusively, no. 18 Q. All right. Are you going to render an 19 opinion in this case that the involuntary 20 or the decision by the decision makers to 21 use involuntary Electroconvulsive Therapy 22 beginning in December of 2003 in and of 23 itself was a deviation from the standard 24 of care? 25 A. Relative to the lack of informed consent

Page 22	Page 23
1 and the failure to explore alternatives 2 prior to instituting such a process, yes. 3 Q. All right. Is it in and of itself a 4 deviation from the standard of care to 5 involuntarily give someone 6 Electroconvulsive Therapy? 7 A. Not by itself. 8 Q. Okay. And in this case, what makes that a 9 deviation from the standard of care, that 10 decision -- let me preface my question -- 11 that decision to give the plaintiff in 12 this case involuntary Electroconvulsive 13 Therapy? 14 A. The failure to do an adequate evaluation 15 for alternatives, the failure to institute 16 treatments to restore the patient to 17 competency, continuing to proceed with 18 Electroconvulsive Therapy without 19 adequate, an adequate informed consent 20 process, an adequate process of monitoring 21 and re-evaluation. 22 Q. Anything else? 23 A. That is some of what -- let me just take a 24 quick look at my original, my original 25 notes here. Yes.	1 Instituting Electroconvulsive 2 Therapy in a patient who would be 3 foreseeably vulnerable to some of the 4 known and recognized side effects of ECT 5 without considering alternative treatment 6 methods and instituting alternative 7 treatment methods which would not have had 8 these risks; the presentation of 9 Electroconvulsive Therapy as an inevitable 10 choice of treatment when it wasn't; and 11 then continuing it well beyond the 12 generally accepted number of treatments 13 including the use of ECT on an ongoing 14 maintenance basis without exploring 15 alternatives; a failure to perform an 16 adequate assessment of decision making 17 competence while instituting involuntary 18 ECT; proceeding with involuntary ECT which 19 by itself is a foreseeably traumatic 20 process to a patient who is already 21 feeling helpless, hopeless and worthless 22 by reason of having a mood disorder with 23 depressive and manic components to it; 24 without adequately providing the patient 25 with ongoing psychotherapy which could
Page 24	Page 25
1 explore with the patient, support the 2 patient and minimize the potentially 3 traumatic effects of involuntary ECT; 4 proceeding with ECT in a context of an 5 extended ECT, in the context where there 6 was a potential conflict of interest among 7 the people who gave so-called substituted 8 judgment; not exhausting reasonable 9 medical choices prior to instituting a 10 course of 80 plus ECT treatments from 2003 11 to 2008; proceeding with such a course of 12 ECT without giving Ms. Johnson the 13 opportunity to benefit from a 14 comprehensive program of psychotherapy; 15 proceeding with ECT, including long-term 16 bilateral ECT, without sufficient 17 monitoring of the foreseeable risk of 18 cognitive impairment, even when Ms. 19 Johnson was complaining about it; and then 20 insufficient response to such impairment 21 when it obviously was occurring. And 22 finally, there seems to be no 23 consideration given to the foreseeably 24 traumatic experience of forced ECT or the 25 terror Ms. Johnson was likely to	1 experience under these circumstances. 2 Q. All right. Those are the, your opinions 3 in this case? 4 A. Yes, they are. 5 Q. Okay. All right. Do you have a -- 6 A. I should also add that in exploring the 7 informed consent forms which have been 8 signed in this case, they are absolutely 9 inadequate relative to the kind of 10 informed consent process for ECT, which 11 both the hospital guidelines indicate as 12 well as the generally accepted guidelines 13 for ECT such as the NICE, N-I-C-E, 14 Guidelines which are the British National 15 Health Service Guidelines for ECT, 16 especially given the fact that what we 17 have here is 80 plus ECT's over a course 18 of almost five years. 19 Q. All right. Well, let me -- are those all 20 your opinions in this case, Doctor 21 Bursztajn? 22 A. There may be more specifics under each 23 opinion which we can go into, but I think 24 that is the gist of it. 25 Q. Okay. And I do plan to go into each of

Page 26	Page 27
1 them. I just wanted to see if I could get 2 you to state them all first and then kind 3 of pick back through them as we can go 4 through them as you just stated. Are 5 there any others that you have as we sit 6 here today in July of 2013? 7 A. Let me just double-check my notes to make 8 sure that I have articulated all the 9 general headings of each of these opinions 10 and then, as you say, we can go into the 11 specifics of each opinion. 12 Q. Okay. Since you have referenced notes, 13 did you bring any with you? 14 A. I did, the ones which were sent to you 15 this morning so you should have them also. 16 Do you have them? 17 Q. I haven't received anything today. 18 A. Okay. You should have received them 19 because they were sent this morning. 20 Q. I got something late yesterday from Mr. 21 Ravenel's office that I hadn't seen before 22 but I certainly haven't seen anything 23 today. 24 A. I think what you got late yesterday may be 25 it. I don't know if it was sent today or	1 yesterday, but it should have been sent to 2 you. 3 MR. RAVENEL: Will? 4 MR. EARLY: Yes. 5 MR. RAVENEL: Cravens, I have 6 Tricia Phyfer, who is my paralegal, sent, 7 I believe, to both of you this morning at 8 9:53 some additional notes that he, that 9 Doctor Bursztajn produced to me. 10 MR. EARLY: Okay. I will tell 11 you -- 12 MR. RAVENEL: They are just his 13 notes. 14 MR. EARLY: Let's go off the 15 record for just a second. 16 MR. RAVENEL: All right. 17 (Brief recess.) 18 MR. EARLY: Let's mark that as 19 Exhibit 2, please. 20 (Document marked as Exhibit 2 21 for identification.) 22 MR. EARLY: Thank you. 23 Q. Doctor Bursztajn, I have briefly looked at 24 what was e-mailed to me this morning. And 25 do those, what you have memorialized there
Page 28	Page 29
1 in addition to what you just told me, 2 encompass all of your opinions in this 3 case as we sit here today on July 26, 4 2013? 5 A. Yes. And some of this may be redundant 6 also, but this was just a way of making 7 sure that I wasn't wasting your time and 8 my time doing the deposition, basically. 9 Q. Sure. It sounded like some of them ran 10 together, and I am going to go through 11 them. 12 A. Sure. 13 Q. But I kind of jumped out of order just so 14 I don't lose my place. Tell me what your 15 rate is for your testimony in deposition 16 and trial, if you've got different rates? 17 A. No. My time is all the same forensically. 18 It is \$500 per hour for any time, and 19 expenses are billed at cost. 20 Q. All right. And that includes travel time? 21 A. Up through -- it gets capped so if I have 22 to go ahead and travel and be out-of-state 23 for the day, the most that the client will 24 go ahead and pay is for ten hours of my 25 time or \$5,000 a day, but it doesn't go	1 beyond that. 2 Q. All right. Are you Board certified 3 currently? 4 A. In Psychiatry. 5 Q. How about in Neurology? 6 A. I am not certified in Neurology. I have 7 never taken that exam. But I am certified 8 by the American Board of Psychiatry and 9 Neurology in Psychiatry. 10 Q. I am sorry. Could you repeat that one 11 more time? I lost you with your accent. 12 A. No problem. I am certified by the 13 American Board of Psychiatry and Neurology 14 in Psychiatry. 15 Q. Oh, I got you. But you are not Board 16 certified in the field of Neurology, is 17 that fair? 18 A. Yes. 19 Q. Have you taken any boards other than that 20 which you just told me that you are now 21 certified in? 22 A. In my younger days I took the specialty 23 boards in forensic psychiatry, and I was 24 certified in that as well. 25 Q. Did you let that lapse or what happened?

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1 A. Yes. I didn't need to repeat it because I 2 had been, quote, qualified enough after 3 that. 4 Q. All right. And you -- do you currently 5 hold any positions that allow you to admit 6 patients to hospitals? Do you have any 7 admitting privileges? 8 A. I do not have any admitting privileges. 9 When one of my patients needs to get 10 admitted to a hospital, I ask one of my 11 younger colleagues who works exclusively 12 in hospitals to go ahead and do that 13 admission. I continue to consult to that 14 colleague during the admissions process 15 and during the hospitalization as a whole. 16 Q. Who is that colleague? 17 A. Oh, it's anyone. It depends on the 18 hospital, it depends on the patient, it 19 depends on the time of year. So -- 20 Q. Okay. I understand. We have been 21 provided some bills, Doctor Bursztajn, and 22 I think they are tabbed in the notebook 23 that I sent you. At least I hope my staff 24 tabbed them. If they didn't, I apologize. 25 A. No, they did. It is a well-tabbed	1 notebook. Thank you, that helps. 2 Q. You're welcome. Can you tell me, based 3 upon that, I can't tell what checks have 4 been going and invoices, could you tell me 5 basely if you're currently owed any money 6 by the plaintiff's counsel and what you 7 have billed? 8 A. I know I spent about 120 -- I had invoiced 9 about 125 hours beginning from August of 10 2010. And beyond that, there is also time 11 I have not invoiced which I have not 12 totaled up yet so I am not sure how much 13 additional time that will be. But there 14 has been about 125 hours of time invoiced 15 since the end of August of 2010. 16 Q. And can you estimate how much time you 17 spent since August, the last invoice? 18 A. Again, this is just a rough guess because 19 -- but I would think somewhere maybe an 20 additional, an additional 35 to 45 hours 21 of additional time. 22 Q. So roughly 160 to 170 hours in this case? 23 A. Yes, as an estimate. 24 Q. All right. And at your rate of \$500 an 25 hour, that is approximately 80 to \$85,000?
Page 32	Page 33
1 A. Yes. 2 Q. Okay. Currently, Doctor Bursztajn, what 3 is your split between, speaking about your 4 income, between the work you do seeing 5 patients versus your forensic work? 6 A. It is about 70 percent income forensic, 7 about 30 percent income clinical. 8 Q. Do you know how much you made in the 9 calendar year 2012 based upon your 10 forensic work? 11 A. No. 12 Q. Have you ever been disciplined by any 13 board or hospital? 14 A. No. 15 Q. Have you ever been sued? 16 A. The only time that someone filed a lawsuit 17 against me was when they also filed a 18 lawsuit against a judge and both the 19 prosecutor and the defense attorney; and 20 it was by a prisoner, a man had committed 21 murder and I didn't -- when I examined him 22 I didn't think he was -- I thought he was 23 sane, so he got very upset and he decided 24 that the judge, the prosecutor in New 25 Hampshire and the defense attorney and	1 myself were all part of a big conspiracy. 2 So he filed a lawsuit, but it was 3 dismissed. 4 Q. Any other suits against you or any 5 hospital based upon your alleged conduct, 6 Doctor Bursztajn? 7 A. No. 8 Q. Have you ever testified in South Carolina 9 before? 10 A. No, I don't believe so. Although again, 11 you know, I have been doing this since 12 1982, but I don't believe so. 13 Q. Have you ever testified for Mr. Ravenel or 14 anybody in his firm? 15 A. Not as far as I know. 16 Q. Have you ever testified in a case 17 involving Electroconvulsive Therapy before 18 this one? 19 A. I have been consulted in such cases but I 20 don't believe I have ever testified in 21 cases where the issue of ECT and informed 22 consent was a primary issue. 23 Q. What was the issue in any ECT case that 24 you may have been consulted with in the 25 past?

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1 A. Guardianship issues and whether or not
2 someone was appropriate for guardianship
3 in ECT, and whether or not involuntary ECT
4 should be ordered by the Court.
5 Q. Are you a member of any professional
6 organizations or associations?
7 A. At this point, although I participate in
8 several, I don't think I am a member of
9 any professional organization.
10 Q. Have you ever been a member of the
11 American Psychiatric Association, APA?
12 A. I used to be.
13 Q. Do you subscribe to any trade journals in
14 your field of medicine?
15 A. Fortunately, one of the benefits of being
16 a faculty member at Harvard Medical School
17 is I have access to any journal I want
18 through the medical school library system
19 so I don't need to subscribe. The medical
20 school does the subscriptions instead of
21 me.
22 Q. All right. Do you or have you in the past
23 performed Electroconvulsive Therapy on any
24 of your patients?
25 A. The only time that I can think where I may

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1 Q. Is that true today?
2 A. Yes.
3 Q. And is there a machine or machines at
4 Harvard in the hospital system itself
5 where they perform those therapeutic
6 treatments?
7 A. Yes.
8 Q. Do you know the manufacturer of those
9 machine or machines?
10 A. No.
11 Q. Do you know any of the physicians that
12 conduct Electroconvulsive Therapy
13 treatments at Harvard?
14 A. I believe there are several that do, yes.
15 I do know them, yes.
16 Q. All right. When you say several, is that
17 two or is that ten? Can you be more
18 specific?
19 A. Well, two come immediately -- one comes
20 immediately to mind and I think there may
21 be several other colleagues. I am just
22 not sure at this point who does what, how
23 often, how and so on. But I know of at
24 least one person who does it on a regular
25 basis.

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1 have been involved in that, although I
2 wasn't the primary person doing the ECT,
3 was very early on in my career, but not
4 since then.
5 Q. Have you ever had any training in
6 Electroconvulsive Therapy?
7 A. Part of standard residency training and
8 post residency was training in
9 Electroconvulsive Therapy. Actually,
10 beginning in medical school we were
11 exposed to it.
12 Q. Have you consulted with any physicians at
13 Harvard or anywhere else regarding this
14 case?
15 A. No.
16 Q. Does Harvard Medical Center have a
17 Electroconvulsive Therapy department?
18 A. There is no specific Electroconvulsive
19 Therapy department, but there are
20 physicians at Harvard Medical School in
21 our Department of Psychiatry who
22 regularly, who do administer
23 Electroconvulsive Therapy to carefully
24 sectioned and carefully monitored
25 patients.

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1 Q. All right. Can you tell me who that is
2 and any others that you know, physician or
3 physicians at Harvard that are currently
4 performing Electroconvulsive Therapy?
5 A. Dr. Kerry Bloomingdale is the person who I
6 know who regularly performs
7 Electroconvulsive Therapy.
8 Q. Any others?
9 A. None immediately come to mind. But I am
10 sure if you gave me enough time to think
11 about it, I could probably think of a few
12 others.
13 Q. Okay. Have you read Doctor Breggin's
14 deposition in this case?
15 A. Yes.
16 Q. Do you agree with his opinion that Clair
17 Johnson's manic symptomatology that
18 required hospitalizations in the past were
19 induced by her drug and alcohol problem?
20 A. Again, I haven't analyzed that so I don't
21 either agree or disagree with his opinion
22 as far as that is concerned. That has not
23 been the focus of my analysis.
24 Q. All right. Let's talk a little bit about
25 this case. Who were you first contacted

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1 by in this case? And what I have in front 2 of me and you is a series of letters. The 3 first one I have, I will tell you, is 4 tabbed as Letter Bursztajn 82310, which is 5 a cover letter from Mr. Ravenel to you. 6 A. Okay. 7 Q. Do you see that? 8 A. Yes. 9 Q. Whom were you first contacted by in this 10 case? 11 A. You know, I am not sure if it was by Mr. 12 Ravenel or by the client – or his client. 13 I am just not sure. I believe it was Mr. 14 Ravenel but I wouldn't swear by it. 15 Q. Okay. Is that written anywhere in maybe 16 one of your bills, or would you have that 17 anywhere? 18 A. No. I know that my first substantial 19 contact was with Mr. Ravenel. 20 Q. All right. It is my understanding, after 21 deposing Ms. Maia, who is a friend of the 22 plaintiff – 23 A. Yes. She may have actually contacted my 24 office initially. I may have spoken with 25 her briefly over the phone.	1 Q. All right. Do you remember the substance 2 of that conversation? 3 A. No. I think it was primarily logistics. 4 I know I would have sent her my Curriculum 5 Vitae, which is what I usually do on 6 initial contact. 7 Q. Okay. Do you know how she found you? 8 A. No. 9 Q. Exhibit 2, which is I believe what I had 10 not seen, was going to be one of my 11 questions, what all have you reviewed in 12 this case. 13 A. Yes. 14 Q. And that looks like it is, in the first 15 portion of that exhibit, a letter dated 16 July 25, 2013, or yesterday. 17 A. Let me just see here. Yes, mm-hmm, yep. 18 Q. Is that the sum and substance of 19 everything you have reviewed in this case? 20 (Witness perusing document.) 21 A. You mean the index of materials here? I 22 – let me just double-check here. I am 23 going to – I just want to make sure I am 24 looking at the same thing that you're 25 looking at, so let me just make sure.
Page 40	Page 41
1 Q. It was Exhibit 2. Carol should have it. 2 A. All right. I think this is it but I am 3 just going to go through here and – you 4 know what, I hope that everything I have 5 reviewed has made it into it because that 6 is what I wanted to do. It is possible I 7 may have omitted something, but hopefully 8 not. So – 9 Q. All right. Since I am looking at you on 10 video, what you have in front of you does 11 not look like what I have in front of me. 12 MR. EARLY: Madam Court Reporter, 13 could you hand him the most recent exhibit 14 that we just marked? 15 COURT REPORTER: Yes, he has it. 16 A. Let me show it to you. So there are the 17 notes and then there is an index. 18 Q. It may be out of order. 19 A. Okay. Is this any better? 20 Q. What I am looking at says List of 21 Materials Received as of July 25, 2013. 22 A. Yes. This should be somewhere here. Hold 23 on. Let's see. Yikes. You know, I don't 24 think that made it in here actually. It 25 should have but –	1 Q. Look in the body of your Exhibit 2. Flip, 2 flip that exhibit that you have in your 3 hand, the other one. 4 A. Yes. 5 Q. Flip to the next page and see if that has 6 it, the exhibit that is laying down right 7 now, the Exhibit 2. 8 A. You know, no. Unfortunately, I don't 9 think it is there. 10 MR. EARLY: Madam Court 11 Reporter, just to help Doctor Bursztajn, I 12 think he just stacked up some records and 13 underneath that stack is an exhibit. So 14 you may want to check on that so it 15 doesn't get misplaced right there. 16 THE WITNESS: Okay. 17 MR. EARLY: Off the record, 18 please. 19 (Discussion off the record.) 20 MR. EARLY: Back on the record, 21 please. 22 Q. Doctor Bursztajn, we were off the record a 23 second ago, but the list of materials 24 received as of July 25, 2013, that was 25 apparently e-mailed to me this morning, is

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1 that the sum and substance of all the
2 materials you have reviewed in this case
3 in forming your opinion?
4 A. It is the sum and substance of all the
5 materials that I have reviewed and
6 analyzed, other than all the literature
7 that I reviewed and analyzed which I
8 haven't kept track of, but I have reviewed
9 and analyzed a variety of background
10 literature.
11 Q. All right, right. What I meant is the
12 factual information pertaining to the
13 details of this case, this list is the sum
14 and substance of all the materials that
15 you have been provided by either Ms. Mala
16 or Mr. Ravenel regarding the plaintiff,
17 Clair Johnson?
18 A. Yes, Mr. Early.
19 Q. Okay. And have you requested any, any
20 further material or data that you have not
21 received that you feel like you need in
22 rendering any opinions in this case?
23 A. Well, just any additional discovery that
24 will be developed in the course of
25 discovery. For example, if you proceed to

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1 updated on that.
2 Q. Other than any expert or fact witnesses
3 and their deposition testimony or reports,
4 there is nothing that you have requested
5 Mr. Ravenel to obtain from either myself
6 or Mr. Scott or our clients at this time,
7 correct?
8 A. Yes.
9 Q. All right. Okay. Well, let's kind of go
10 back to where we were.
11 My notebook that you have in
12 front of you, the first report I have
13 would be dated 11/1/10 and it is called
14 Analysis. Do you see that?
15 A. Let me just go to it. Give me one second.
16 Q. I am sorry. It says Analysis, 11/1/10
17 Initial. There are two different
18 documents on 11/1/10.
19 A. Let me just find it to be sure.
20 Q. Okay. Take your time.
21 MR. EARLY: I tell you what,
22 Doctor Bursztajn, both of us on our end
23 would like to take a quick restroom break.
24 THE WITNESS: No problem.
25 MR. EARLY: Okay. Five minutes.

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1 retain your own experts and they have
2 their reports, I would like to read them
3 and think about them and see what their
4 point of view is and see where the
5 differences may be between us. If there
6 are any additional facts that emerge
7 subsequent to this deposition, anything
8 that any party receives, please send it
9 along so that I receive it eventually so I
10 can go ahead and update my opinion.
11 Q. I understand that. But is there anything
12 right now as we sit here today that you
13 feel like you need based upon reviewing
14 this list in Exhibit 2 that you would need
15 to form or assist your opinions in this
16 case?
17 A. Not at this point in time.
18 Q. All right. Have you asked Mr. Ravenel to
19 request any additional documents other
20 than what any experts that I or Mr. Scott
21 may hire or give?
22 A. No. Unless there are any additional
23 factual witnesses that may emerge, I would
24 like to go ahead, any expert or factual
25 witness that may emerge, I do want to be

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1 THE WITNESS: No problem.
2 (Brief recess.)
3 MR. EARLY: Back on the record.
4 Q. Doctor Bursztajn, we are back on the
5 record. I had asked you to look for what
6 is tabbed Analysis 11 or November 1, 2010,
7 and it has got the word "initial" under
8 it. Do you see that?
9 A. You know, I think is it 2011 maybe that we
10 are looking at? I have an April 1, 2011,
11 not 2010.
12 Q. Well, keep going back in the notebook a
13 couple more tabs.
14 A. It was April 2011.
15 Q. I got that yesterday. But if you keep
16 going back, chronologically it says
17 November 1, 2010 --
18 A. The only --
19 Q. Analysis Initial.
20 A. The only thing I have here is one page but
21 I think that the page behind it is left
22 out. So no, it is not in here.
23 Q. Keep going, keep going.
24 MR. RAVENEL: There is an April
25 1, 2011.

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1 A. 2011, yes. There is a 2011 one but -- 2 Q. Keep going. 3 A. It may be misfiled here because I don't 4 see it. You know, I don't know if it made 5 it into the notebook. What I have is an 6 April 1, 2011 one and I have a letter from 7 -- 8 MR. RAVENEL: What is that there? 9 THE WITNESS: No. Maybe I am 10 missing it but I don't see it here, no. 11 It never made it into this notebook. 12 MR. EARLY: Okay. 13 Q. Well, I have a letter from you dated 14 November 1, 2010, and it says Initial 15 Analysis of Merit. And I think it was 16 essentially cut and pasted into the April 17 of 2011 portion of that where you were 18 just referencing, that letter as well. 19 A. I see. 20 Q. So maybe we can look at that together. 21 A. Sure, yes. Yes, I have that. I have the 22 April 1, 2011 one. 23 Q. And it says "draft" on it? 24 A. Yes, yes. 25 Q. All right. If you will look, Doctor	1 Bursztajn, at the bottom of that, the 2 first page of that letter, the last 3 sentence says, "I have also treated and 4 performed forensic evaluations of numerous 5 victims of trauma, including traumas 6 caused by human agency," A-G-E-N-C-Y, 7 "such as medical iatrogenesis." 8 Did I read that right? 9 A. Yes. 10 Q. All right. Have you ever tested anyone or 11 done any type of testing that you believe 12 resulted from trauma that you believe was 13 resulted from Electroconvulsive Therapy 14 prior to Clair Johnson? 15 A. Yes. 16 Q. On how many occasions have you done that? 17 A. Over the course of the past 30 some odd 18 years, it is infrequent so, you know, 19 somewhere between five to seven times. 20 Q. And what was the context of that testing 21 done in, why were you testing those 22 particular individuals? 23 A. To check for their competency, to check 24 for their level of impairment, to check 25 for reasonable accommodations for their
Page 48	Page 49
1 level of impairment, to consult to other 2 physicians about what kind of treatment or 3 therapy might be helpful. 4 Q. These were patients who had already 5 undergone Electroconvulsive Therapy? 6 A. Yes. 7 Q. Were any of these done in the litigation 8 context? 9 A. No. 10 Q. And were the tests that you performed on 11 Clair Johnson, all of those tests, same 12 tests performed on these five to seven or 13 eight or how many patients you have done 14 this on in the past? 15 A. Yes. 16 Q. All right. And what is the purpose of 17 that testing as it relates to trauma as 18 you state in this sentence? 19 A. First, to evaluate whether or not the 20 patient may be either misreporting, either 21 underreporting or exaggerating their level 22 of impairment. Secondly, to evaluate what 23 the cause of their impairment was. Third, 24 of all, to go ahead and to make 25 recommendations as to whether there was a	1 need for guardianship, whether there is 2 some other accommodation that needs to be 3 made, and what kind of treatment or 4 therapy the person may be best responsive 5 to or most helped with. 6 Q. All right. And you had indicated that 7 part of the testing was to determine what 8 the cause of the impairment was. 9 How do you determine through this 10 testing that the cause of the impairment 11 was due to Electroconvulsive Therapy 12 versus some other type of either trauma or 13 nontraumatic experience? 14 A. By reviewing, my integrating the results 15 of the unstructured and structured 16 interview and the psychological testing 17 with a review and analysis of all the 18 available medical and in some instances 19 legal records. 20 Q. And have you ever conducted any brain 21 imaging studies such as either a CT scan 22 or MRI on any of these patients? 23 A. I have in several instances made a 24 recommendation. I haven't conducted the 25 study myself. I made a recommendation

Page 50 1 that such neuroimaging studies be 2 obtained. 3 Q. All right. And you presumably contacted a 4 radiologist for that or a 5 neuroradiologist? 6 A. Or simply the referring physician who was 7 the treating physician., 8 Q. Okay. And have you reviewed either any of 9 the reports or the images themselves from 10 any of those patients? 11 A. I have reviewed the reports. The images 12 themselves, although I have reviewed them, 13 I don't rely on my review of them. I 14 would rely on the report itself. 15 Q. All right. You are not a radiologist, 16 correct? 17 A. Yes. 18 Q. And you are not a neurologist, is that 19 fair? 20 A. Yes. 21 Q. And are you qualified to render any 22 opinions that any, anything you see on 23 either a CT or MRI resulted from trauma 24 that you believe is associated with 25 effects from Electroconvulsive Therapy?	Page 51 1 A. I am competent to integrate reports from 2 radiologists or neuroradiologists into a 3 forensic neuropsychiatric opinion as to 4 what the cause is of someone's structural 5 deficits. 6 Q. All right. You are not going to do this 7 in this case by looking solely at either 8 the scan or the radiology report that was 9 done on Ms. Johnson, are you? 10 A. Correct. 11 Q. All right. Have you seen any of the 12 imaging scans themselves for Ms. Johnson 13 either done in 2002 or the one most 14 recently that was ordered by Expert 15 Breggin? 16 A. Yes. 17 Q. And you have actually seen the scans? 18 A. Yes. 19 Q. All right. And you are not going to 20 render any opinions based upon those scans 21 themselves, I believe you just told me, 22 correct? 23 A. Yes. 24 Q. All right. Doctor Bursztajn, what is a 25 LAMB Warning? I see reference to that in
Page 52 1 the bottom of page two. 2 A. That is the standard shorthand in the 3 State of Massachusetts for letting the 4 examinee know that I do not have a 5 doctor/patient relationship with them, I 6 won't be prescribing any medications, I 7 won't be treating them in any way, that 8 anything that they say to me will not have 9 the protection of confidentiality, that it 10 also says who retains me and it informs 11 the patient that once the decision is made 12 to have me present my testimony I will 13 need to testify honestly about anything 14 that they say to me, so that the usual 15 protections of confidentiality in the 16 doctor/patient relationship which are even 17 higher in a psychiatric, psychiatric 18 relationship, will not apply in this 19 instance. 20 Q. I understand that a LAMB Warning was given 21 to both Ms. Maia and Clair Johnson. 22 A. Yes. 23 Q. Okay. Looking at page three of this draft 24 analysis, you, E, midway through the 25 pages, talk about relevant literature.	Page 53 1 A. Yes. 2 Q. And did you pull and read all 51 of those 3 articles in preparing for this report and 4 your opinions in this case? 5 A. They form part of the background and I 6 have considered them as background. 7 Q. All right. Number eight is an article 8 that you either wrote or co-wrote on page 9 four, at the top of page four. Do you see 10 that? 11 A. Yes. 12 Q. Can you give me briefly the gist of that 13 article? 14 A. Yes. That it is not just a matter of 15 cognition or anything, but also in some 16 instances such as, for example, when 17 someone is feeling overwhelmingly 18 depressed or helpless and hopeless and 19 worthless, they may not be able to become 20 sufficiently competent to give meaningful 21 informed consent to treatment. By 22 meaningful informed consent, when it is 23 the standard of being able to understand 24 and appreciate the risks, the benefits, 25 and the alternatives of a recommended

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1 treatment. It is not just thinking, but 2 feeling, which makes -- it is not just a 3 problem with thinking but can also be a 4 problem with overwhelming emotions, 5 overwhelming feelings. 6 Q. All right. You are not going to testify 7 or state to a jury that Ms. Johnson was 8 depressed or helpless or feeling hopeless 9 when she presented to the hospital and was 10 an inpatient in a manic state, are you? 11 A. Beginning -- there is -- the simple answer 12 is she was never appropriately evaluated 13 for that, but it is a reasonable inference 14 that at that point in time she may well 15 have been. 16 Q. Even when she was manic? 17 A. Even when she was manic, she was not 18 competent. 19 Q. Okay. Understand. And you agree that she 20 was rendered incompetent by at least two 21 physicians on those occasions when she was 22 given involuntary ECT at the Medical 23 University of South Carolina, correct? 24 A. We agree and I think it is a reasonable -- 25 what I disagree with is the process of	1 evaluation. But I think it is a 2 reasonable inference that she was 3 incompetent when she was manic. What I 4 fail to see in the evaluation is any 5 appropriate evaluation for competence by 6 either of these two physicians, or any 7 attempt to make her or to restore her to 8 competence prior to involuntary ECT. 9 Q. Okay. Just so I understand that, you are 10 not disagreeing that she was incompetent 11 during that time period. You just 12 disagree with the process by which these 13 physicians determined that she was 14 incompetent. Is that fair? 15 A. Yes. And the fact that they took no steps 16 once they made the determination, short of 17 ECT, to try to bring her back to 18 competence prior to instituting ECT. 19 Q. Okay. All right. Other than the 20 medication regimen that she had tried and 21 been tried on in the past, what else 22 should they have done to try to, as you 23 put it, restore her competency prior to 24 the ECT when she was an inpatient for her 25 manic symptoms?
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1 A. First of all, they could have initiated a 2 course of medication which had not been 3 tried before such as Klonopin, for 4 example, on an acute basis which can at 5 least in some instances control a manic 6 episode. Also, Ativan can be used for 7 control of an acute manic episode. There 8 is a variety of -- they could have also 9 tried again to use medication which had 10 not previously been successful, because it 11 was a different setting, by combining it 12 with psychotherapy. Most importantly, to 13 the extent that there was a fundamental 14 issue whether there was some conflict of 15 interest in helping hospitalize, in the 16 hospital where her brother-in-law, I 17 believe, was the Chair of the Board of 18 Trustees and where her husband had 19 admitting privileges, and given the fact 20 that there was obviously some family 21 stress which ultimately culminated in a 22 divorce, she could have been offered the 23 option of being transferred to a different 24 hospital where there would not have been 25 the same fundamental conflict of interest	1 which would have been a foreseeable 2 stressor, which was a foreseeable stressor 3 which, if she was already depressed and 4 somewhat paranoid, would have made her 5 feeling more helpless, more hopeless, more 6 frightened and, therefore, more paranoid. 7 So certainly, those are some of the simple 8 steps which could have been taken to 9 restore her to competence prior to 10 instituting involuntary ECT. The 11 evaluation -- 12 Q. Okay. 13 A. The evaluation itself should have taken 14 those factors into account. And this 15 simply did not happen, from what I can 16 see, and from everything I have reviewed 17 so far. 18 Q. All right. Klonopin and Ativan are what? 19 A. They are benzodiazepines which can be used 20 to control overwhelming fear and terror 21 which often compounds any other kind of 22 effective instability, resulting in a 23 manic episode. 24 Q. All right. And you had indicated they 25 should have combined or tried to combine

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1 this with psychotherapy. You are aware
2 that Ms. Johnson was seeing an outside
3 psychiatrist at this time, correct?
4 A. She was. But from what I can tell, that
5 was relatively -- there was no meaningful
6 psychotherapy which addressed the
7 fundamentally terrifying issues to her of
8 -- this is someone who had been adopted as
9 a child to begin with -- of being
10 abandoned and being divorced.
11 Q. Well, you do agree that she was seeing an
12 outside psychiatrist at this time,
13 correct?
14 A. Yes, Doctor Roberts.
15 Q. And you had mentioned that her
16 brother-in-law was the Chair of the Board
17 of Trustees. Did you -- you read Dr. John
18 Johnson's deposition, correct?
19 A. Yes.
20 Q. And in his deposition he testified under
21 oath that he did not know any of the
22 physicians that were treating Ms. or his
23 now ex-wife at the Institute of Psychiatry
24 at the Medical University of South
25 Carolina, correct?

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1 institution where her husband was on the
2 staff, where there were family
3 relationships, should not be surprising to
4 anyone. It wouldn't be surprising to you
5 in the law firm analogy. The fact that
6 she wasn't -- when she came in manic, it
7 wasn't at least some recommendation made
8 to her parents that she should be
9 transferred to another institution so
10 things could be sorted out is way below
11 the standard of care.
12 Q. Okay. Doctor Bursztajn, in every
13 instance, to be fair, in every instance
14 where Doctor Johnson consented or signed a
15 consent on behalf of Clair to be treated,
16 you agree that the parents also consented
17 and agreed to this same treatment.
18 Correct?
19 A. What I would say is that neither Doctor
20 Johnson nor the parents gave meaningful
21 informed consent, only pro forma informed
22 consent. And they were not informed of
23 this fact that there was a potential
24 conflict of interest which was a stressor.
25 Neither Doctor Johnson was informed of

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1 A. That is what he said. But it doesn't mean
2 that none of them knew him and that they
3 didn't know that he was affiliated with
4 the same institution.
5 If one of my colleagues was to
6 send his obviously somewhat estranged wife
7 to me for treatment, I would refer her to
8 someone else because I would feel that as
9 a colleague I cannot go ahead, I would
10 have a conflict of interest. It is a
11 little bit like if, let's say, someone in
12 your law firm was getting divorced and
13 they asked one of the, asked you, Can I
14 send my wife to you to represent her. You
15 would say no, I have a potential conflict
16 of interest, even if you never met the
17 guy. Let's say you work for a huge law
18 firm, right, you still would say no, they
19 really should seek another firm to
20 represent her. Similarly here. Divorce
21 itself is an extremely stressful and
22 anxiety-provoking time for anyone. For
23 someone who was as vulnerable as Clair
24 was, it was terrifying. The fact that she
25 would not feel safe and secure in the

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1 this, from what I could tell, although
2 eventually he brought it up himself, nor
3 were her parents informed of this.
4 Whereas, at a minimum the people who
5 signed an informed consent form should
6 have been informed that one alternative to
7 ECT was simply to transfer her to an
8 institution where there was no potential
9 conflict of interest, where she could --
10 where there was at least some potential
11 for a meaningful therapeutic alliance to
12 be formed so that meaningful medication
13 and psychotherapy could be tried before
14 resulting to involuntary ECT to either
15 treat her or arguably restore her to
16 competence.
17 Q. Okay. And Ms. Johnson had been to
18 numerous hospitals across South Carolina
19 prior to coming in to MUSC?
20 A. She had had prior hospitalizations at
21 different institutions and in no instance
22 that I can tell was it necessary to use
23 involuntary ECT. This was the first and
24 only occasion that I know of unless you
25 tell me otherwise.

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1 Q. Well, I am not telling you otherwise. But 2 she had been involuntarily hospitalized on 3 numerous occasions at other hospitals 4 throughout the South Carolina area. You 5 are aware of that, correct? 6 A. Yes. And she had always been restored to 7 competence without the need to resort to 8 involuntary ECT, which carries its own 9 risks of a post-traumatic disorder, 10 complicating the mood disorder, 11 complicating, potentially, the bipolar 12 illness that she was suffering from. 13 Never before during any involuntary 14 hospitalization had there been a necessity 15 to use involuntary ECT. 16 Q. Oh, okay. You are not going to testify 17 that ECT was not indicated when it was, 18 when it was first performed on Clair 19 Johnson in December 2003, are you? 20 A. It was not indicated because there were 21 other measures which could have been done, 22 other alternatives which have a more 23 favorable benefit risk ratio, especially 24 when administered on an involuntarily 25 basis.	1 Q. Such as Ativan and Klonopin? 2 A. Such as transfer to another institution 3 and then attempting to treat her with a 4 combination of a variety of different 5 kinds of medications and psychotherapy, 6 while removing the foreseeable stressor 7 that she was in an institution which was 8 her husband's institution, she would 9 identify as being her husband's 10 institution in the midst of a potential 11 divorce hanging over her head. 12 Q. All right. Okay. All right. Looking, 13 keeping in tune with this April 1, 2011 14 report, on page five, number 28 is titled 15 Neuropsychiatric considerations in the use 16 of Electroconvulsive Therapy. 17 Can you give me the gist of that 18 article and in what way it bears on your 19 opinions in this case? 20 A. I would have to consult the article to 21 reconstruct how it contributed to the 22 background, and I don't have the article 23 in front of me. However, if you would 24 like me to, I can simply go ahead and take 25 the article again and then specifically
Page 64	Page 65
1 tell you once I refresh my memory how it 2 contributes to my opinion. 3 Q. All right. Well, did you read it prior to 4 preparing this report? 5 A. Yes. 6 Q. All right. How about number 38, 7 "Long-term Maintenance ECT: A 8 Retrospective Review of Efficacy in 9 Cognitive Outcome? 10 A. Again, I would -- 11 Q. What is the gist of that article? Can you 12 tell me without referring to it or not? 13 A. I would need to refer to it to give you a 14 meaningful answer. 15 Q. Do you have these articles pulled already, 16 Doctor? I know you are a member of 17 Harvard Medical Center so you don't have 18 to actually pull them. 19 A. No, I go ahead online and read them 20 online. That saves a lot of paper and a 21 lot of trees. 22 Q. Sure. So you haven't actually printed any 23 of these articles? 24 A. No. I try to go as paperless as I 25 possibly can.	1 Q. I understand. The reason I ask is it 2 costs me money to get them and it doesn't 3 cost you any money to get them. 4 A. If you go to the University of South 5 Carolina, they should be able to pull all 6 of these articles to you, for you, without 7 any additional cost. I would guess that 8 for some of them they had the same, 9 substantially, as Harvard Medical School 10 does. There may be a few that they don't, 11 but for most of them they should. 12 Q. All right. In looking at the bottom of 13 page six, Doctor Bursztajn, the last 14 sentence, you refer to some severely 15 impaired mental capacities including 16 reality testing. 17 Can you tell me what you mean by 18 that, Doctor Bursztajn? 19 A. I can, Mr. Early, except I see Carol is 20 having problems. We are having noise 21 coming in again. I don't know if that is 22 a problem. There seems to be some 23 background noise. Would you mind 24 repeating your question maybe because it 25 was very, it came across in a very, with

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1 lots of background noise.
2 Q. Sure. I am asking about your last
3 sentence on page six.
4 A. Right.
5 Q. You say that, talking about Ms. Johnson,
6 she was having some severely impaired
7 mental capacities in and around 2003. And
8 my question is what you are referring to.
9 Is that a symptom or is that a -- what are
10 you referring to there? What do you mean
11 by that?
12 A. If I may go ahead and refer to my notes
13 because what I tried to do, I tried to
14 type parts of the medical record so I
15 could easily read it. So do you mind if I
16 refer to my notes?
17 Q. Please do. But what I would ask is at the
18 end of the deposition if we could mark a
19 copy of that as well and mark that --
20 A. That is Exhibit 2. That is the index of
21 materials that you see.
22 Q. Okay. I thought you meant handwritten
23 notes.
24 A. No, no, no. What I did was I tried to
25 have typed those passages that might be

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1 Q. Notes for Deposition Preparation?
2 A. Yes.
3 Q. And the one today dated, titled Parties.
4 I don't have anything that says the Index
5 of Materials.
6 A. You don't? It should have been sent
7 because I --
8 THE WITNESS: Wasn't it sent?
9 MR. RAVENEL: Yes.
10 THE WITNESS: Yes, it was sent
11 apparently.
12 MR. EARLY: Well, I didn't get
13 it, but Mr. Scott did and he printed it
14 off what he got sent and brought it here,
15 which is in front of me, and that is not
16 in that.
17 THE WITNESS: Are you sure you
18 printed everything? Was there an
19 attachment maybe that was not printed?
20 MR. SCOTT: I am not sure. This
21 was done by my paralegal. I didn't even
22 go into the office this morning so I don't
23 know.
24 MR. EARLY: Let's go off the
25 record for one second.

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1 useful as references. So let me look.
2 And it is an annotated index of materials
3 with my annotations.
4 Q. Okay.
5 A. So let's see. Where was it? There it is.
6 Okay.
7 I am looking at page 29 of my
8 notes, page 29 of the index of materials.
9 Q. We are obviously not on the same page
10 because I don't have anything that's even
11 near 29 pages.
12 A. Do you have my -- you have my index of
13 materials. Those were in the three
14 documents that were marked and you had
15 received it.
16 Q. Is it dated July 25, 2013?
17 MR. RAVENEL: Yes.
18 A. Yes.
19 MR. RAVENEL: Index of
20 Materials.
21 MR. EARLY: Okay. All right.
22 Q. The only three things I have that are on
23 that date are a list of materials
24 received.
25 A. Yes.

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1 (Brief recess.)
2 MR. EARLY: Back on the record.
3 Madam Court Reporter, could you
4 -- my last question, I believe, could you
5 please read it back to me?
6 (Record read back as requested.)
7 MR. EARLY: Thank you.
8 Q. Doctor Bursztajn, on the bottom of page
9 six of the letter that we have been going
10 over, your April 1, 2011 letter to Mr.
11 Ravenel, the last sentence, you indicate,
12 "In or around 2003, she," being Ms.
13 Johnson, "manifested severely impaired
14 mental capacities."
15 And my question I think before
16 the break was what you were referring to
17 there, and then you wanted to look at your
18 notes which I haven't gotten. So would
19 you read me what you are talking about?
20 A. What you will be getting is page six of my
21 notes. And it refers to the medical
22 record, to Dr. John Roberts' medical
23 record. And the date on that is September
24 12, 2003. And in his medical record he
25 says that she is grandiose, that she is

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1 hypervigilant and paranoid. Parents and 2 friends worried about her. Afraid that 3 she is unsafe driving. Says she is not 4 taking Concerta, losing and misplacing 5 things. 6 Then later on, if we continue 7 here, we have a note from October 28, 8 2003, which says that she is hypomanic. 9 It is page seven of my notes, so when you 10 get my notes it will be clearer. 11 "Thinks Will's wife (divorce 12 final this month) is one who persecuted 13 her and had her committed from hotel rooms 14 since 1997." So again, she is paranoid at 15 this point. 16 There was a note here on November 17 17, 2003, it is page 47 of Doctor Roberts' 18 notes, which indicates that she is 19 irritable and grandiose, paranoid, 20 delusional, impulsive spending, and so it 21 goes. 22 I can give you a bunch of other 23 examples, but those are illustrative. But 24 they are all in the medical record and you 25 will find them all in the medical record.	1 Q. Okay. All right. And those type of 2 symptoms are indicative of a manic 3 patient, are they not? 4 A. Of a hypomanic, a patient suffering from 5 either hypomania or manic impairment or 6 someplace in the spectrum. 7 Q. All right. You weren't referring, when 8 you said mental capacities, to anything 9 referencing her memory, were you? 10 A. No, not at that point, no. 11 Q. All right. Okay. And the vast portion of 12 the next two pages of that letter, I 13 believe and you can correct me if I am 14 wrong, pages seven and at least the top of 15 page eight are dealing with your opinion 16 that she didn't gain enough mental 17 capacities until June of 2010 to 18 appreciate any harm from ECT. 19 Is that a fair statement without 20 going through it all? 21 A. It is a fair statement to say that it 22 wasn't until June 2010 that she could 23 appreciate what harm had been done to her 24 by the ECT. 25 Q. All right. You are not testifying that
Page 72	Page 73
1 she did not have any problems that she 2 related to others from ECT prior to June 3 of 2010, are you? 4 A. I am not testifying as to that way, no. 5 That is not my opinion. 6 Q. All right. In fact, she relayed to 7 physicians and others that she believes 8 she was having problems with ECT as early 9 as early 2009, didn't she? 10 A. Yes. 11 Q. All right. Just for the record, and 12 Doctor, the gentlemen walked in and handed 13 me now your notes so I have them. 14 A. Oh, good. That will save us time, yes. 15 Q. Okay. Great. All right. Looking at page 16 eight. 17 A. Okay. 18 Q. Your examination observations, you had 19 indicated earlier that you met with Ms. 20 Johnson for between four and five hours at 21 some point prior to this letter. Correct? 22 A. Yes. I met with her specifically, I can 23 give you the specific date here, it was -- 24 one second. Date of my exam, January 31, 25 2011.	1 Q. Okay. And she came to your office with 2 her friend Anna Maia, correct? 3 A. Yes. 4 Q. Was Mr. Ravenel also present or was it 5 just the two of those ladies? 6 A. It was just Clair Johnson and Anna Maia. 7 Q. Okay. Looking at number two of your 8 examination observations, and I may skip 9 out of order here but you state, "Although 10 Ms. Johnson was made vulnerable to 11 cognitive impairment by bipolar disorder 12 and a history of head trauma," and it goes 13 on from there. 14 You agree with me that bipolar 15 disorder and specifically depression 16 itself can also cause memory loss in and 17 of itself. Agree? 18 A. It can cause some kinds of memory 19 impairment, but not the kind that she was 20 experiencing and that she was reporting. 21 Her pattern of cognitive impairment is 22 much, is not consistent with depression 23 per se. It is consistent with a 24 subsequent brain injury caused by ECT. 25 Q. Would it also be consistent with a chronic

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1 long-term alcohol and illegal drug user? 2 A. It would not be consistent with most forms 3 of long-term alcohol or drug use. 4 Specifically, the areas that she mentioned 5 were much more areas which are in the 6 frontal lobe, in the areas where the ECT 7 would be functioning and, as we understand 8 the mechanisms of the ECT, the ECT, if it 9 is administered for too long and it is 10 given too much, can impair. There were 11 other kinds of memory impairments which 12 would be consistent with long-term alcohol 13 use or many kinds of substance use. 14 Q. That she exhibited in her testing, 15 correct? 16 A. That overall the pattern is much more 17 consistent with the kind of impairment one 18 would expect from 80 plus ECT's. 19 Q. Okay. You will concede that some of the 20 findings from her examinations are 21 consistent with a person who has a history 22 of long-term alcohol and drug abuse, won't 23 you? 24 A. There was some overlap, but as far as the 25 whole is concerned, no. And moreover, the	1 reason why I mentioned her prior history 2 is that prior, since her alcohol and drug 3 abuse was many years ago, you would expect 4 it would have -- she would not have been 5 able to, for example, receive a B.A. in 6 public affairs if the impairments, if she 7 had had the impairments subsequent to ECT, 8 prior to ECT. So overall, it is not 9 consistent. I mean I considered it 10 initially as part of the differential 11 diagnosis, but it is just not likely that 12 the fundamental impairments which she was 13 exhibiting in my office on my examination 14 are the impairments from alcohol and drug 15 use, which she had engaged in many years 16 prior. 17 Q. All right. What is your understanding of 18 the last time or time frame where Ms. 19 Johnson was engaging in illegal drug use? 20 A. That is not clear to me. But what is 21 clear to me is that she, again, was able 22 to be employed in a business and had past 23 accomplishments which were just not 24 consistent with substantial impairment 25 from alcohol and drug use of the kind that
Page 76	Page 77
1 was manifested in my examination. 2 Q. All right. You will concede that after 3 she became unemployed and even after she 4 was married, that her mother or at least 5 her medical records show that her mother 6 found an illegal drug pipe in her 7 belongings. Do you remember seeing that? 8 A. Yes. 9 Q. All right. Do you have any reason to 10 disagree with that? 11 A. No. 12 Q. All right. Do you agree that long-term 13 depression can also cause physiological 14 changes in the brain? 15 A. That is a matter of controversy at this 16 point. It is certainly a possibility but 17 the kinds of changes which it can -- which 18 could conceivably be attributed to 19 long-term depression are not the kinds of 20 impairments that she was manifesting on my 21 examination and that have also been 22 confirmed by observation of her, of Chip, 23 for example. 24 Q. Of what? 25 A. Of Chip Craver, her brother.	1 Q. Her brother, sorry? 2 A. Her brother, Chip Craver. 3 Q. All right. 4 A. And they were not consistent with what has 5 been reported in the medical record in 6 terms of prior to 2003. She simply did 7 not have the kind of, these kinds of 8 impairments before the ECT. 9 Q. All right. Looking down at the last 10 sentence, if you will, of number two on 11 that page, page eight, you indicate, "In 12 any case, her ongoing impairments indicate 13 how severely impaired she is likely to 14 have been throughout that course of ECT." 15 Where did you get that 16 information and what evidence did you have 17 that she was severely impaired by looking 18 at her medical records during her course 19 of ECT? 20 A. For one thing, she was judged to be 21 incompetent and in need of involuntarily 22 ECT. If she was not severely impaired at 23 that point in time, why would she be 24 judged as being incompetent and getting 25 involuntary ECT?

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1 We can also go through specific 2 pieces of the record and we can talk about 3 significant pieces of impairment which you 4 saw that. 5 Q. When you say severely impaired, you are 6 talking about her competency and not her 7 mental status. Is that fair? 8 A. Her competency is a function of her mental 9 status or it should be a function of her 10 mental status. 11 Q. Well, maybe I said it wrong. Memory loss, 12 you are not talking about anything to do 13 with memory loss at that time, correct? 14 A. Correct. 15 Q. Okay. That is what I was getting at. 16 Looking at the bottom of that page, on 17 number three you indicate that this 18 selective impairment is consistent with 19 other indications in the record. 20 What are you referring to there, 21 Doctor Bursztajn? What other indications 22 in her record are you referring to? 23 A. She begins to -- let me just look at the 24 record and I can address that. I am going 25 to look at the index of materials now so	1 -- 2 Q. I've got it now. 3 A. Okay. Now, in terms of your question, 4 would you just mind repeating your 5 question one more time because I want to 6 be sure I am answering it specifically. 7 Q. Well, I guess I'm asking a question that 8 you state in your letter, you talk about 9 other indications in the records that deal 10 with her maintaining difficult -- 11 maintaining attention, etcetera? 12 A. No, no, no. 13 Q. And I am simply asking what you are 14 referring to. 15 A. Well, if you read to page nine, I think 16 the problem is it is consistent with 17 indications in the records that both the 18 ECT itself and its first administration 19 over an extended period of time 20 constituted a significant traumatic 21 experience for Ms. Johnson, involving 22 feelings of helplessness and terror. And 23 the record is filled throughout her ECT 24 course of feelings of helplessness and 25 terror which often manifest themselves in
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1 a paranoid state. So what we have here is 2 the first and voluntary administration of 3 ECT to someone who is already feeling 4 helpless and terrified, compounding the 5 helplessness and the terror. She becomes 6 more paranoid at times, not less paranoid 7 with the ECT. That is what I am referring 8 to. We can go to the specific notes if 9 you would like me to in the medical 10 record, but that is what I am referring 11 to. 12 Q. Okay. Are you testifying that her mania 13 was driven by her feelings of helplessness 14 and terror because she was going to have 15 ECT, and that was the reason that she was 16 hospitalized? 17 A. No. That would be a caricature of what I 18 just said. I am sorry if I 19 miscommunicated it to you so that you 20 heard it that way. 21 What I am saying is that to the 22 extent that her mood swings between 23 depression and mania were indicative of 24 feelings of helplessness, hopelessness, 25 worthlessness and fear, to the extent that	1 she presented herself as being delusional. 2 Q. Okay. 3 A. To that extent, the involuntary 4 administration of ECT compounded those 5 feelings and made things worse, not 6 better. And this should have been clearly 7 part of the ongoing evaluation. And there 8 were notes in the record here, if I may go 9 ahead and refer to them, which go ahead 10 and state -- I am looking at page 34 of my 11 notes. 12 Q. What page? 13 A. 34, page 34. 14 Q. Okay. 15 A. And if you read that last sentence there, 16 "She has been undergoing ECT with a fair 17 to poor response. Her insight into her 18 treatment on this is very impaired." 19 So what we have here is not that 20 the ECT is helping her, but it raises a 21 question which would need to be evaluated, 22 is the ECT actually hurting her. If you 23 go down further, on December 12, 2006, 24 "Angry over ECT, it is forced and it is 25 not helping," so the patient is telling

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1 you it is not helping. The designated
2 examiner says it is a fair to poor
3 response. What we have here --
4 Q. Well --
5 A. -- as we go through this course is the
6 fact that the patient is receiving massive
7 doses, repeatedly, of ECT without any
8 clear indication, clear indication that it
9 is being helpful to her, and there is some
10 question which the patient feels it is
11 actually being worse, and the fact that it
12 is involuntary is going to be a
13 foreseeable trauma and that is not being
14 addressed by psychotherapy, that is not
15 being addressed by trying to transfer her
16 to another setting where she might be less
17 frightened, given her husband and her
18 husband's connections to the hospital she
19 is in. Nothing is being done to address
20 this except more ECT and more involuntary
21 ECT. This is a problem and it is a very
22 very very serious problem.
23 Q. Well --
24 A. Look, if you were basically advising the
25 hospital from a risk management point of

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1 view or from a -- and they said to you,
2 you know, we have someone who is married
3 to someone on our staff and, by the way,
4 his brother is the Chair of the Board of
5 Trustees and she is really complaining,
6 and she has herself brought up in 2003 the
7 idea that there was a conflict of interest
8 there, it was a conflict of interest,
9 wouldn't you advise them at that point to
10 recommend that she be transferred to
11 another hospital and another setting to
12 see whether she might have a better
13 response than this. I mean --
14 Q. Doctor, I am going to let you talk about
15 the conflict of interest, but I was simply
16 asking you to refer to any records that
17 you referred to or that you were talking
18 about on number three of page eight.
19 A. Right.
20 Q. And so if you could just answer my
21 question, I will try to get through it a
22 lot faster.
23 A. Okay.
24 Q. Since you wrote that, is there any
25 indication that Doctor Faust knew that

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1 Clair Johnson's husband might have been
2 associated with the medical university in
3 any way when he saw her?
4 A. It should have been his business to find
5 out if he didn't know. That is not the
6 issue. The issue isn't did he know or
7 didn't he know. The issue is should he
8 have known. It is part of a family
9 history that the psychiatrist takes when
10 you are treating a patient as to a patient
11 going through a divorce as to what her
12 spouse's or ex-spouse-to-be's job is or
13 what the connections may be and why isn't
14 the patient responding. Most patients
15 should respond extremely well between six
16 to 12 sessions of ECT. She is not
17 responding extremely well. What is the
18 problem here?
19 The evaluation is not being done.
20 I don't see any evaluation being done for
21 why she hasn't responded with -- I mean I
22 have had patients who have responded
23 within three sessions to ECT. Why hasn't
24 she responded to the ordinary course of
25 ECT? That evaluation is not being done.

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1 If you look at the NICE Guidelines, that
2 evaluation needs to be done when the
3 patient isn't responsive to a limited
4 number of ECT's. You don't go up to 80
5 without doing the evaluation.
6 Q. All right. Let's go further in the letter
7 because I don't want to get too bogged
8 down in extraneous stuff. But if you look
9 at number four, you indicate Ms. Johnson
10 self reports an examination consistent
11 with a persistent failure on her part for
12 her treating clinicians to obtain her
13 informed consent.
14 Is that a self report she gave
15 you at the examination in January of 2011
16 or is that something you saw in the
17 records?
18 A. It is something which the records failed
19 to evaluate for even, and it is primarily
20 based on my observations of how helpless
21 she appeared to be when she talked about
22 the involuntary nature of the ECT and when
23 she talked about the boundary violations
24 committed by Doctor Roberts and her
25 treating clinicians in treating her in a

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1 hospital where she was protesting there 2 was a conflict of interest. These were 3 boundary violations fundamentally. A safe 4 place was not created for the patient. 5 Again, that is the -- that is fundamental. 6 To treat a patient who is feeling so 7 frightened that she is paranoid and so 8 helpless, you need to treat her in a safe 9 setting. If she is complaining of a 10 conflict of interest and there is a 11 reasonable conflict potential for someone 12 perceiving it as being a conflict of 13 interest, you are going to transfer her to 14 another institution where that won't 15 exist, that won't get in the way of the 16 therapeutic alliance. That was never, 17 from what I can tell, considered. It 18 never happened. 19 Q. All right. Did her parents to your 20 knowledge ever raise any conflict issues 21 during their discussions with the doctors 22 or their consents? 23 A. They were not in a position to do so. 24 Most lay people are not. It is remarkable 25 --	1 Q. Most what? 2 A. Most lay people -- I mean lawyers would 3 be. You know, if -- I am sure if this was 4 your loved one, you would be. But to the 5 extent that people are not lawyers for 6 hospitals, they wouldn't have enough 7 knowledge to be able to raise it as an 8 issue. 9 What is amazing is that she 10 herself did raise it as an issue as early 11 as 2003. 12 Q. All right. Again, are you aware of any 13 situation where Doctor Johnson consented, 14 when either of her parents did not consent 15 to her having involuntary ECT, yes or no? 16 A. There was -- I can't answer that question 17 as a yes or no. What I can say is that 18 neither Doctor Johnson on her parents gave 19 any reasonable consent, only pro forma 20 consent for ECT. So whenever he gave pro 21 forma, so did they. But there was no 22 meaningful informed consent either with 23 Doctor Johnson or with her parents. 24 Q. And the basis of that is what? Have you 25 reviewed the medical records in this case?
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1 A. I have in detail. 2 Q. All right. And tell me the basis of them 3 not getting any informed consent or giving 4 any informed consent? 5 A. Any meaningful informed consent is a 6 process, any pro forma. The only informed 7 consent that I could mention or informed 8 consent that I could find were either very 9 brief notations saying informed consent 10 obtained over the telephone, that is not, 11 to me informed concept, or a very long, 12 very detailed form which is signed which 13 maybe has what, about a thousand words or 14 so where alternatives is mentioned once at 15 the very beginning and then it is not 16 mentioned at all. There is no mention 17 that this may be a potentially stressful 18 situation for her given the fact that she 19 is complaining of a conflict of interest. 20 There is no mention made of the potential 21 of transferring her to another institution 22 where she might be more responsive to 23 medication and treatment. So I haven't 24 seen in this record any meaningful 25 informed consent that is along the	1 meaningful informed consent process. And 2 neither Doctor Johnson nor her parents 3 should feel that they are responsible for 4 signing forms when they were not informed 5 of the alternatives, meaningfully of the 6 alternatives to her receiving involuntary 7 ECT, as well as the risks of involuntary 8 ECT which can be compounding a manic 9 episode with post-traumatic episode unless 10 the involuntary nature of the ECT is 11 adequately, the meaning of it is 12 adequately explored with the patient, 13 which it never was in this instance. I 14 mean there was an absence here in the 15 record of anyone talking with the patient 16 or the patient's family, the patient's 17 parents or Doctor Johnson about what the 18 risks of the ECT being involuntary might 19 be and why any post-traumatic 20 complications should be, could be treated, 21 should be treated and at least should be 22 considered. But they never are. 23 Q. What about the consent form itself 24 deviates from the standard of care? I 25 think you had indicated that earlier.

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1 A. There was not sufficient mention other
2 than one word, in a very long form, about
3 alternatives. No specific alternatives
4 are identified, other than in some general
5 terms, medication and psychotherapy. It
6 fails to mention that, for this particular
7 patient, one alternative would be a change
8 of setting, transferring her from a
9 hospital where she was complaining of a
10 conflict of interest to an institution
11 where there would be no conflict of
12 interest. There was not sufficient
13 elaboration of the potential for
14 medication and psychotherapy to treat her
15 condition. The risks of the ECT being
16 involuntary rather than voluntary are not
17 sufficiently, are not mentioned at all, in
18 fact. The fact that one alternative might
19 be to try to restore her to competency so
20 that she could decide whether or not she
21 should undergo ECT is not detailed in any
22 meaningful manner. I mean this is as pro
23 forma as it gets.
24 Q. All right. Other than the -
25 A. It is documentation rather than an

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1 Q. All right. Have you ever given informed
2 consent to a patient who is about to have
3 ECT?
4 A. Yes.
5 Q. All right. On how many occasions and what
6 were the circumstances?
7 A. Oh, in my career, since 1979, easily,
8 gosh, easily over 50 times.
9 Q. Well, didn't you testify earlier that you
10 had never given a patient ECT before?
11 A. I myself have not administered it, but I
12 have been asked by the person who has
13 administered it since I knew the patient
14 best to go over the risks, benefits and
15 alternatives of ECT since I was the
16 treating physician or the attending
17 physician in a unit where a patient was
18 being given ECT or one of my own patients
19 received ECT. That is one of the things
20 -
21 Q. What would be the - I am sorry. I
22 thought you were finished.
23 A. That is okay. Please go on. I don't mean
24 to be long-winded here so go ahead.
25 Q. When is the last time you have given an

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1 informed consent process.
2 Q. All right. Other than the consent forms,
3 you are telling me you don't see anywhere
4 in the medical record where Doctor Faust
5 explained to the family, including her
6 parents and her ex-husband, the risks
7 including memory loss and alternative
8 treatments to ECT in the medical record?
9 A. Well, Doctor Faust explains the risks. He
10 does so, at least based on the
11 documentation, in a perfunctory manner.
12 The risks of ECT being voluntary rather
13 than involuntary, I don't see Doctor Faust
14 explaining at all, that involuntary ECT
15 carries its own special risks beyond
16 voluntary ECT. The alternative of
17 transferring her to another institution,
18 from what I can tell from the
19 documentation and from Doctor Faust's
20 deposition, he never explains to the
21 family.
22 Now, if you can show me
23 otherwise, I would be willing to consider
24 it. Maybe I have overlooked something in
25 this haystack, but I don't see it.

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1 informed consent for an ECT therapy?
2 A. Sometime in the past five to seven years,
3 five to eight years maybe.
4 Q. All right. Do you know where the consent
5 form that MUSC was using back in 2003,
6 where they got the language from or what
7 it was modeled after?
8 A. I do not. But the problem isn't with the
9 form per se. The problem is with how it
10 is being used as a substitute for
11 meaningful informed consent.
12 Q. Well, you didn't indicate earlier that you
13 had a problem with the form itself so I am
14 asking -
15 A. Well - go ahead.
16 Q. Let me finish my question, if you would?
17 A. Absolutely. I am sorry about that,
18 Mr. Early. Please correct me.
19 Q. That is okay. Were you critical of the
20 form itself? And my question was do you
21 know what our form or MUSC's form was
22 modeled after? And if you so, great. If
23 you don't, that is fine too. My question
24 is if you know.
25 A. I don't know. And my criticism is only in

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1 the context of the overall informed 2 consent process. If this form had been 3 accompanied by an extended discussion of 4 the risks of involuntary ECT, if it had 5 been accompanied by a discussion of the 6 likelihood that it was best for this 7 patient given her own perceptions of there 8 being a conflict of interest that she 9 should be transferred to another 10 institution, there would be no conflict 11 with the form per se. 12 But there was no such 13 conversation. The form itself as a whole 14 could certainly use improvement, but it is 15 not about the form. It is about the 16 process. 17 Q. You keep using the term "process". I am 18 sorry. Did you read Doctor Faust's 19 deposition where he used the term 20 "process" when he described his relaying 21 the risks and benefits to patients 22 including Clair Johnson? 23 A. Yes, I did. And let me just check one 24 thing if I may. Give me one second. 25 Q. Certainly, Doctor.	1 A. Okay. Please go ahead. Mm-hmm. 2 Q. My question was did you read Doctor 3 Faust's deposition where he described the 4 word, where he used the term "process" 5 that you continue to use in relaying the 6 risks, benefits and alternatives of ECT to 7 his patients including Clair Johnson? 8 A. He did use that word, but I did not see in 9 his deposition nor his notes with Ms. 10 Johnson any meaningful process which 11 addressed specifically the risks of 12 involuntary ECT or the fact that, given 13 her perceived conflict of interest, it 14 would be best to transfer her to another 15 institution prior to considering, and 16 seeing whether that would help restore the 17 competency prior to administering ECT. 18 Again, I may have overlooked it; and if I 19 have, please let me know. 20 Q. Well, was Doctor Faust ever asked to 21 explain his process that he relayed to 22 Clair Johnson in his deposition? 23 A. I would not trust my memory as to what 24 questions were asked by the attorney of 25 Doctor Faust. I would need to look at the
Page 96	Page 97
1 deposition per se to refresh my memory. 2 If Doctor Faust now testifies that he did 3 in fact advise that she should be 4 transferred to another institution, that 5 he did in fact inform the parents and the 6 ex-husband of the risks of proceeding with 7 involuntary ECT and the conflict of 8 interest situation, then I would wonder 9 why he didn't document it because that is 10 something, it is so vital in this case, 11 you would need to document it. I mean the 12 failure to document it itself would be 13 below the standard of care because these 14 are vital points in this particular case. 15 These are vital for the informed consent 16 process. 17 Q. Okay. 18 A. So you know, whether he was asked, why 19 wouldn't he volunteer that part of his 20 informed consent process was to recommend 21 that she be transferred to another 22 institution because of the potential 23 conflict of interest that she was raising 24 and which was actually there and 25 reasonably there, and why wouldn't he	1 mention the fact that part of his informed 2 consent process was to inform the parents 3 and Doctor Johnson of the risks of 4 involuntary ECT or the risks of extended 5 ECT or massive ECT? I don't see the 6 documentation there. 7 Q. All right. Doctor Bursztajn, you used the 8 term "apparent collusion" in speaking with 9 or about Dr. John Johnson and the 10 physicians in this case. 11 Are you going to testify that 12 there was in fact collusion to do harm to 13 Clair Johnson in this case between any 14 physicians? 15 A. Well, not in any legal sense. I am not an 16 attorney, I am not a judge, and I would 17 not make the judgment. But it was 18 apparent, but Ms. Johnson herself felt 19 that there was, so you see. And so when a 20 patient feels that is so then the 21 patient's feelings need to be explored and 22 addressed because there would be a -- it 23 was apparent to Ms. Johnson; and if it was 24 apparent to Ms. Johnson, then that is a -- 25 and she was complaining about it, right,

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1 so that is something which would have 2 needed to have been addressed in the 3 course of treatment, given the potential 4 conflict of interest that she herself was 5 raising. 6 Q. Okay. Let's assume for the sake of just a 7 hypothetical, if you would, that Ms. 8 Johnson was transferred to another 9 hospital in South Carolina. Would you 10 have any problem with them doing 11 involuntary ECT after getting consent from 12 both her now ex-husband and her parents 13 back in 2003? 14 A. They would -- before proceeding 15 immediately, I would have a problem of 16 them proceeding immediately to ECT 17 because, given the trauma that Ms. Johnson 18 had experienced in the previous setting, 19 it would take some time to create a 20 therapeutic alliance with her, it would 21 take some time for medications to begin to 22 work and for her to feel that she was in a 23 safe setting. The way I think of it and 24 the way psychiatrists who I have taught 25 and how all my colleagues think of it, but	1 certainly the way I think of it is that 2 any psychiatric intervention is only as 3 good as the intervention itself 4 interacting with the setting in which it 5 is given, is it a safe setting, and a 6 mindset of the patient. And the setting 7 of this particular hospital, given the 8 potential conflicts of interest with the 9 patient, if anyone listened to the 10 patient, an intervention, especially an 11 involuntary intervention was not likely -- 12 was likely to -- was foreseeably going to 13 have some very serious harmful effects on 14 the patient's mindset which already was 15 vulnerable and the patient's ability to 16 have a therapeutic alliance to be able to 17 trust the physicians who she was working 18 with. To be even more specific, if I may, 19 I have in my practice patients who have 20 been transferred to me by psychiatrists 21 who are treating a couple in couple's 22 therapy and one of the patients does 23 become, did become hypomanic. And the 24 reason why they transferred that patient 25 to me is because they felt that they were
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1 the physician for their husband, there 2 would be a potential conflict of interest 3 for that patient. When they tried to 4 treat that patient with medications, 5 medications were not working. When I 6 treated that same patient with the same 7 medications when there was no -- the 8 patient knew that I was their, my interest 9 was their interest, the medications 10 worked. We established a therapeutic 11 alliance. We were able to do some 12 meaningful therapy, and low and behold, 13 not only did the medications work but it 14 worked in a lower dosage than it had been 15 previously prescribed at times. So you 16 see, in psychiatry it is the intervention 17 plus interacting with the mindset of the 18 patient and setting, the amount of trust 19 that is in the doctor/patient or the 20 institution/patient relationship. 21 Q. Okay. I am not sure you answered my 22 question, Doctor. 23 If Ms. Johnson would have been 24 transferred, if she would have 25 hypothetically been transferred to another	1 facility in South Carolina before she ever 2 got ECT at MUSC, assume all that, can you 3 assume that for me? 4 A. I can assume that. But are you also 5 assuming that she was receiving 6 appropriate, subsequently an appropriate 7 trial of medication and psychotherapy for 8 some extended period of time? 9 Q. All right. I am speaking simply of the 10 conflict which you keep going into, 11 dovetailing from other questions. But if 12 she would have been transferred as you 13 said she should have been done, if she 14 should have been transferred to another 15 hospital in South Carolina where the law 16 requires her husband and parents and in 17 this case both of them gave consent, if 18 she would have been transferred to another 19 hospital, would it have been a deviation 20 from the standard of care to get consent 21 from her husband, now ex-husband, and her 22 parents, and go through with involuntary 23 ECT? 24 A. It would not, it would have been a 25 deviation and it would not be meaningful

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1 informed consent unless she first felt she 2 received in that institution an adequate 3 and comprehensive evaluation and then 4 adequate trial of medication and 5 psychotherapy before recommending 6 involuntary ECT. 7 Q. All right. So we stop it here. What 8 evaluation should have been done that 9 wasn't done in your opinion? 10 A. The evaluation would have included 11 exploring her concerns about her marriage, 12 the potential conflict of interest 13 situation that she had felt herself placed 14 in previously, the helplessness that she 15 felt when being hospitalized at her 16 husband's institution, and a medication 17 trial would be part of that evaluation to 18 see whether she could now respond the way 19 she had responded in her previous 20 hospitalizations to a combination of 21 medication and psychotherapy before trying 22 ECT, before especially on an involuntary 23 basis. 24 Q. All right. Do you know how she ended up 25 at the Medical University of South	1 Carolina, Doctor Bursztajn? 2 A. I would have to consult the medical, the 3 records for that. I don't want to go 4 ahead and rely on my memory. 5 Q. Do you know whether her parents, her 6 friends including herself requested that 7 she be transferred to that institution in 8 Charleston, South Carolina? 9 A. Again, even if they did, they should have 10 been told that this was contraindicated, 11 given the potential conflict of interest 12 at that point in time. 13 Q. Well -- 14 A. Given the status of her marriage, given 15 the status of her marriage which was very 16 shaky to say the least, given her concerns 17 about it, given her fears of abandonment 18 and helplessness. 19 Q. Okay. All right. Let me -- I am going to 20 try to trudge through the main opinions 21 you gave early on. If you could to the 22 extent you can, I know you have covered a 23 lot with regards to the conflict of 24 interest and I am not trying to limit your 25 answer but just answer my question, we
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1 might be able to get done a little 2 quicker. Now, let me find my -- okay. 3 Beginning on -- and I am going to ask you 4 about your testing in a second. 5 But beginning on page 13 of that 6 same letter that you sent Mr. Ravenel back 7 in April of 2011, do you see where you 8 have corroborative data? 9 A. Page -- which page are we on now? Yes, 10 13, right. 11 Q. Thirteen. 12 A. Page 13, right. Okay. 13 Q. Okay. Looking at that, I want to make 14 sure what I am looking at is the same 15 thing that you are looking at. You talk 16 about some preexisting vulnerability. Is 17 that the gist of that opinion? 18 A. Yes. 19 Q. All right. And some of that, you include 20 a childhood head injury regarding falls in 21 gymnastics and being hit by a baseball. 22 Are you aware of any treatment or medical 23 scans that she had as a result of those 24 falls or that instance where she was hit 25 by a baseball?	1 A. No. The only brain imaging that I am 2 aware of is the brain imaging which was 3 done in 2002, which showed brain atrophy 4 more advanced than would be expected for 5 her age, which would be consistent with 6 that. But none at the -- but none at the 7 time. 8 Now, I should also mention that 9 when she was a child, even the CT scans 10 that were used were used much less and 11 brain imaging was used much less than it 12 was by 2002. 13 Q. Okay. But do you know whether even she 14 went to see a doctor at all for the fall 15 or falls and the time she was hit by a 16 baseball? 17 A. I don't believe she did. But again, I 18 would have to refresh my memory on that. 19 Q. All right. And the CT that you refer to 20 was done in 2002. That, at least her 21 neurologist who consulted with her in 22 Columbia Palmetto Baptist indicated that 23 was consistent with drug use, did he not? 24 A. It can be consistent with drug use as 25 well, yes.

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1 Q. All right. And that in and of itself, 2 that particular scan was ordered by the 3 physicians at MUSC during the pre-ECT 4 workup of Clair Johnson. You agree with 5 that? 6 A. Yes. 7 Q. And that CT scan in and of itself would 8 not be a contraindication for 9 Electroconvulsive Therapy. You agree with 10 that, at least you say that in your 11 record? 12 A. Yes. It is not an absolute 13 contraindication, but it is an indication 14 for proceeding carefully, establishing a 15 baseline, potentially doing some new or 16 psychological testing to establish a 17 baseline to begin with so that you can 18 closely monitor the patient as you 19 proceed. And then once you exceed the 20 NICE Guidelines, that is the National 21 Institute Center for Excellence, the 22 British which were available at that point 23 in time in 2003. And they basically are a 24 nice and relatively unbiased set of 25 guidelines. More biased guidelines were	1 put out by people who do ECT, but this was 2 the National Health Service, the British, 3 which doesn't have a dog in the fight, 4 basically, about ECT. Once you begin to 5 go beyond 12, I mean once, if she doesn't 6 have a clear, ongoing positive response 7 after about between six to 12 ECT's, that 8 would be a very good indication for 9 stopping the ECT at that point. It 10 certainly is below the standard of care 11 not to continue to monitor her, especially 12 in light of this prior vulnerability shown 13 in the CT scan. I mean just to not 14 continue to not do any serious monitoring 15 other than simply, you know, meeting with 16 her, that is not good enough. You have to 17 begin to do some, some monitoring. The 18 problem with her self-reports are -- 19 Q. We are never going to get through this. 20 A. That there would be, to the extent of her 21 memory would be affected by the ECT 22 itself, they would not be reliable. She 23 could not report impairment unless you 24 were to go ahead and either do new 25 psychological testing or, as I did, give
Page 108	Page 109
1 her a series of checklists where she could 2 recognize impairment which she might not 3 be able to recall herself. 4 Q. All right. You used the term 5 "monitoring". What wasn't done that 6 should have been done in your opinion just 7 with regards to monitoring, simply with 8 monitoring? 9 A. Yes. She should have been given a series 10 of checklists, of cognitive symptoms 11 checklists so that even if she might not 12 remember what her impairments are, she 13 could recognize -- even if she couldn't 14 recall her impairments, she could 15 recognize her impairments. Many mental 16 status exams could have been done. Serial 17 neuropsychological testing could have been 18 done. And none of this was done. 19 Q. All right. Mental status exams were not 20 done, in your opinion, based on what you 21 have seen? 22 A. Not adequate formal mental status exams. 23 What was done was perfunctory and 24 unsuitable for a patient as vulnerable as 25 this patient is and was.	1 Q. And her vulnerabilities are based on her 2 childhood head trauma, hit by the baseball 3 and falling, and migraine headaches. 4 Anything else, any other vulnerabilities 5 that this patient had? 6 A. She did have a history of substance usage 7 including alcohol, so that is an 8 additional vulnerability. So you have 9 three sets of vulnerabilities. She was, 10 had also been prescribed stimulants which 11 potentially is another vulnerability but 12 more arguably so. So you have at least 13 three clear sets of vulnerabilities here 14 which require careful, thoughtful, timely 15 monitoring by repeated testing, by 16 structured interviews with the patient, 17 not simply when you talked with her and 18 she doesn't say there is anything wrong or 19 says I didn't see anything wrong. That is 20 not good enough. That is not -- that is 21 not -- that is not monitoring, not for 22 this patient anyway. 23 Q. Is it possible -- is it possible to do the 24 type of monitoring that you are suggesting 25 on a patient that is delusional and

Page 110 1 suffering the type of acute mania that Ms. 2 Johnson presented to MUSC with on numerous 3 occasions? 4 A. During the acute manic episode it is 5 difficult but not impossible. I have had 6 something to do with patients who are 7 acutely manic. But she was not always 8 manic, right. So subsequent, subsequent 9 to each episode, that could have been 10 done. It could also have been done on an 11 outpatient basis by Doctor Roberts when 12 she was relatively stable and euphenic. 13 So there is a -- there were times and 14 places where it wasn't difficult to do and 15 it should have been done. There were 16 other times where it was difficult to do 17 but still should have been done. 18 Q. All right. Are you aware of any instance 19 where Ms. Johnson was admitted as an 20 inpatient at MUSC where she was not 21 presenting in a state where she was 22 acutely manic? 23 A. I am not aware of any such instance, but I 24 am aware of plenty of instances where she 25 was discharged and she wasn't acutely	Page 111 1 manic and then the testing still could 2 have been done. 3 Q. All right. Looking at paragraph B or on 4 yours it would be two. 5 A. Yes. Page 14? 6 Q. Well, I am looking at one of your other 7 letters. But give me a second, I can 8 compare them. 9 A. Okay. 10 Q. All right. You say, "ECT was not an 11 inevitable choice of treatment," but you 12 are not, again, saying that ECT was not 13 indicated based upon her symptoms. 14 Correct? 15 A. I am saying that involuntary ECT was not 16 indicated based on her symptoms. 17 Q. All right. You don't believe that she was 18 a -- you don't believe when she presented 19 in -- well, she wasn't given involuntary 20 ECT on her first admission to MUSC, was 21 she? 22 A. She wasn't. That assessment was not made. 23 But for all intents and purposes, the ECT 24 was given to someone who was impaired 25 enough so it should have been given. An
Page 112 1 assessment should have been made for 2 whether she was competent to consent. 3 Q. Now, I guess I am talking about something 4 different. You were aware that she 5 presented at MUSC for the first time about 6 three months prior to her ever getting an 7 ECT, correct? 8 A. Yes. 9 Q. All right. Doctor Bursztajn, do you have 10 a -- are you going to opine at trial that 11 the use of bilateral ECT was a deviation 12 from the standard of care in this case 13 simply because of the choice of the 14 electrode placement? 15 A. Not simply because of the choice of the 16 electrode placement. 17 Q. Well, are you going to opine that the use 18 of bilateral ECT in this case was a 19 deviation from the standard of care? 20 A. For it to be administered in the context 21 of an involuntary basis for as long as it 22 was without looking at reasonable 23 alternatives, yes. 24 Q. All right. Are you aware of the efficacy 25 of unilateral Electroconvulsive Therapy on	Page 113 1 patients suffering from acute mania? 2 A. The issue of efficacy, although there were 3 some studies out there, I haven't seen 4 anything which is conclusive or 5 definitive. I think there is a tremendous 6 amount of variability based on the 7 individual patient. 8 Q. All right. 9 A. The reports I have seen show a great deal 10 of variability. 11 Q. Okay. And have you -- I lost my train of 12 thought. 13 You have not looked at the 14 efficacy of unilateral placement of 15 electrodes on a patient who has suffered 16 from acute mania, is that fair? 17 A. No. I have looked at various reports. I 18 haven't seen any studies which I would 19 consider to be reliable and definitive for 20 this, for this patient such as Clair 21 Johnson. What I have seen at this point 22 is either some methodologic problems in 23 those studies or they would not apply to 24 Ms. Johnson. 25 Q. Ms. Johnson did have a favorable or

Page 114	Page 115
1 positive outcome from ECT during her 2 initial or first couple of courses of 3 treatment. 4 You agree with that, correct? 5 A. It is unclear whether whatever gains she 6 made were due to the ECT or due to a 7 variety of changes in her medication and 8 her social situation. To attribute the 9 favorable outcome to the use of ECT is a 10 stretch. 11 Q. Why do you say that? What about her 12 social situation changed in December of 13 2003? 14 A. Well, for one thing, even though she was 15 placed in a setting where she was 16 frightened, she was removed from daily 17 contact, from, from living, from a life 18 situation where there was constant 19 conflict with now her ex-husband. 20 Secondly -- let me consult my notes here. 21 Q. Well, do you think she was living with her 22 ex-husband then, Doctor Bursztajn? 23 A. No, I didn't say then. I said constant 24 conflict is not the same as living with. 25 But it was a conflictual situation with	1 her. 2 No, she wasn't he living with 3 him. I didn't think that, no. 4 Let's just take a look here. 5 Okay. I mean she is someone who responds 6 to hospitalizations. She has responded to 7 previous hospitalizations without ECT. 8 The fact that she eventually responded to 9 this hospitalization with ECT doesn't mean 10 that it is the ECT that causes the 11 response to the hospitalization. If 12 anything, arguably, it made her less 13 responsive to the hospitalization itself. 14 Q. Anything else about her social situation 15 that you just referred to other than what 16 you just said? 17 A. Well, that is the elephant in the room. 18 Q. All right. Number three, "The ongoing 19 assessment of decision making competence 20 was called for in Ms. Johnson's case." 21 Is there anything else about that 22 particular opinion that you haven't 23 already stated in this deposition? 24 A. I believe I have stated the gist of it. 25 Q. All right. Number four, "Insufficient
Page 116	Page 117
1 consideration appears to have been given 2 to the choice of substitute decision 3 makers and to the clinical and ethical 4 implications of that choice." 5 Other than her parents and her 6 now ex-husband at the time, what other 7 substitute decision makers could have been 8 considered? 9 A. There were some instances -- well, first 10 of all, her husband shouldn't, should not 11 have been considered as a substitute 12 decision maker. It boggles the 13 imagination that, given their 14 estrangement, he would be and, again, 15 especially for someone who is feeling 16 helpless and who obviously will have some 17 potential abandonment issues. There was 18 some conflict with her father and, again, 19 whether or not it would help if her 20 parents were substitute decision makers 21 was something that should have been 22 assessed and evaluated rather than just 23 simply assumed. And there are times where 24 one proceeds to get a guardian ad litem, 25 the Court appoints a guardian. Someone	1 like yourself, for example, is appointed 2 or someone like Mr. Scott or Mr. Ravenel. 3 That could have been considered in this 4 particular case as well. And I certainly 5 have consulted in more than one 6 guardianship case where, even though the 7 family is well-meaning and well 8 intentioned, the family dynamics are such 9 that there is a counter indication to the 10 family being the guardian. Without, you 11 know, without in any way devaluing anyone 12 in the family, that evaluation should have 13 been done. And I just don't see any such 14 evaluation. Why not? I don't understand. 15 I mean I have looked at the depositions, I 16 have looked at the medical records. And 17 again, if you can tell me why that wasn't 18 done or at least not documented, that 19 would be very helpful. 20 Q. Well, I guess I am not sure what you are 21 saying. I am asking what other substitute 22 decision makers other than her mom, her 23 dad and her current husband at the time 24 should have been considered. 25 A. And I answered, a guardian ad litem such

Page 118	Page 119
1 as yourself or Mr. Scott or Mr. Ravenel or 2 anyone else who has an interest in mental 3 health and the law. 4 Q. Do you know who her guardian ad litem was 5 that was appointed by the Court in her 6 family court case which was running 7 concurrent at this same time was? 8 A. I don't remember off the top of my head. 9 Q. Okay. Are you familiar with the South 10 Carolina Law for alternative substitute 11 consenters? 12 A. I -- I am in terms of having reviewed it 13 but I couldn't recite it and I would not 14 rely on my memory for the black letter of 15 the law. I am sure that -- but if you 16 wanted to give it to me, I can simply 17 comment on it, recognize it and comment on 18 it. 19 Q. Well, would you -- well, without doing 20 that, would you expect the physicians at 21 MUSC to follow that law when it comes to 22 the hierarchy of who should be the 23 substitute alternate consenters for Ms. 24 Johnson? 25 A. They need to do an evaluation to see what	1 the hierarchy is and then follow the law. 2 But you have to do an evaluation before 3 you can go, the family dynamics before you 4 can interpret the law. 5 Q. All right. This evaluation you are 6 talking about is different than the 7 evaluation we were talking about a little 8 while ago. Is this just an evaluation 9 with regards to the substitute consenters? 10 A. There needs to be a specific evaluation as 11 to what is the best interests of this 12 patient clinically. That is, you know, as 13 a clinician, your duty is to the patient. 14 If you feel that if you need to do an 15 evaluation when you are applying for 16 guardianship to see who would be in the 17 best position to be a substitute decision 18 maker and protect the patient's best 19 interests at the same time, that 20 evaluation needs to include a 21 comprehensive evaluation of family 22 dynamics such as, Gee, are these people 23 getting a divorce right now, are they at 24 least estranged and separated from each 25 other right now, is it a good idea to have
Page 120	Page 121
1 her estranged husband be one of the 2 substitute decision makers? 3 I don't believe that South 4 Carolina law tells the clinician that an 5 estranged husband has to be the substitute 6 decision maker. You could prove me wrong 7 on that. 8 Q. All right. Have you reviewed the South 9 Carolina Substitute Consenter, the Act 10 that I am referring to? 11 A. I believe I have, yes. That is one of my 12 long -- one of my special interests is 13 guardianship issues, as you know from my 14 publications nationally, and I served on 15 the ABA Mental Health Law and Disability 16 Commission. So yes, that is one of the 17 laws I have reviewed. 18 But again, if you can recite it 19 to me, I can recognize it and then I can 20 go ahead and give you my opinion as to 21 whether or not the clinicians followed the 22 law or not. 23 Q. All right. So you have given opinions as 24 to clinicians not following the law 25 before?	1 A. I have given an opinion that clinicians 2 have done an inadequate assessment of 3 family dynamics before so as to have 4 someone be appointed a guardian who 5 shouldn't be a guardian. 6 Look, if you have a, for example, 7 a father who abuses a daughter, the 8 daughter gets sick, you don't have the 9 guardian, the father be appointed a 10 guardian. That is not the law. 11 If you have a husband who is 12 estranged from the a wife and the wife is 13 worried about being abandoned to him, you 14 don't nominate him to be the guardian. 15 That is not the South Carolina 16 law, is it? I mean if it is, please let 17 me know. I would be interested to write 18 about it. 19 Q. Well, do you know whether the South 20 Carolina law addresses the spouse in the 21 process of separation in the context of 22 this South Carolina Alternative Adult 23 Health Care Consent Act, do you know or 24 don't you know? 25 A. I simply don't remember off the top of my

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1 head. But I would be shocked if it
2 precludes a clinician from doing an
3 evaluation on this specific point. I mean
4 if it does, please show me.
5 Q. Well, I am not suggesting it precludes an
6 evaluation. But if it does, if it does
7 talk about an evaluation and it gives a
8 hierarchy of who should be the substitute
9 consent, you would not follow the law in
10 that context?
11 A. Oh, no. That is a misleading question.
12 Of course you follow the law, but you have
13 to do an evaluation to know whether or not
14 what the hierarchy should be and whether
15 there should be an exception to the
16 hierarchy or not. And if an evaluation
17 wasn't done, whether there is good reason,
18 there is every indication that such an
19 evaluation should have been done. Not to
20 do it is below the standard of care. And
21 you can't hide behind the law to say that
22 the law does not command you to practice
23 below the standard of care. South
24 Carolina law doesn't do it, any law that I
25 know doesn't do it, not in the United

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1 mania, correct?
2 A. Yes. But on none of those occasions did
3 she subsequently need ECT.
4 Q. Well, what other medications other than
5 Lamictal could have prevented her acute
6 mania and recommitments to the hospital,
7 if you will?
8 A. Well, once she had been traumatized by
9 this 80 plus ECT dosages, medication
10 management foreseeably became much more
11 difficult because now you have a
12 combination of not just a bipolar disorder
13 but also a post-traumatic disorder
14 secondary to the involuntary ECT that she
15 suffered. So I am not surprised that
16 subsequently she was not as responsive to
17 medication management. At the same time,
18 even at the time that she was
19 hospitalized, as I mentioned, Ativan and
20 Klonopin could have been tried on an acute
21 basis and it could have been also a re-try
22 in other institutions and safe settings of
23 other medications that did not previously
24 work because they might work this time
25 around if she felt safe enough.

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1 States anyway.
2 Q. All right. Let's move on from number four
3 to number five. You are talking about
4 conflict of interest in this particular
5 paragraph. It goes on to page 16.
6 Is there anything with regards to
7 your opinion on the conflict of interest
8 that you haven't already articulated in
9 this deposition?
10 A. I believe you have the gist of it.
11 Q. Well, if there is anything you haven't
12 told me already I would certainly like to
13 hear it now before trial.
14 A. Absolutely. And again, I think I have
15 said the gist of my opinion.
16 Q. All right. Okay. Number six, you talk
17 about reasonable medication choices as
18 alternatives and you give in the first
19 sentence an example of Lamictal.
20 A. Yes.
21 Q. You are aware now since you wrote this
22 letter to Mr. Ravenel that Ms. Johnson was
23 in fact taking Lamictal and,
24 notwithstanding that, was hospitalized on
25 several subsequent occasions for acute

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1 Again, the effect of any
2 psychiatric intervention including
3 medication, it is a combination of the
4 medication, the substance, the setting,
5 the therapeutic alliance, and the mindset
6 of the patient. And this was simply not
7 considered.
8 Q. All right. Are you going to tell the jury
9 that her most recent hospitalizations for
10 acute mania in Columbia, South Carolina
11 resulted from post-traumatic stress
12 disorder versus her underlying chronic
13 bipolar disorder dating back to her teens?
14 A. Again, I would need to go ahead and review
15 and analyze those in detail to be
16 definitive. But there is no question that
17 her risk of subsequent decompensation and
18 recurrent hospitalizations has increased
19 due to the involuntary ECT creating a post
20 traumatic, creating trauma and a
21 post-traumatic stress disorder spectrum
22 for someone who is already vulnerable due
23 to bipolar illness.
24 That at the time she was
25 hospitalized, she was in an unhappy

Page 126 1 unstable marriage initially. Now she is 2 divorced so she doesn't have that hanging 3 over her head anymore. But what she does 4 have is the trauma of ECT. Basically, one 5 psychosocial stressor has gone out of her 6 life which would foreseeably tip over a 7 patient vulnerable to bipolar in an 8 essentially manic episode; namely, the 9 threat of divorce and abandonment is not 10 gone from her life. But what you have 11 instead is the helplessness, the 12 hopelessness and the horror which was 13 attendant to her experience with 14 involuntary ECT and the subsequent loss of 15 memory that she has suffered as well, 16 which together create significant trauma 17 which continues to be an ongoing 18 destabilizing stressor and makes her much 19 more difficult to manage on an outpatient 20 basis over extended periods of time. 21 Q. All right. I guess my question is now 22 limited to, Doctor, I guess part of your 23 job is to give some causation opinions. 24 Are you going to testify that the cause of 25 her recent hospitalizations, and if you	Page 127 1 are that is fine, I just want to know, are 2 caused by her post-traumatic stress 3 disorder or her underlying bipolar 4 disorder; and if so, which ones? 5 A. Well, it is her post-traumatic stress 6 disorder which causes it because she is 7 vulnerable by reason of bipolar disorder. 8 So her post-traumatic stress disorder, 9 given her bipolar vulnerability, tips her 10 over into a manic state. 11 Q. All right. Can you say to a reasonable 12 degree of medical certainty, 13 notwithstanding her post-traumatic stress 14 disorder, that she would not have required 15 those hospitalizations recently with her 16 underlying bipolar condition? 17 A. More likely than not, with appropriate 18 treatment of bipolar disorder, without the 19 post-traumatic complication, she would be 20 and she should be stabilized by now so 21 that she would not require repeated 22 hospitalizations. 23 Q. Well, why did she have to have those 24 hospitalizations recently, Doctor? 25 A. Because she is still experiencing the
Page 128 1 trauma of helplessness and hopelessness 2 and lack of trust engendered by the 3 involuntary ECT in a setting where she was 4 getting divorced, where she was estranged 5 from her husband and she was hospitalized 6 in her husband's hospital, and her 7 brother, where her brother-in-law was the 8 Chair of the Board of Trustees. 9 Q. All right. How about the ones prior to 10 her ECT, what caused her to be 11 hospitalized for those? 12 A. Her bipolar disorder, complicated by the 13 growing estrangement from her husband was 14 a major factor, and her growing fears of 15 abandonment by him. 16 Q. All right. How about prior to her getting 17 married, what caused those 18 hospitalizations for acute mania? 19 A. Ongoing fears of, a combination of fears 20 of abandonment which she self medicated by 21 alcohol and drug use and subsequently 22 became overwhelmed and became bipolar, 23 became manic. She always has had some 24 bipolar vulnerability, mood instability 25 but --	Page 129 1 Q. So in your opinion -- 2 A. Yes. 3 Q. So in your opinion, Doctor Bursztajn, it 4 has always been some external factor and 5 nothing to do with the underlying disease 6 component of Clair Johnson that has caused 7 her to have these multiple 8 hospitalizations. Is that your opinion? 9 A. No, that is a misunderstanding of my 10 opinion. I am distinguishing between a 11 vulnerability and a proximate cause. A 12 stressor with most bipolar patients tends 13 to be the proximate cause and it is 14 certainly Ms. Johnson's case that is true. 15 There is a vulnerability that is there, a 16 vulnerability to a variety of different 17 stressors. And in Ms. Johnson's case, it 18 is the stressor to which she is vulnerable 19 to the most is abandonment, helplessness, 20 hopelessness, which is what you would 21 expect given her life history. She tries 22 to self medicate, using stimulants and 23 using drugs and alcohol. It doesn't work 24 for her. It makes things worse. 25 Q. All right. So just if I can put that in a

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1 nutshell, the proximate cause of her 2 hospitalizations prior to her getting 3 married were drugs and alcohol, and the 4 proximate cause of her hospitalizations 5 during her marriage were the way she was 6 treated by her husband, and the proximate 7 cause of her hospitalizations after her 8 ECT treatments are now post-traumatic 9 stress disorder. Is that what you are 10 saying? 11 A. No. Again, that is a misunderstanding 12 throughout. Overwhelmingly, she is very 13 vulnerable to overwhelming feelings. 14 Before her marriage, the feelings of, the 15 fear of abandonment and helplessness and 16 hopelessness resulted in drug use and 17 together they resulted in her becoming 18 manic and needing to be hospitalized. 19 During her marriage, the ongoing fear of 20 abandonment and the stress in the 21 relationship with her now ex-husband was a 22 major precipitating factor. And then 23 subsequent to her hospitalization in 2003, 24 even though the divorce is now done, the 25 major factor is the trauma that she	1 experienced during this protracted course 2 of first involuntary ECT both in an 3 inpatient and then in an ongoing 4 outpatient basis in a situation where 5 anyone would be foreseeably feeling 6 terrified by, especially someone that is 7 vulnerable as she is to mood, she has a 8 mood disorder basically. Mood disorders 9 are triggered into either major, manic or 10 depressive phases by external stressors. 11 The stressors are foreseeable. If they 12 are not addressed adequately through a 13 combination of psychotherapy, changes in 14 social intervention and then appropriate 15 medication management, the patient becomes 16 unstable. 17 To give you an example, if I may, 18 but I can stop here if you want me to. I 19 mean I don't need to — 20 Q. Well, I don't want you to cut you off. I 21 do want you to answer my question. We've 22 only paid for a certain amount of time. 23 When did she start experiencing 24 symptoms that you relate to post-traumatic 25 stress disorder?
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1 A. If I may consult my notes, where did I put 2 that? I would need to check the specific 3 points in time where she begins to 4 complaint of conflicts of interest. But I 5 think at that point what you have is 6 someone who is clearly experiencing a 7 degree of trauma due to the setting that 8 she is in. So again, I — let's see here. 9 Where does that begin? 10 This isn't the passage I was 11 looking for, but one place in my notes is 12 on December 17, 2003. I am in the middle 13 of the page and it is page 214 in the 14 hospital records. The resident discusses 15 with Clair Johnson she plans to live with 16 her husband, but the resident is aware of 17 the husband's separation and divorce plans 18 and knows that CJ is unaware of these 19 plans. Now, at that point in time you 20 have a situation where a patient who had 21 been previously terrified — oh, here it 22 is. 12/9/03, page 197. 23 "Patient was agitated, reporting 24 a conflict of interest in her 25 hospitalization." At that point in time,	1 you have clear manifestation of how 2 frightened she is, she is agitated about 3 this potential conflict of interest. A 4 few days later on December 17th, she is 5 saying that she is planning to live with 6 her husband, even though the resident 7 knows that her husband plans to separate 8 and divorce from her. 9 Now, if that doesn't create a 10 situation which would undermine trust, I 11 don't know what will. So certainly, by 12 December 9th of 2003, we have clear 13 evidence of a post-traumatic stress 14 element due to the involuntary nature of 15 the ECT which her husband has, husband who 16 is planning to divorce, has signed coming 17 into play. Unfortunately, this was never 18 further explored or pursued with her. 19 Q. What was never explored or pursued with 20 her? 21 A. The meaning, what it meant for her that 22 her husband, that the staff knew about her 23 husband's planning to divorce her when she 24 didn't, what it meant for her that her 25 husband, who was planning to divorce her,

Page 134 1 was signing the consent form for her 2 involuntary ECT – what is it –and for 3 her to have complaints of a conflict of 4 interest that went unheeded, unexplored 5 and unaddressed. This was never explored 6 with her that I can see. 7 Q. Doctor Bursztajn, we just talked about a 8 series of external factors. Isn't it 9 prudent medical practice to suppress as 10 many external factors that are causing 11 stress on Ms. Johnson during her 12 hospitalization as possible and then later 13 have a family meeting like subsequently 14 occurred? 15 A. It is not prudent to go ahead and to have 16 a, if you are aware that a husband is 17 planning to, if the wife is estranged from 18 the husband, to go ahead and have the 19 estranged husband who is planning divorce 20 sign the consent form for her ECT. It is 21 not only imprudent, it is reckless. 22 Q. All right. You are taking what she says 23 during her medical records of December of 24 2003 at face value. Does that mean that 25 you are believing everything she says in	Page 135 1 December of 2003 or just taking bits or 2 pieces that support your opinion? 3 A. I am not simply choosing bits and pieces 4 to support my opinion. I have considered 5 the record as a whole. I am focusing on 6 those elements which are most relevant, 7 relative to what we have here and her 8 presentation, which was not simply bipolar 9 disorder but someone who has a bipolar 10 vulnerability which under stress becomes 11 manic, with the stress, with the stress of 12 involuntary ECT, where her estranged 13 husband is chosen as being the substitute 14 decision maker, the helplessness that she 15 experienced in that process. 16 Q. Doctor Bursztajn, are you suggesting that 17 the substitute decision maker for this 18 course of ECT treatment that you are now 19 talking about was her husband or her 20 parents? 21 A. It is the reality, even if it was her 22 parents, the fact that her husband was 23 involved, the fact that she was in her 24 husband's institution where his brother 25 was the Chairman of the Board of Trustees
Page 136 1 made it, as she says herself, clearly a 2 conflict of interest. That is what I am 3 saying. It is a conflict of interest 4 which compounded her helplessness and her 5 fear. 6 Q. All right. And she was aware of that, 7 Clair Johnson was aware of that and 8 related that to others in 2003? 9 A. Yes. 10 Q. All right. So there is a cause of action 11 in 2003, Clair Johnson was aware of it for 12 a conflict of interest? 13 A. She was not aware that it would produce 14 post-traumatic stress disorder, but she 15 was aware that this was a conflict of 16 interest. You have to be a clinician who 17 understands the nature of therapeutic 18 alliance and the importance of a 19 therapeutic alliance for the effective 20 management of bipolar illness through a 21 combination of medication and 22 psychotherapy to be able to understand the 23 causal connection. She did not have the 24 capacity to understand the causal 25 connection. And moreover, she was sick,	Page 137 1 she was – 2 Q. Well, I had asked you a second ago to tell 3 me when you first see symptoms of 4 post-traumatic stress disorder, and this 5 is the record that you pointed me to in 6 December of 2003. 7 A. Yes. She knew something was terribly 8 wrong about this conflict of interest. 9 But could she go ahead and know that this 10 was a cause of action in her state of 11 mind, no. She knew she was terrified of 12 it. She felt terrified of it. 13 Q. Was she disabled mentally in December of 14 2003? 15 A. She, she still was impaired sufficiently 16 in 2003 so as not to be able to engage in 17 any kind of self diagnosis. 18 MR. EARLY: Okay. I tell you 19 what, let's take a quick break. And I am 20 really just going to ask you about your 21 testing after the break and then look 22 through my notes. But I am going to pass 23 the baton to Mr. Scott and have him ask 24 you some questions. He has been sitting 25 over here jumping on his hands.

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1 **THE WITNESS:** Very good,
2 gentlemen. Let's proceed.
3 (Brief recess.)
4 **MR. EARLY:** Back on the record.
5 **Q.** Doctor Bursztajn, we took a brief break.
6 Again, Will Early here. We been talking
7 for many hours about your opinions and
8 your criticisms of the Medical University
9 of South Carolina. I think we have
10 indicated off the record I am going to ask
11 you questions for about 15 minutes and
12 leave this deposition open and I may have
13 some more, and Mr. Scott certainly will.
14 **A.** Sure.
15 **Q.** But have you now given me verbally all of
16 your criticisms that you have with regards
17 to anything to do with fault or
18 malpractice or deviations from the
19 standard of care with regards to any
20 personnel at MUSC from the president all
21 the way down to the janitor?
22 **A.** Let me just check my notes so --
23 **Q.** Okay.
24 **MR. RAVENEL:** There is some
25 question about the janitor.

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1 afternoon, only has eight, and if you've
2 got nine then we're looking at you've got
3 more than what I've got.
4 **A.** Oh, yikes, let's see here. Let's look and
5 see. Can you bear with me to page 17?
6 Page 17.
7 **Q.** Okay.
8 **MR. SCOTT:** I've got nine.
9 **A.** Nine, it is nine unless --
10 **MR. SCOTT:** And then eight --
11 **Q.** I was looking at the wrong part of the
12 report. You are correct.
13 **A.** Okay.
14 **Q.** You had eight in the previous section?
15 **A.** Yes, yes, yes. It is between pages --
16 let's see. It gets enumerated, yes, pages
17 13 to 17, pages 13 to 17.
18 **Q.** Pages 13 to 17?
19 **A.** Yes, under C.
20 **Q.** Okay.
21 **A.** Now, let me just check two other places
22 real quick.
23 **Q.** Well, before you do that, have we talked
24 about all of those areas? I think we have
25 but I want to make sure you tell me that

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1 **THE WITNESS:** The ice machine.
2 **MR. RAVENEL:** Yes.
3 **A.** Let me just check my notes. Well, you
4 know, if you go through the draft of my
5 report, I don't know if we went through
6 all the points from one to nine, but I
7 think those points plus there is a set of
8 notes, let me just check those. I
9 summarize --
10 **Q.** Well, let's make sure we are on the same
11 page. Which report, because I have gotten
12 three and I got one late yesterday, so
13 which report are you talking about?
14 **A.** Well, first it is the draft report that
15 was sent, I believe, on April the 1st,
16 2011.
17 **Q.** Right.
18 **A.** Okay. And I am just going to check two
19 other places to be sure that I am not
20 leaving something out which you have every
21 right to know about. So can you give me a
22 couple seconds?
23 **Q.** Okay, right. Before you do that, Doctor
24 Bursztajn, my draft report from April 1st
25 of 2011, which again I got yesterday

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1 we have on the record.
2 **A.** I think we have also. I think there are
3 details that we could go into and go into,
4 but I think that we have the gist of it.
5 Again --
6 **Q.** Okay.
7 **A.** Let me just double-check to make sure that
8 -- we talked about causation and my
9 opinion about causation. We talked about
10 --
11 **Q.** Where are you looking?
12 **A.** Now I am looking at my affidavit that was
13 filed which you should have a copy of.
14 **Q.** Yes.
15 **A.** Yes. So here I think so. We talked about
16 that. We also talked about why I don't
17 think that Clair Johnson had the capacity
18 to understand the harm that was being
19 caused to her as a result of this, I am
20 sure, 2010, in any meaningful way.
21 **Q.** We did.
22 **A.** Let me just make sure there is nothing
23 else I have omitted here. One more page I
24 need to find. I am just looking now at
25 Exhibit 2, the notes for deposition.

Page 142 1 preparation. 2 Q. Okay. I've got it. 3 A. We talked about one, we talked about two, 4 we talked about three. We talked about 5 four, we talked about five. We talked 6 about six, we talked about seven. We 7 talked about eight and how it is a 8 deviation from the hospital policy itself 9 it is also a deviation from what NICE, 10 that is the National Institute for the 11 Center of Excellence, but we talked about 12 it, the National Health Service, what the 13 British Guidelines recommend. And we 14 talked about nine, so I think we have 15 covered it at this point. 16 Q. Okay. Well, let me just have a few 17 follow-ups. In looking back at Exhibit 2, 18 your notes -- 19 A. Yes. 20 Q. On number eight -- 21 A. Yes. 22 Q. Which hospital standard or what hospital 23 standard was violated in your opinion? 24 A. I am just going to look at this. I have 25 the standard with me so let me make sure I	Page 143 1 am referring to the specific standard 2 then. 3 Q. Okay. 4 A. Let me not leave you in the dark here. 5 Q. Okay. 6 A. Yes. If he look at E, Consent for ECT, 7 informed consent for ECT is a process 8 which is not concluded with the signing of 9 the formal consent document but continues 10 throughout the ECT course. That consent 11 was only done in a very perfunctory 12 fashion at best. I mean I think that this 13 violates the hospital standard, as I 14 understand the standard. 15 Q. Yes. But you said that dealing with 16 number eight on your Exhibit 2 -- 17 A. Yes. 18 Q. What does that have to do with cognitive 19 assessment? 20 A. Let's see here. Let me just check that 21 here. Good question, very good question. 22 Yes, because, you see, the consent, well, 23 part of informing the consenter about a 24 perceived need for an unusually large 25 number of treatments is you need to do the
Page 144 1 assessment so you can inform the 2 consenter. If you don't do the proper 3 monitoring and assessment, you can't 4 properly inform the consenter. That is 5 important. 6 Let me just look at one other 7 thing here. Yes, okay. I think -- I 8 believe that that was it but let me just 9 check to make sure there was nothing else 10 that I was referring to here. 11 Q. Okay. 12 A. Yes. Now, I was referring, I was 13 referring to that. And then also number 14 six actually on that, this is on page 15 under E, Concept for ECT, number six, a 16 consideration of reasonable treatment 17 alternatives. I just don't see that on an 18 ongoing basis, do you? I mean if you do 19 then let me know, but I just don't see it 20 on an ongoing basis. So that would be E, 21 the top of the letter, E6. 22 Q. Okay. But it is not important what I see. 23 It is important to me what you see and 24 what you don't see. 25 A. Yes. But those were the two places,	Page 145 1 mm-hmm. 2 Q. Okay. Finally, a couple of follow-ups. 3 And you had mentioned earlier that early 4 on in the decision one of the opinions you 5 gave that I don't think you have written 6 but you said it was continued well beyond 7 the generally accepted number of 8 treatments. 9 What in your opinion or where are 10 you getting any data that show what the 11 generally accepted number of treatments, 12 specifically maintenance treatments are? 13 A. Although there was no absolute number, the 14 NICE Guidelines clearly indicate that to 15 go beyond 12 treatments requires a very 16 careful evaluation as to why you would go 17 beyond 12 treatments including even if the 18 term "process" is spread out and these 19 treatments were spread out. But you have 20 80 plus treatments over the course of, you 21 know, less than five years. That is a 22 lot. 23 Q. Doctor Bursztajn, you read Doctor Short's 24 deposition where he talks about six to 12 25 treatments per course?

Page 146

1 A. Yes.
2 **Q. Are you referring to total number of**
3 **treatments or treatments per course?**
4 A. I am referring to total number of
5 treatments. For maintenance ECT, again,
6 according to NICE Guidelines, alternative
7 steps should be considered to maintenance
8 ECT per se, and especially once you get
9 beyond the standard six to 12 treatments.
10 I know he talks about it per course, but
11 the reality is once -- maintenance ECT is
12 not an actual -- actually, 80 ECT's is not
13 the usual, not standard care, and simply
14 not indicated simply to prevent the
15 recurrence of depression. You have to do
16 an evaluation.
17 **Q. But there is nothing that you have seen in**
18 **either NICE or the MUSC standards or**
19 **anywhere else that talks about a number, a**
20 **specific number, where you go over that it**
21 **is a deviation or you stay under that.**
22 **When I am talking about a number, I am**
23 **talking about a total lifetime treatment**
24 **number, correct?**
25 A. There was no specific number per se, but

Page 148

1 physiological changes in the brain.
2 **Q. In your opinion, is a CT scan sufficient**
3 **to see those physiological changes if they**
4 **exist?**
5 A. It may give you false negatives. You may
6 overlook changes which are not apparent in
7 a CT scan because they are too subtle to
8 be picked up by a simple CT scan.
9 **Q. Well, but can you see them if they exist**
10 **on a CT scan?**
11 A. If you -- you can certainly. If you see
12 progression of atrophy in the context of
13 ongoing neuropsychiatric impairment, then
14 that progression in the context of ongoing
15 neuropsychiatric impairment is consistent
16 with too much ECT being given on an
17 involuntary basis and combined with the
18 pose traumatic industries disorder, which
19 follows. PTSD itself can produce
20 physiologic changes in the brain. That
21 has been documented, documented by
22 neuroimaging.
23 **Q. All right. If those -- I am sorry. If**
24 **those changes do exist, you would agree**
25 **with me that that would be a question**

Page 147

1 there is clear statements in the NICE
2 Guidelines that you have to seek
3 alternatives to maintenance ECT.
4 **Q. All right. I think you answered this**
5 **earlier. I've got like two or three more**
6 **questions for today.**
7 A. Mm-hmm.
8 **Q. You told me earlier that you don't have**
9 **any opinion that Clair Johnson suffered**
10 **any physiological brain injury or damage**
11 **as a result of ECT, do you?**
12 A. There is a reasonable likelihood that she
13 did in fact suffer some neuropsychiatric
14 impairments due to a combination of the
15 ECT and the post-traumatic stress disorder
16 subsequent to her involuntary ECT and her
17 protracted course of ECT.
18 **Q. All right. Do these physiological brain**
19 **changes --**
20 A. Any neuropsychiatric impairments take
21 place because they are all physiological
22 brain changes. They don't occur without
23 the brain being involved physiologically.
24 We all have a brain and when we exhibit
25 neuropsychiatric impairments, it is due to

Page 149

1 **better answered for either a radiologist**
2 **or a neuroradiologist?**
3 A. No. Because neuroradiologists are not
4 experienced in combining neuroradiology
5 reports with neuropsychiatric impairments.
6 They don't do neuropsychiatric testing,
7 they don't evaluate people for impairment.
8 They simply look at the image and what is
9 on the image.
10 **Q. Well, how about the degree of components**
11 **simply of the physiological changes**
12 **between one CT and another CT, would you**
13 **agree with me that that degree of change**
14 **would be better appreciated by**
15 **radiologists or neuroradiologists than**
16 **somebody like yourself?**
17 A. No.
18 **Q. You don't agree with that?**
19 A. I don't agree with that.
20 **Q. Okay. All right. Finally, for today at**
21 **least, are you going to opine that Clair**
22 **Johnson suffered anything other than**
23 **memory loss and now PTSD, which I heard**
24 **for the first time yesterday, as a result**
25 **of her ECT treatments?**

Page 150

1 A. I am going to opine that the
2 neuropsychiatric impairments which I found
3 on my examination and which she reported
4 and on her cognitive symptom checklists
5 are primarily due to a combination of the
6 PTSD that she suffered due to the
7 involuntary ECT and the massive dosages of
8 ECT that she received.
9 MR. EARLY: And we will go over
10 those tests when we reconvene because we
11 don't have time to do that right now.
12 Doctor, I appreciate your time. It is
13 3:00 Eastern Time. I appreciate your
14 time.
15 Just for the record, Cravens, we
16 are agreeing to leave this deposition open
17 based on several circumstances, correct?
18 MR. RAVENEL: Yes, yes. I mean
19 I don't want to do it but I think it is
20 the only reasonable thing to do under the
21 circumstances. I hate to give you all
22 more time to go think of more questions
23 but --
24 THE WITNESS: That is okay.
25 MR. RAVENEL: That's the way it

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1 is and I think it is only reasonable for
2 me to permit that and so that I am going
3 to -- yes, the answer to your question is
4 yes.
5 MR. EARLY: Okay. All right.
6 Thank you.
7 (At which time the matter was
8 concluded at 3:02 p.m.)
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Page 152

1 ERRATA SHEET DISTRIBUTION INFORMATION
2 DEPONENT'S ERRATA & SIGNATURE INSTRUCTIONS
3
4 ERRATA SHEET DISTRIBUTION INFORMATION
5 The original of the Errata Sheet has
6 been delivered to D. Cravens Ravenel, Esq.
7 When the Errata Sheet has been
8 completed by the Deponent and signed, a
9 copy thereof should be delivered to each
10 party of record and the ORIGINAL forwarded
11 to William Early, Esq., to whom the
12 original deposition transcript was
13 delivered.
14 INSTRUCTIONS TO DEPONENT
15 After reading this volume of your
16 deposition, please indicate any for
17 corrections or changes to your testimony
18 and the reasons therefor on the Errata
19 Sheet supplied to you and sign it. DO NOT
20 make marks or notations on the transcript
21 volume itself. Add additional sheets if
22 necessary. Please refer to the above
23 instructions for Errata Sheet distribution
24 information.
25

Page 153

1 PLEASE ATTACH TO THE DEPOSITION OF
2 HAROLD B. BURSZTAJN, M.D.
3 CASE: Johnson vs. Roberts
4 DATE TAKEN: July 26, 2013
5 ERRATA SHEET
6 PAGE LINE CHANGE REASON
7
8
9
10
11
12
13
14 I have read the foregoing transcript
15 of my deposition, and except for any
16 corrections or changes noted above, I
17 hereby subscribe to the transcript as an
18 accurate record of the statements made by
19 me.
20 Executed this ___ day of _____, 2013.
21
22
23
24
25 Harold B. Bursztajn, M.D.

1 COMMONWEALTH OF MASSACHUSETTS)
2 COUNTY OF SUFFOLK } ss.
3
4 I, Carol A. Pierimonte, a Notary
5 Public within and for the Commonwealth of
6 Massachusetts, duly commissioned,
7 qualified and authorized to administer
8 oaths and to take and certify depositions,
9 do hereby certify that heretofore, on the
10 date cited above, the witness personally
11 appeared before me at the above location
12 and testified in the above-captioned case;
13 that the said witness was by me duly sworn
14 to testify to the truth, the whole truth
15 and nothing but the truth; that thereupon
16 and while said witness was under oath, the
17 deposition was taken down by me in machine
18 shorthand at the time and place therein
19 named and was reduced to typewriting
20 thereafter.

21
22 I further certify that the said
23 deposition constitutes a true record of
24 the testimony given by the said witness.

25 I further certify that I am not
26 interested in the event of this action.

27 IN WITNESS WHEREOF, I have hereunto
28 subscribed my hand this 7th day of August,
29 2013.

30
31 _____
32 Carol A. Pierimonte
33
34
35

EXHIBIT 4

me

ID#

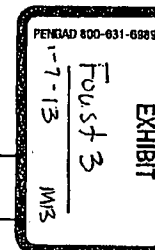
14758

DOB

4/2/66

Primary Psychiatric Dx: Schizophrenia (246.44)Medical History: hypertension, diabetes

ds at time of first Tx: _____

Handwritten notes:
12/10/03
12/12/03
12/15/03
12/17/03
12/19/03
4/4/05
4/6/05
4/12/05
4/14/05
4/16/05
4/18/05

Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEG	Device	PT STAT	Comments
12/10/03	0.2	70	60	Phen 12.5 for 30	50	252	4.7	0.9	60	0.5	1010	(B)	27	36	Th	I	
12/12/03	0.2	70	60	Phen 12.5 for 30	50	252	4.7	0.9	60	0.5	771	(B)	28	50	Th	I	Thyroid Dx
12/15/03	0.2	70	60	Phen 12.5 for 30	50	252	4.7	0.9	60	0.5	2550	(B)	21	42	Th	I	CB 10/23/02
12/17/03	0.2	100	60	Phen 12.5 for 30	50	252	4.7	0.9	60	0.5	2090	(B)	20	41	Th	I	
12/19/03	0.2	130	60	Phen 12.5 for 30	60	302	5.6	0.9	60	0.5	2510	(B)	25	27	Th	I	
4/4/05	0.2	100	60	Phen 12.5 for 30	50	250	7	0.89	40	0.5	290 2190	(B)	NA	16	IV	I	9/28/05
4/6/05	0.2	100	60	Phen 12.5 for 30	60	288.9	6.7	0.89	50	0.5	279 1860	(B)	7	17	IV	I	9/28/05
4/12/05	0.2	100	60	Phen 12.5 for 30	70	349.1	7.8	0.89	50	0.5	260 1950	(B)	6	25	IV	I	
4/14/05	0.2	100	60	Phen 12.5 for 30	80	399.5	7.5	0.89	60	0.5	260 1730	(B)	10	12	IV	I	Micro stim to 95%
4/16/05	0.2	100	60	P 12.5 for 30	95	474.6	7.6	0.89	70	0.5	260 1790	(B)	13	23	IV	I	
4/18/05	0.2	100	60	Phen 12.5 for 30	100	499.9	8	0.89	70	0.5	250 2000	(B)	7	18	IV	I	

Page 4 of 95

Name: Johnson, (Cav)

ID# 747750

DOB 8/25/66

Primary Psychiatric Dx: BPD, depressed 296.44

past Medical History: hypertension, negative

Hesher
Savings

leads at time of first Tx: _____

0279

#	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEO	Device	PT STAT	Comments
	4/20/05	0.2	100	60	Phen 12.5 100 30	00	489.5	8	0.89	70	0.5	220 2100	13	16	37	IV	I	
	10/18/05	0.2	100	60	Phen 12.5 100 30	50	248.6	7.9	0.89	40	0.5	250 1310	13	15	19	IV	I	
	10/24/05	0.2	100	60	Phen 12.5 100 30	60	249.8	6.7	0.89	50	0.5	240 1540	13	14	37	IV	I	
	10/24/05	0.2	100	60	Phen 12.5 100 30	70	343.1	7.8	0.88	60	0.5	220 1230	13	23	31	IV	I	
	10/26/05	0.2	100	60	Phen 12.5 100 30	70	348.9	7.8	0.89	50	0.5	200 1580	13	23	31	IV	I	
	10/28/05	0.2	100	60	Phen 12.5 100 30	70	351.0	7.8	0.89	50	0.5	230 1510	13	23	35	IV	I	
	10/31/05	0.2	100	60	Phen 12.5 100 30	70	354.0	7.8	0.90	50	0.5	240 1740	13	13	37	IV	I	
	11/2/05	0.2	100	60	Phen 12.5 100 30	80	400.0	7.5	0.89	60	0.5	230 1510	13	9	31	IV	O	
	11/15/05	0.2	100	60	Phen 12.5 100 30	90	449.1	7.7	0.87	70	0.5	260 1720	13	16	32	IV	O	
	11/23/05	0.2	100	60	Phen 12.5 100 30	90	450.8	7.2	0.89	70	0.5	250 1610	13	7	25	IV	O	? E-forn 7.2.1m

11mer/ectreat. (rnp)

Dev. 11/21/05

Name Johnson, Cleo

ID#

9/7758

DOB

8/25/1966Primary Psychiatric Dx: RPAI

Past Medical History:

Teds at time of first Tx:

Northshore
Society

#	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEG	Device	PT STAT	Comments
1	11/28/05	0.2	100	60	Phen 17.5 100 30	100	570.8	8	0.89	70	0.5	260 1520	(13)	18	38	IV	I	E form.
1	11/30/05	0.2	100	60	Phen 17.5 100 30	100	520.1	8	0.89	70	0.5	250 1770	(13)	33	49	IV	I	
1	12/3/05	0.2	120	60	Phen 17.5 100 30	100	495.6	8	0.87	70	0.5	260 1680	(13)	28	52	IV	I	
1	12/15/05	0.2	120	60	Phen 17.5 100 30	100	498.8	8	0.87	70	0.5	250 2180	(13)	31	55	IV	I	
1	12/22/05	0.2	120	60	Phen 17.5 100 30	100	477.1	8	0.89	70	0.5	310 2570	(13)	25	52	IV	I	
1	12/28/05	0.2	120	60	Phen 17.5 100 30	100	495.6	8	0.89	70	0.5	330 2740	(13)	29	60	IV	I	
1	1/13/06	0.2	120	60	Phen 17.5 100 30	100	478.3	8	0.89	70	0.5	290 2270	(13)	32	57	IV	I	
1	1/24/06	0.2	120	60	Phen 17.5 100 30	100	498.0	8	0.89	70	0.5	290 2000	(13)	28	49	IV	I	
1	1/27/06	0.2	120	60	Phen 17.5 100 30	100	498.1	8	0.89	70	0.5	290 1470	(13)	18	48	IV	I	
1	1/30/06	0.2	120	60	Phen 17.5 100 30	100	498.78	8	0.89	70	0.5	280 1890	(13)	47	28	IV	I	↑ Sux
1	2/3/06	0.2	120	60	Phen 17.5 100 30	100	478	8	0.89	70	0.5	270 2700	(13)	29	50	IV	I	Consider Rabinul to -3

11nor/ect/treat fm/1

Name: Johnson, Alan

ID# 947758

DOB 8/23/66

Primary Psychiatric Dx: BPD

Past Medical History: _____

Heathcare Surgery
(Medcost)

Meds at time of first Tx: _____

Tx#	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedence	EP	EMG	EEG	Device	PT STAT	Comments
1	2/10/06	0.2	Eto 12	80	Phen 17.5 100 30	100	497.4	8	0.89	20	0.5	310 2860	B	29	42	IV	0	1 succ.
1	2/16/06	0.2	Eto 12	100	Phen 17.5 (+0.2 Eto)	100	492.8	8	0.89	20	0.5	300 1760	T3	36	9	IV	0	
1	2/15/06	0.2	Eto 12	100	Phen 17.5 100 30	100	495.5	8	0.89	20	0.5	280 1610	T3	NA	62	IV	0	
1	3/2/06	0.2	Eto 12	100	Phen 17.5 100 30	100	488.8	8	0.89	20	0.5	280 1780	T3	31	76	IV	0	
2	3/10/06	0.2	Eto 12	100	Phen 17.5 100 30	100		8	0.89	20	0.5	270 1460	T3	27	46	IV	0	
1	3/13/06	0.2	Eto 12	100	Phen 17.5 100 30	100	497.1	8	0.89	20	0.5	220 1540	T3	28	32	IV	0	
1	3/16/06	0.2	Eto 12	100	Phen 17.5 100 30	100	499.7	8	0.89	20	0.5	260 1760	T3	NA	50	IV	0	
1	3/21/06	0.2	Eto 12	100	Phen 17.5 100 30	100	499.7	8	0.89	20	0.5	260 1160	T3	30	42	IV	0	
1	3/24/06	0.2	Eto 12	100	Phen 17.5 100 30	100	498.8	8	0.89	20	0.5	290 1400	T3	29	29	IV	0	
1	4/4/06	0.2	Eto 12	100	Phen 17.5 100 30	100	498.7	8	0.89	20	0.5	220 220	T3	28	28	IV	0	
1	4/12/06	0.2	Eto 12	100	Phen 17.5 100 30	100	501.5	8	0.89	20	0.5	220 220	T3	32	73	IV	0	

Iner/ectreat.frm/1

0281

Primary Psychiatric Dx: BIPAD (296.62)

ID# 247758

DOB 8/25/68

Past Medical History: _____

Meds at time of first Tx: _____

meds at / first Tx

Tx#	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMO	EEG	Device	PT STAT	Comments
M	4/18/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	499.7	8	0.89	70	0.5	250 1100	13	21	55	IV	0
M	4/25/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	500.5	8	0.89	70	0.5	250 846	13	21	44	TV	0
M	5/2/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	499.1	8	0.89	70	0.5	270 1180	13	30	61	IV	0
M	5/9/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.8	8	0.89	70	0.5	250 1120	13	29	42	IV	0
M	5/16/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.8	8	0.89	70	0.5	250 1310	13	26	63	IV	0
M	5/25/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	500.5	8	0.89	70	0.5	240 840	13	30	60	IV	0
M	6/8/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.3	8	0.89	70	0.5	250 1390	13	28	39	IV	0
M	6/22/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.7	8	0.89	70	0.5	270 1230	13	30	52	IV	0
M	7/13/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.0	8	0.89	70	0.5	290 1480	13	29	54	IV	0
M	8/1/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	498.8	8	0.89	70	0.5	290 1230	13	55	91	IV	0
M	8/22/06	0.2	Eto	12	100	Phen 12.5 lor 30	100	499.1	8	0.89	70	0.5	270 1040	13	70	64	IV	0

Inser/ectreat.frm/1

0282

Primary Psychiatric Dx: DMNOL

ID# 74758

DOB 8/25/66

1st Medical History: _____

eds at time of first Tx: meds off / 2006-09

DR. Robert 181-0455 181-6878 (Fax)

#	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEG	Device	PT	STAT	Comments
1	9/1/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.6	8	0.89	70	0.5	280 1290	13	50	166	IV	0		
1	9/21/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.3	8	0.89	70	0.5	280 1400	13	29	70	IV	0		
	10/5/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.8	8	0.89	70	0.5	300 1570	13	43 50	50	IV	0		
	10/19/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.3	8	0.89	70	0.5	300 1500	13	35	39	IV	0		
	10/31/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.6	8.0	0.89	70	0.5	300 2000	13	30	64	IV	0		
	11/2/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.0	8.0	0.89	70	0.5	300 1920	13	17	20	IV	0		
	11/6/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.8	8	0.89	70	0.5	280 1110	13	27	62	IV	0		
	11/8/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.3	8	0.89	70	0.5	310 2020	13	25	42	IV	0		
	11/16/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.1	8	0.89	70	0.5	280 1520	13	33	51	IV	0		
	11/29/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.7	8	0.89	70	0.5	280 1600	13	32	8	IV	0		
	12/1/06	0.2	Eto	100	Phen 12.5 10v 30	100	478.0	8	0.89	70	0.5	280 1680	13	33	70	IV	0		

recttreat.frm/1

Medical University of South Carolina
Electroconvulsive Therapy Record Sheet

Name: Johnson, C/CI

ID #: 947758

8/25/66
D.O.B. 8/25/1966

Primary Psychiatric Diagnosis: BSPAD

Allergies: None Known

Insurance: Cigna

Significant Risk Factors: hypertension (on med)

Referrer: Dr. John Roberts

Medications at Time of First Treatment: 12/20/65 Fluoxetine 50mg BID, Lorazepam 1mg TID, Risperidone 4mg BID, Levetiracetam 1500mg BID

Weight: 80kg

x #	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEG	Device	Pt Stat	Comments
1	12/15/00	0.1	Eto	12	Phen 12.5 on 30	100	498.7	8	0.87	70	0.5	270	13	17	35	IV	I	
2	12/18/06	0.2	Eto	12	Phen 12.5 on 30	100	477.6	8	0.87	70	0.5	300	13	22	43	IV	I	
3	12/27/06	0.2	Eto	12	Phen 12.5 on 30	100	477.6	8	0.87	70	0.5	300	13	22	43	IV	I	
4	1/3/07	0.2	Eto	12	Phen 12.5 on 30	100	496.4	8	0.87	70	0.5	310	13	32	58	IV	I	+ Resp. count 37.5
5	1/11/07	0.2	Eto	12	Phen 12.5 on 30	100	499.2	8	0.87	70	0.5	310	13	31	45	IV	I	
6	1/18/07	0.2	Eto	12	Phen 12.5 on 30	100	498.1	8	0.87	70	0.5	310	13	33	42	IV	I	+ Resp. count 37.5
7	2/1/07	0.2	Eto	12	Phen 12.5 on 30	100	498.9	8	0.87	70	0.5	310	13	ND	42	IV	I	+ Resp. 37.5
8	2/15/07	0.2	Eto	12	Phen 12.5 on 30	100	499.9	8	0.87	70	0.5	310	13	ND	43	IV	I	+ Resp. 37.5
9	3/1/07	0.2	Eto	12	Phen 12.5 on 30	100	498.4	8	0.87	70	0.5	310	13	ND	54	IV	I	+ Resp. 37.5
10	3/15/07	0.2	Eto	12	Phen 12.5 on 30	100	496.7	8	0.87	70	0.5	310	13	ND	54	IV	I	+ Resp. 37.5
11	3/22/07	0.2	Eto	12	Phen 12.5 on 30	100	499.1	8	0.87	70	0.5	310	13	35	42	IV	I	+ Resp. 37.5
12	4/1/07	0.2	Eto	12	Phen 12.5 on 30	100	499.1	8	0.87	70	0.5	310	13	34	43	IV	I	Respir 37.8

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Rev 1/7/11

**Medical University of South Carolina
Electroconvulsive Therapy Record Sheet**

Name: Johnson, Chai

ID #: 947758

D.O.B.: 5/25/66

Primary Psychiatric Diagnosis: BPAD

Insurance: Signa Humana (M'care)

Allergies: None

Referrer: Dr. John R. B. - 6

Significant Risk Factors: h/o hypothyroidism

Weight: 80kg

Medications at Time of First Treatment: _____

#	Date	Antichol	Anesth	Relax	Other	% Energy	Charge	Duration	Current	Freq	PW	Impedance	EP	EMG	EEG	Device	Pt Stat	Comments
M	4/24/07	0.2	Eto	100	Phen 2.5	100	497.68	0.89	70	0.5	300	7470	T3	54	51	IV	0	+ RCP 37.5
n	5/24/07	2	Eto	100	Phen 2.5	100	494.38	0.88	70	0.5	300	7470	B	37	48	IV	0	+ RCP 37.5
M	6/21/07	0.2	Eto	100	Phen 2.5	100	486.18	0.87	70	0.5	300	7470	T3	40	46	IV	0	+ RCP 37.5
M	7/19/07	0.2	Eto	100	Phen 2.5	100	487.48	0.89	70	0.5	300	7470	T3	44	54	IV	0	+ RCP 37.5
M	8/3/07	0.2	Eto	100	Phen 1.5	100	488.58	0.89	70	0.5	300	7470	B	36	49	IV	0	+ RCP 37.5
M	10/11/07	0.2	Eto	100	Phen 2.5	100	488.78	0.87	70	0.5	300	7470	T3	35	57	IV	0	
M	11/22/07	0.2	Eto	100	Zofen	100	488.38	0.89	70	0.5	300	7470	T3	NA	39	IV	0	Zofen 4
M	1/17/08	0.2	Eto	100	Zofen	100	488.38	0.89	70	0.5	300	7470	T3	33	51	IV	0	
M	3/17/08	0.2	Eto	100	Zofen	100	488.78	0.89	70	0.5	300	7470	T3	44	54	IV	0	
M	6/26/08	0.2	Eto	100	Zofen	100	488.78	0.89	70	0.5	300	7470	T3	36	47	IV	0	

EXHIBIT 5

Original Article

Neuropsychopharmacology (2007) 32, 244–254. doi:10.1038/sj.npp.1301180; published online 23 August 2006

Clinical Research

The Cognitive Effects of Electroconvulsive Therapy in Community Settings

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Abstract

Despite ongoing controversy, there has never been a large-scale, prospective study of the cognitive effects of electroconvulsive therapy (ECT). We conducted a prospective, naturalistic, longitudinal study of clinical and cognitive outcomes in patients with major depression treated at seven facilities in the New York City metropolitan area. Of 751 patients referred for ECT with a provisional diagnosis of a depressive disorder, 347 patients were eligible and participated in at least one post-ECT outcome evaluation. The primary outcome measures, Modified Mini-Mental State exam scores, delayed recall scores from the Buschke Selective Reminding Test, and retrograde amnesia scores from the Columbia University Autobiographical Memory Interview–SF (AMI–SF), were evaluated shortly following the ECT course and 6 months later. A substantial number of secondary cognitive measures were also administered. The seven sites differed significantly in cognitive outcomes both immediately and 6 months following ECT, even when controlling for patient characteristics. Electrical waveform and electrode placement had marked cognitive effects. Sine wave stimulation resulted in pronounced slowing of reaction time, both immediately and 6 months following ECT. Bilateral (BL) ECT resulted in more severe and persisting retrograde amnesia than right unilateral ECT. Advancing age, lower premorbid intellectual function, and female gender were associated with greater cognitive deficits. Thus, adverse cognitive effects were detected 6 months following the acute treatment course. Cognitive outcomes varied across treatment facilities and differences in ECT technique largely accounted for these differences. Sine wave stimulation and BL electrode placement resulted in more severe and persistent deficits.

Keywords: electroconvulsive therapy, major depression, memory, cognitive side effects, amnesia

INTRODUCTION

Electroconvulsive therapy (ECT) is widely considered the most effective antidepressant treatment, with medication resistance its leading indication (American Psychiatric Association, 2001). However, critics contend that ECT invariably results in substantial and permanent memory loss (Breggin, 1986; Sterling, 2000), with some patients experiencing a dense retrograde amnesia extending back several years (Donahue, 2000; Sackeim, 2000). In contrast, some authorities have argued that, with the introduction of general anesthesia and more efficient electrical waveforms, ECT's adverse cognitive effects are short-lived, with no persistent effects on memory (Abrams, 2002; Fink, 2004).

Shortly following the ECT course, most patients manifest deficits in retaining newly learned information (anterograde amnesia) and recalling events that occurred in the weeks or months preceding the ECT course (retrograde amnesia) (Sackeim, 1992; Squire, 1986). Randomized-controlled trials have shown more severe short-term memory deficits with sine wave compared to brief pulse stimulation (Valentine et al, 1968; Weiner et al, 1986), bilateral (BL) compared to right unilateral (RUL) electrode placement (Lancaster et al, 1958; Sackeim et al, 1986; Sackeim et al, 1993; Sackeim et al, 2000), and higher electrical dosage (McCall et al, 2000; Ottosson, 1960; Sackeim et al, 1993). These adverse effects are reduced by the use of RUL ECT with brief or ultrabrief pulse stimulation and electrical dosage titrated to the needs of the individual patient (Sackeim, 2004b). Nonetheless, a minority of US practitioners still use sine wave stimulation, approximately half do not adjust dosage relative to the patient's seizure threshold, and a majority administer mainly or exclusively BL ECT (Farah and McCall, 1993; Prudic et al, 2004; Prudic et al, 2001). The continued use of treatment techniques associated with more severe short-term cognitive deficits may reflect the beliefs that the cognitive deficits are transient and that older treatment methods provide greater assurance of efficacy (Scott et al, 1992).

Empirical information about ECT's long-term effects derives mainly from small sample studies conducted in research settings, with follow-up intervals frequently limited to 2 months or less. By excluding individuals with significant medical and psychiatric comorbidities, use of optimized forms of ECT, and limited statistical power, these studies could not adequately assess the severity and persistence of long-term deficits. In a sample treated in community settings, we conducted the first large-scale, prospective long-term study of cognitive outcomes following ECT. We characterized the profile of cognitive change immediately and 6 months following completion of ECT, and examined the relationships of treatment technique and patient characteristics to cognitive outcomes. We also determined whether a patient subgroup had especially marked long-term deficits and whether particular forms of ECT administration were overrepresented among these patients.

PATIENTS AND METHODS

Study Sites and Study Participation

The study was conducted at seven hospitals in the New York City metropolitan area: two private psychiatric hospitals, three community general hospitals, and two hospitals at university medical centers. A clinical outcomes evaluator was assigned to each hospital and collected all research information. The study was conducted by investigators at the New York State Psychiatric Institute

(NYSPI), and patients at this facility did not participate. Institutional Review Boards at NYSPI and each of the seven hospitals approved the study.

Participants were recruited from the in-patients and outpatients referred for ECT with a clinical diagnosis of a depressive disorder. Over a 26-month period, 751 patients were so referred (see [Prudic et al \(2004\)](#) and [Figure 1](#) for details on sample composition). Study participants met the Diagnostic and Statistical Manual (DSM-IV) criteria for a major depressive episode (unipolar or bipolar) or schizoaffective disorder, depressed, on the basis of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I/P) ([First et al, 1996a](#)). Patients were excluded if they received ECT in the past 2 months, scored below 15 on the Mini-Mental State Exam ([Folstein et al, 1975](#)), or spoke neither English nor Spanish. Patients were at least 18 years of age and provided informed consent after study procedures had been fully explained.

Figure 1.

Participant flow.

[Full figure and legend \(65K\)](#)

Study Measures

The primary instrument to assess severity of depressive symptoms was the Hamilton Rating Scale for Depression (HRSD, 24-item) ([Hamilton, 1967](#)). Comorbid DSM-IV psychiatric Axis I disorders, including substance abuse or dependence, were determined using a full SCID-I/P interview ([First et al, 1996a](#)). Medical comorbidity was assessed with the Cumulative Illness Rating Scale (CIRS) ([Miller et al, 1992](#)). At pre-ECT baseline, the North American Adult Reading Test (NAART) provided an estimate of premorbid intelligence ([Johnstone et al, 1996](#)).

An extensive neuropsychological battery was administered at pre-ECT baseline, within days of completing the ECT course, and at 6-month (24-week) follow-up. A description of the battery and the derived outcome measures are presented in [Table 1](#). The modified Mini-Mental State exam (mMMS) ([Stern et al, 1987](#)), a measure of global cognitive status and an expanded version (range 0–57) of the original MMS ([Folstein et al, 1975](#)), has shown sensitivity to variation in ECT technique ([Sackeim et al, 1993, 2000](#)). Psychomotor function was assessed with three measures of reaction time (RT): Simple (SRT) ([Benton, 1977](#)), Choice (CRT) ([Benton and Blackburn, 1957](#)), and Stroop RT ([MacLeod, 1991](#)). In each task, median RT for correct response was determined. Although psychomotor function is of practical importance with respect to driving and other motor activities, the impact of ECT on this domain has rarely been examined ([Calev et al, 1995; Sackeim, 1992](#)). Attention was assessed with the Stroop ([MacLeod, 1991](#)) and the Continuous Performance Test (CPT) ([Ballard, 1997; Cornblatt et al, 1984](#)). In severe depression, attention is often impaired, but believed to improve with symptomatic remission ([Sternberg and Jarvik, 1976; Zakzanis et al, 1998](#)). However, there is virtually no information on the effects of ECT on these classic attentional measures.

Table 1 - Neuropsychological Battery.
Full table

Anterograde and retrograde amnesia are the two deficits most characteristic of ECT. Anterograde learning and memory were assessed with the Complex Figure Test (CFT) (Rev, 1941; Spreen and Strauss, 1998) and the Buschke Selective Reminding Test (BSRT) (Buschke, 1973; Hannay and Levin, 1985). Deficits in delayed recall on the BSRT have been repeatedly documented shortly following ECT, and found to be sensitive to variation in the treatment technique (Sackeim et al, 1993; Sackeim et al, 2000). Retrograde amnesia for autobiographical information was measured with the Columbia University Autobiographical Memory Interview-Short Form (AMI-SF) (McElhiney et al, 1997, 1995). The original version of the AMI, containing 281 items, has shown strong reliability and validity as a measure of retrograde amnesia, and sensitivity to variation in ECT technique (Lisanby et al, 2000; McElhiney et al, 1995; Sackeim et al, 1993, 2000; Sobin et al, 1995).

Three alternate versions of the mMMS, CFT, and BSRT were randomized to testing occasion. The order of the stimuli in each of the computerized tasks was newly randomized at each testing occasion. To allow for comparison of scores across tests and time points, the baseline scores on each test were converted to standardized scores, with a mean of 0 (SD=1) for the total sample. Scores at the two subsequent assessments were standardized in relation to the distribution of scores at baseline. In all cases, higher standardized scores reflected superior performance.

The primary cognitive outcome measures were post-ECT scores on the AMI-SF, mMMS, and delayed recall on the BSRT. The primary measure at the 6-month follow-up was the AMI-SF score. To identify a subgroup with marked and persistent retrograde amnesia, the most common source of complaint regarding long-term deficits, individuals were identified who following both the post-ECT and 6-month follow-up assessments had decreases of at least -2.0 SD units or greater on the AMI-SF.

Study Procedures

The outcomes evaluators screened all patients scheduled to start ECT at the facility with a provisional clinical diagnosis of a depressive disorder ($N=751$; Figure 1). After obtaining consent and determining eligibility, the evaluator administered the clinical assessment and neuropsychological batteries before the first ECT treatment ($N=398$). The intent-to-treat sample included those patients who received at least one treatment and participated in a post-ECT clinical outcome evaluation ($N=347$). Time limitations and other factors resulted in variable rates of completion of the cognitive tasks, especially at the baseline evaluation. For the baseline assessment, the sample size for the cognitive measures ranged from 242 (CPT) to 347 (mMMS). The ranges were 224–346 and 202–260 at the post-ECT and 6-month follow-ups. Thus, 99% of the intent-to-treat sample participated in all or part of the cognitive evaluation at post-ECT and 75% did so at the 6-month follow-up.

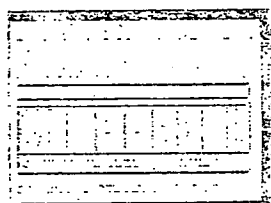
The outcomes evaluator attended ECT treatments and documented the type and doses of medications, type of physiological monitoring, ECT device model, electrical waveform, electrode placement, stimulus dosing strategy, and the specific parameters used for stimulation. The duration of the motor convulsion and, when monitored, the EEG seizure were recorded.

When the treating psychiatrist indicated that the acute ECT course was completed, the patient was scheduled for the post-ECT assessment. The aim was to test patients between 3 and 7 days after ECT. For the 347 patients in the intent-to-treat sample, the average interval to post-ECT assessment was 4.37 days (SD=4.19). At the post-ECT assessment, the Structured Clinical Interview for DSM-IV Axis I Personality Disorders (SCID-II) was administered to derive DSM-IV diagnoses of personality disorders (First *et al.* 1996b). All consenting patients were clinically monitored for a period of 24 weeks following the acute ECT course. They were administered the HRSD at 4-week intervals and interviewed regarding the treatments received since last contact. At the 6-month time point, the clinical and neuropsychological evaluations were repeated.

A group of 24 healthy comparison participants, with negative lifetime histories of psychiatric illness, were matched to the patient sample in the distributions of age, gender, and education. The comparison sample completed the same neuropsychological battery at time points corresponding to the assessment periods in patients and each test was scored in standardized units relative to the patient distribution at baseline. Only one measure, d' or sensitivity on the CPT, showed a practice effect, with significant improvement from baseline to the post-ECT time point and stable thereafter. The scoring of the AMI-SF necessarily results in higher scores at baseline than follow-up. The CPT and AMI-SF scores in the patient sample were adjusted for the average change seen in the comparison sample, removing the temporal effects on these two measures.

Average raw scores for the patient sample and average raw and standardized scores for the healthy comparison sample are presented for the baseline evaluation in **Table 2**. Analyses of covariance (ANCOVAs), with age, gender, and education as covariates indicated that the healthy comparison sample had superior scores on nine of 11 of the baseline cognitive measures.

Table 2 - Clinical and Demographic Characteristics of the Intent-to-Treat Sample (N=347).



Full table

Statistical Methods

The pattern of change in neuropsychological scores was determined for the total sample by conducting paired t -tests contrasting scores at post-ECT and 6-month follow-up with pre-ECT scores. Differences among the sites in cognitive outcomes were tested with ANCOVAs. For each measure, an ANCOVA was conducted on the score at post-ECT with site (seven levels) as a between-subject term and patient age, estimated premorbid IQ (based on the NAART), gender, HRSD score at time of assessment, number of days intervening between the end of ECT and post-

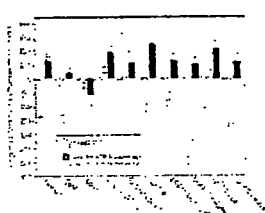
ECT assessment, and pre-ECT baseline cognitive score as covariates. The ANCOVAs conducted on the neuropsychological measures at the 6-month follow-up used the same model except that the number days since end of ECT was dropped and whether or not patients had received further treatment with ECT in the follow-up period was added as a covariate. The covariates in these models were selected *a priori* based upon reported associations with post-ECT cognitive measures (Sackeim *et al.*, 1992; Sobin *et al.*, 1995; Zervas *et al.*, 1993). Other potential covariates screened for inclusion in the analyses were cumulative medical burden (CIRS score), other Axis I diagnosis, Axis II diagnosis, psychotic depression subtype, in-patient vs outpatient treatment setting, history of previous ECT, length of current depressive episode, and number of previous depressive episodes. The criterion for inclusion of a covariate in the final analyses was a significant association ($p < 0.05$) with at least two of the primary outcome measures. None of the screened variables met this criterion. *Post hoc* Tukey-Kramer comparisons identified pair-wise differences among the sites.

The associations between treatment technique and cognitive outcomes were first tested in the subgroup of patients who were treated with only one electrode placement, BL or RUL ECT, during acute-phase treatment. Patients treated exclusively with bifrontal (BF) ECT ($n=12$), a mixture of BL, RUL, and/or BF ECT ($n=75$), or exclusively with RUL ECT with sine wave stimulation ($n=2$) were dropped from these analyses. The ANCOVAs used the same models as the analyses of site differences, except that the site term was deleted and terms for electrode placement, waveform nested within electrode placement, stimulus dosage, and number of treatments were added. Stimulus dosage was computed as the percentage of maximal device output averaged across all treatments. To corroborate findings, a second set of ANCOVAs was conducted in the intent-to-treat sample. In these analyses, the terms for the number of BF, BL, and RUL treatments (three factors) replaced the categorical classification of electrode placement and the term for the total number of treatments. To determine whether the site differences were attributable to differences in treatment technique, the last set of analyses was repeated adding site as a between-subject factor. A logistic regression analysis was conducted to determine which treatment technique factors were related to likelihood of manifesting especially marked and persistent retrograde amnesia.

RESULTS

Compared to baseline performance, at the post-ECT time point the total patient sample showed deficits in the mMMS ($t(345)=8.0$, $p < 0.0001$), SRT ($t(281)=4.2$, $p < 0.0001$), sensitivity (d') on the CPT ($t(221)=7.4$, $p < 0.0001$), learning phase of the BSRT ($t(314)=3.5$, $p < 0.0001$), delayed recall on the BSRT ($t(301)=10.5$, $p < 0.0001$), delayed reproduction on the CFT ($t(270)=7.2$, $p < 0.0001$), and in AMI-SF scores ($t(328)=21.7$, $p < 0.0001$) (Figure 2). At this time point, the Stroop interference effect was reduced ($t(264)=5.3$, $p < 0.0001$). The deficits following ECT were greatest for the measures assessing memory for autobiographical events (AMI-SF), retention of newly learned information (delayed performance on the BSRT and CFT), global cognitive status (mMMS), and simple reaction time (SRT). Compared to the pre-ECT baseline, there was significantly improved performance at the 6-month follow-up on all tasks other than the three RT measures (SRT, CRT, and Stroop RT) and sensitivity (d') on the CPT. Furthermore, AMI-SF scores remained markedly below baseline values ($t(251)=21.1$, $p < 0.0001$).

Figure 2.

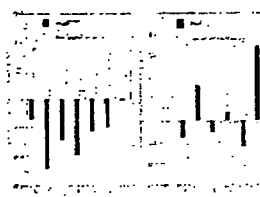


Scores on 11 cognitive measures immediately following and 6 months after a course of ECT. Scores for each test, other than the AMI-SF were standardized relative to the distribution of scores at baseline.

Full figure and legend (19K)

There were no significant differences among the seven hospitals in ANCOVAs conducted on the pre-ECT baseline cognitive measures. In contrast, the seven hospitals differed in mMMS and AMI-SF scores at both the post-ECT (mMMS: $F(6,333)=3.25$, $p=0.004$; AMI-SF: $F(6,313)=2.70$, $p=0.01$) and 6-month follow-up (mMMS: $F(6,248)=3.43$, $p=0.003$; AMI-SF: $F(6,240)=2.26$, $p=0.04$) time points (**Figure 3**). In addition, there were significant differences among the hospitals at the post-ECT assessment for five other cognitive measures: CRT ($F(6,244)=3.34$, $p=0.004$), Stroop RT ($F(6,252)=3.02$, $p=0.007$), CPT sensitivity (d') ($F(6,211)=2.23$, $p=0.04$), BSRT learning ($F(6,302)=2.14$, $p<0.05$), and BSRT delayed recall ($F(6,289)=2.19$, $p=0.04$). Across these seven measures and time points, patients at hospital D consistently showed marked deficits, whereas patients at hospital G showed the least impairment. The site differences in short- and long-term cognitive outcomes persisted following statistical control for the patient features most strongly associated with the cognitive measures.

Figure 3.



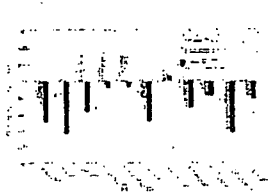
Scores on the modified Mini-Mental State Exam (mMMS) and the Columbia University Autobiographical Memory Interview: Short Form (AMI-SF) immediately and 6 months following ECT at each of the seven sites.

Full figure and legend (32K)

When the sample was restricted to patients treated with a uniform electrode placement ($N=258$), there were marked effects of specific aspects of ECT practice on short- and long-term cognitive measures. At post-ECT, stimulus waveform had a significant impact on four of the 11 cognitive measures (**Table 3, Figure 4**). In each case, performance was poorer with sine wave compared to brief pulse stimulation. There were robust effects of sine wave stimulation on all three RT measures. At post-ECT, patients treated with BL or RUL ECT differed significantly in five of the 11 cognitive measures (**Table 3, Figure 4**). BL ECT was associated with greater amnesia than RUL ECT on two of the three primary outcome measures, delayed recall on the BSRT and memory for autobiographical events (AMI-SF). The effects of electrode placement and number of ECT treatments were especially marked on the AMI-SF (**Figure 5**).

Figure 4.

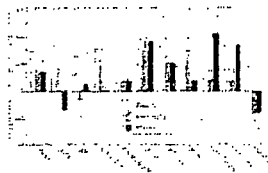
Scores on the 11 cognitive measures immediately following the ECT course for patients treated with brief pulse right unilateral (RUL) ECT, brief pulse bilateral (BL) ECT, and sine wave BL ECT. Filled boxes indicate a significant effect of waveform in the ANCOVA (■)



= $p < 0.05$; ■ = $p < 0.01$; ■ ■ = $p < 0.001$). Filled circles indicate a significant effect of electrode placement in the ANCOVA (● = $p < 0.05$; ● ● = $p < 0.01$; ● ● ● = $p < 0.001$).

Full figure and legend (70K)

Figure 5.



Scores on the 11 cognitive measures 6 months following the ECT course for patients treated with brief pulse right unilateral (RUL) ECT, brief pulse bilateral (BL) ECT, and sine wave BL ECT. Filled boxes indicate a significant effect of waveform in the ANCOVA (■ = $p < 0.05$). Filled circles indicate a significant effect of electrode placement in the ANCOVA (● = $p < 0.05$).

Full figure and legend (70K)

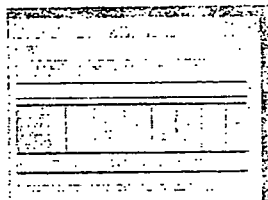
Table 3 - Baseline Cognitive Test Scores for the Depressed and Healthy Comparison Samples.

Full table

At the 6-month follow-up, patients treated with sine wave stimulation continued to have slower RT on the SRT and the Stroop RT tasks (**Table 4, Figure 4**). At this time point, patients treated with BL ECT had inferior performance to patients treated with RUL ECT on the mMMS, SRT, Stroop effect, learning phase of the BSRT, and AMI-SF scores. Greater amnesia for autobiographical events (AMI-SF scores) was significantly correlated with the number of ECT treatments received 6-months earlier (**Table 5**).

Table 4 - Results of the ANCOVAs on Neuropsychological Scores Shortly Following the ECT Course.

Full table

Table 5 - Results of the ANCOVAs on Neuropsychological Scores at the 6-Month Follow-Up.


Full table

In the confirmatory analyses, there were significant linear relationships between the number of treatments administered and post-ECT AMI-SF scores for each of the three electrode placements. However, the slope of the decline in AMI-SF scores with increasing treatment number was substantially greater for BL ECT ($F(1,318)=53.74$, slope=-0.14, SE=0.02, $p<0.0001$) than RUL ($F(1,318)=7.72$, slope=-0.06, SE=0.02; $p=0.005$) or bifrontal ECT ($F(1,318)=8.01$, slope=-0.09, SE=0.03, $p=0.005$). At the 6-month time point, there continued to be a significant relationship between the number of BL ECT treatments and the extent of retrograde amnesia ($F(1,240)=9.61$, $df=1, 240$, slope=-0.06, SE=0.02, $p=0.002$), whereas there were no relationships with the RUL or BF placements. Thus, the magnitude of long-term retrograde amnesia linearly increased with longer courses of BL ECT, but was unrelated to the number of RUL or BF treatments administered.

Of the 306 patients classified, 38 (12.4%) patients met the *a priori* criteria for having marked and persistent retrograde amnesia on the AMI-SF. In the logistic regression analysis, number of BL ECT treatments was the only treatment variable that significantly predicted membership in this subgroup, $\chi^2(1, 296)=14.7$, $p=0.0001$. There was also a gender difference, $\chi^2(1, 296)=5.8$, $p<0.02$, with a greater preponderance of women (81.6%) compared to men (18.4%) in the persistent deficit group.

The analyses of study site effects were repeated now including stimulus waveform and number of treatments with each electrode placement as independent variables. The site effects were no longer significant, with the exception of mMMS scores at the 6-month follow-up. Therefore, the site differences in short- and long-term cognitive outcomes were largely attributable to variation in the type of electrical waveform and electrode placement used in ECT administration.

As seen in **Tables 3** and **4**, several of the covariates had powerful relations with cognitive performance at the post-ECT and 6-month follow-up time points. For every measure and at both time points, baseline scores had strong relationships with subsequent assessments, indicating strong reliability. For eight of the 11 post-ECT measures, cognitive performance was positively related to the number of days that elapsed from the end of ECT until the cognitive assessment. It is noteworthy that this effect did not occur with the AMI-SF, which assessed retrograde amnesia, the deficit thought to be most persistent. Two patient characteristics, age and the estimate of premorbid IQ, had frequent and strong relationships with cognitive outcomes, especially at the post-ECT assessment. In each instance, older patients and those with lower estimated intellectual function had more severe deficits. The gender differences, including the AMI-SF scores at the two time points, reflected greater deficits in women than men, and women were disproportionately represented in the group with marked and persistent impairment on the AMI-SF. Women have a substantially lower seizure threshold than men (**Sackeim et al, 1987**) and electrical dosage was

not adjusted in most cases relative to the individual patient's seizure threshold. This pattern of gender differences might reflect the fact that electrical dosage was more markedly suprathreshold in women. Severity of depressive symptoms showed little relationship with the cognitive measures. At the post-ECT time point, none of the 11 measures were related to concurrent HRSD scores (**Table 4**). Findings were also negative for eight of the 11 measures at the 6-month follow-up. At this time point, lesser severity of depressive symptoms was associated with superior mMMS, delayed BSRT, and AMI-SF scores.

DISCUSSION

This was the first large-scale, prospective study of objective cognitive outcomes of patients treated with ECT. The seven hospitals differed in the magnitude of deficits at the post-ECT assessment (**Figure 2**), with significant differences in seven of the 11 cognitive measures. At the 6-month time point, differences among the hospitals persisted for the measure of global cognitive status (mMMS) and the primary outcome measure that assessed retrograde amnesia for autobiographical events (AMI-SF). In turn, these differences among the hospitals were largely attributable to differences in ECT technique. The use of sine wave stimulation and the BL electrode placement were both associated with greater short- and long-term deficits. In particular, sine wave stimulation had a marked effect on psychomotor response speed. Patients who received this form of stimulation were slowed at the 6-month assessment relative to patients treated with brief pulse stimulation on two of the three RT measures. In contrast, the long-term effects owing to electrode placement were expressed in the magnitude of retrograde amnesia. At both the short- and long-term time points, patients treated with BL ECT had greater amnesia for autobiographical events, and the extent of this amnesia was directly related to the number of BL ECT treatments received.

The demonstration of differences in the long-term cognitive outcomes as a function of hospital setting and treatment technique supports the conclusion that some forms of ECT have persistent long-term effects on cognitive performance. However, the findings do not indicate that the treatments with more benign outcomes are free of long-term effects. It is noteworthy, for example, that most cognitive parameters were substantially improved at 6-month follow-up relative to pre-ECT baseline, presumably because of the negative impact of the depressed state on baseline performance. Without evaluating a comparable group that did not receive ECT, it cannot be concluded, however, that the extent of improvement in any group returned to premorbid levels.

The finding that sine wave stimulation resulted in slowed RT could have reflected a speed/accuracy trade off, with patients receiving sine wave stimulation sacrificing response speed for accuracy. However, the sine wave and brief pulse groups did not differ in accuracy on any of the RT tasks where accuracy could be measured (CRT and Stroop). The fact that relative RT deficits were observed at the 6-month follow-up indicates a persistent change in the speed of information processing, motor initiation, or response execution. Randomized controlled studies have not found an advantage for sine wave stimulation with respect to efficacy (Andrade et al. 1988; Carney and Sheffield, 1974; Scott et al. 1992; Valentine et al. 1968; Weiner et al. 1986), and the American Psychiatric Association (2001) indicated that there is no justification for its continued use. The findings here raise the concern that this form of stimulation has deleterious long-term effects on elemental aspects of motor performance or information processing.

BL ECT results in broader and more severe short-term cognitive effects than RUL ECT, particularly with respect to retrograde amnesia. With respect to the AMI-SF scores, BL ECT

resulted in greater retrograde amnesia than the other electrode placements and, even at the 6-month time point, this effect was linearly related to the number of BL treatments administered during the acute ECT course. The average decrement in AMI-SF scores in patients treated exclusively with BL ECT was 3.4 and 2.8 times the amount of forgetting seen in the healthy comparison groups at the post-ECT and 6-month time points, respectively, suggesting that the deficits were substantial. Furthermore, of a variety of treatment technique and patient characteristic variables, only receipt of BL treatment distinguished the group with marked and persistent retrograde amnesia. For decades, BL ECT represented the gold standard with respect to ECT efficacy, and the equivalence of RUL ECT was uncertain ([Abrams, 1986](#)). Based on accumulating evidence that the efficacy of RUL ECT is strongly influenced by dosage relative to seizure threshold, highly effective forms of RUL ECT are available ([McCall et al, 2000](#); [Sackeim et al, 2000](#)). Indeed, recent work suggests that high dosage RUL ECT delivered with an ultrabrief stimulus maintains efficacy and results in minimal retrograde amnesia even in the period immediately following the ECT course ([Sackeim, 2004b](#)). Consequently, there appears to be little justification for the continued first-line use of BL ECT in the treatment of major depression.

Although there is a large literature on patient characteristics that predict ECT clinical outcome, little is known about the individual difference factors related to cognitive outcomes ([Sobin et al, 1995](#)). Age and premorbid estimate of IQ showed robust associations, especially at the post-ECT time point. In line with prior reports ([Sackeim, 2004a](#)), advancing age was associated with greater deficits. The findings regarding premorbid intelligence are novel. This pattern suggests that individuals with greater premorbid abilities can better compensate for the impact of ECT on cognitive functions ([Stern, 2002](#); [Stern et al, 1994](#)).

Among the limitations of this study is the fact that differences among patients in the treatment received were not randomized, but determined by the usual practices of the setting in which they were treated and other uncontrolled factors. Thus, in theory it is possible that the associations in this observational study between cognitive outcomes and site and treatment technique factors were due to the effects of other unmeasured variables that covaried with the settings and forms of ECT administration. This concern is mitigated by three considerations. First, the findings were consistent with the results of many randomized controlled trials demonstrating that short-term cognitive outcomes are negatively impacted by receipt of sine wave stimulation or use of the BL electrode placement. The long-term effects observed in this study reflect a lack of resolution of specific deficits observed in the immediate post-ECT time period (eg retrograde amnesia). Second, there was evidence that the number of treatments administered, an essential characteristic of dosage, linearly covaried with the extent of long-term retrograde amnesia for autobiographical information for patients treated with BL ECT, but not for patients treated with RUL ECT. This provided internal support for the claim that choice of electrode placement is critical in determining the severity of long-term deficits. Finally, there was considerable variability within some sites in ECT technique, such as choice of waveform and electrode placement. Site differences in cognitive outcomes dissipated when controlling for treatment technique factors. Regardless, this study provides the first evidence in a large, prospective sample that adverse cognitive effects can persist for an extended period, and that they characterize routine treatment with ECT in community settings.

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STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

Clair Craver Johnson,

Plaintiff,

v.

John Roberts, M.D.,

Defendant.

Clair Craver Johnson,

Plaintiff,

v.

The Medical University of South Carolina,

Defendant.

IN THE COURT OF COMMON PLEAS OF
THE NINTH JUDICIAL CIRCUIT

Case No.: 2012-CP-10-2867

CERTIFICATE OF SERVICE

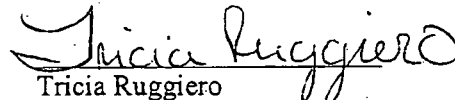
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I, Tricia Ruggiero, paralegal to D. Cravens Ravenel, Esquire of Baker, Ravenel & Bender, LLP do hereby certify that I have this 14th day of February, 2014 served **Plaintiff's Rule 59(e) Motion for Reconsideration** by email and U.S. First Class Mail, postage prepaid and addressed as follows:

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STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

JOHN ROBERTS, M.D.,

DEFENDANT.

IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT
CASE NO. 2012-CP-10-2867

FILED
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JULIE A. JOHNSON
CLERK OF COURT

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

PLAINTIFF,

vs.

MEDICAL UNIVERSITY OF SOUTH
CAROLINA,

DEFENDANT.

IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT
CASE NO. 2011-CP-10-8318

**DEFENDANT MEDICAL UNIVERSITY
OF SOUTH CAROLINA'S RESPONSE
IN OPPOSITION TO PLAINTIFF'S
RULE 59(E) MOTION FOR
RECONSIDERATION**

TO: D. CRAVENS RAVENEL, ESQUIRE, ATTORNEY FOR THE PLAINTIFF:

The Defendant, Medical University of South Carolina ("MUSC"), by and through the undersigned counsel, hereby submits this Response in Opposition to Plaintiff's Rule 59(e) Motion for Reconsideration of the Court's February 4, 2014 order granting summary judgment in favor of the Defendants. In a strained attempt to circumvent the absolute six-year statute of repose barring the instant action, Plaintiff asks this Court to consider arguments not previously raised and, thus, not preserved for review. Even assuming such arguments were preserved, the

issues raised are inapplicable and insufficient to revive Plaintiff's time-barred claims. Accordingly, as more fully set forth below, Plaintiff's motion for reconsideration should be denied.

ARGUMENT

I. PLAINTIFF'S ARGUMENTS WERE NOT PREVIOUSLY RAISED TO THE COURT AND ARE NOT PRESERVED FOR REVIEW.

It is well-settled that an issue not raised and ruled upon cannot be raised for the first time by motion for reconsideration. Dixon v. Dixon, 362 S.C. 388, 399, 608 S.E.2d 849, 854 (2005) (issue raised for first time in Rule 59(e) motion was not preserved for review). Indeed, "[a] party cannot use a motion to reconsider, alter or amend a judgment to present an issue that could have been raised prior to the judgment but was not." RRR, Inc. v. Toggas, 378 S.C. 174, 185, 662 S.E.2d 438, 443 (Ct. App. 2008), cert. granted, decision aff'd, 381 S.C. 490, 674 S.E.2d 170 (2009).

Here, in an eleventh hour attempt to revive her claim, Plaintiff filed the instant motion raising, for the first time, two additional arguments—one grounded in the theory of equitable estoppel, the other concerning the discovery rule as applied in a repressed memory case concerning sexual abuse. Not only are these arguments inapplicable, these issues were neither raised in Plaintiff's brief nor during the January 9, 2014 hearing on the motion. Plaintiff's use of Rule 59(e) to raise these issues at this late juncture is improper and inconsistent with South Carolina's preservation rules. Consequently, to the extent Plaintiff relies on unpreserved arguments, the motion must be denied.

II. EVEN ASSUMING PLAINTIFF'S RULE 59(E) ARGUMENTS ARE PROPERLY BEFORE THE COURT, SUCH ARGUMENTS ARE INAPPLICABLE AND INSUFFICIENT TO DEFEAT THE STATUTE OF REPOSE BAR.

Succinctly stated, Plaintiff's newly raised equitable estoppel and repressed-memory arguments apply solely to the tolling of the statute of limitations and are inapplicable in cases where, as here, the statute of repose has already extinguished a plaintiff's potential claim. Consequently, neither argument has application in the instant matter.

a. Equitable Estoppel

The thrust of Plaintiff's equitable estoppel argument is that MUSC should be equitably estopped from asserting a statute of limitations defense based on alleged misrepresentations by MUSC that memory loss due to electroconvulsive shock therapy ("ECT") treatments would be transient despite medical studies suggesting otherwise. As an initial matter, Plaintiff points to no evidence to support the assertion that any alleged representation by MUSC regarding Plaintiff's memory loss failed to conform to the standard of care in the medical community. Additionally, the only "study" submitted by Plaintiff actually comports precisely with the very misrepresentation upon which Plaintiff relies—that various medical authorities do, in fact, confirm the transient nature of memory loss stemming from ECT. See Plaintiff's Exhibit 5, at p. 2 (stating "authorities have argued that . . . ECT's adverse cognitive effects are short-lived, with no persistent effects on memory."). What's more, the clinical research study relied upon by Plaintiff was the "first large-scale, prospective study of objective cognitive outcomes of patients treated with ECT" and was not even published until August 2006—three years after Plaintiff had commenced ECT treatment. See Plaintiff's Exhibit 5, at p. 10.

Even assuming, arguendo, that MUSC misrepresented the cognitive effects of ECT, Plaintiff's use of the doctrine of equitable estoppel has no application in the instant case. First, "[e]stoppel cannot exist if the knowledge of both parties is equal and nothing is done by one to mislead the other." Evins v. Richland County Historic Pres. Comm'n, 341 S.C. 15, 15, 532

S.E.2d 876, 878 (2000). Here, the alleged misrepresentation by MUSC was consistent with the prevailing knowledge of the medical community, as supported by the only research study submitted by Plaintiff. See Plaintiff's Exhibit 5 at p. 2. Likewise, there is no indication that MUSC misled or intended to mislead the Plaintiff.

Second, the doctrine of equitable estoppel is inapplicable in cases where, as here, a plaintiff's substantive right to file suit has been extinguished by the expiration of a statute of repose. Plaintiff simply cannot overcome the absolute six-year outer limit imposed by S.C. Code Ann. § 15-3-545. See Langley v. Pierce, 313 S.C. 401, 404, 438 S.E.2d 242, 243 (1993) (citation omitted) ("[A] statute of repose is typically an absolute time limit beyond which liability no longer exists and is not tolled for any reason because to do so would upset the economic balance struck by the legislative body."). Thus, even taking as true Plaintiff's assertion that MUSC misled Plaintiff so as to delay the filing of her claim, Plaintiff cannot overcome the statute of repose bar.

b. Discovery Rule based on Repressed Memory

As to the unpreserved repressed memory argument, Plaintiff maintains her alleged lack of capacity was not due to insanity as previously argued; rather, Plaintiff now contends she was unable to discover her injuries due to repressed memory so as to toll the limitations period pursuant to Moriarty v. Garder Sanctuary, 341 S.C. 320, 534 S.E.2d 672 (2000). As above, Plaintiff's argument similarly overlooks the statute of repose bar. The discovery rule upon which Plaintiff relies is inapplicable where a statute of repose has already extinguished Plaintiff's right to bring a claim. See Capco of Summerville, Inc. v. J.H. Gavle Const. Co., Inc., 368 S.C. 137, 142, 628 S.E.2d 38, 41 (2006) ("Statutes of repose by their nature impose on some plaintiffs the hardship of having a claim extinguished before it is discovered, or perhaps before it

even exists.”); Dunbar v. Carlson, 341 S.C. 261, 269, 533 S.E.2d 913, 917 (Ct. App. 2000) (stating the six-year repose provision of § 15-3-545 “imposes an outer limit for filing a medical malpractice action, regardless of when it is discovered.”). Because the discovery rule has no application to the medical malpractice statute of repose, Moriarty is not controlling.

Further, to the extent Plaintiff relies on Moriarty with regard to tolling of the statute of limitations, such reliance is misplaced. As noted in Langley v. Pierce, the only tolling applicable in a medical malpractice action is that provided by Section 15-3-545(D), which provides for limited tolling applicable only to minors. Id. 313 S.C. 401, 403, 438 S.E.2d 242, 243 (1992) (“Inclusion of the phrase “or as tolled by this section” in subsection (A) clearly indicates that the only tolling of § 15-3-545(A) intended by the legislature is that contained in subsection (D).”). As Moriarty involved injuries arising out of sexual abuse and not claims concerning medical malpractice, consideration of § 15-3-545’s limited tolling provision was not at issue. Consequently, Moriarty has no application to the tolling of medical malpractice actions under § 15-3-545 in the instant case.

Furthermore, as this Court determined in granting summary judgment, the limited nature of the tolling provision of § 15-3-545(D) renders the insanity or incompetency tolling provisions of S.C. Code Ann. § 15-3-40 inapplicable to medical malpractice actions. See Langley, 313 S.C. at 403, 438 S.E.2d at 243. Consistent with this Court’s finding, § 15-3-545(D)’s limited application was likewise reaffirmed just last month in Sims v. Amisub of South Carolina, Inc., 2014 WL 551545 (Ct. App. 2014). There, the South Carolina Court of Appeals reinforced the controlling precedent established in Langley, observing that if § 15-3-40 were to apply to medical malpractice actions, it would be in conflict with the six year statute of repose set forth in § 15-3-545(A). Id. at 8.

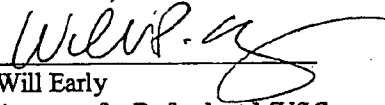
Here, as in Sims and Langley, application of the discovery rule or tolling provided by equitable estoppel or § 15-3-40 will not revive a claim that is filed outside the absolute limitations period established by the statute of repose. Consequently, as this Court properly determined, Plaintiff's claims, having been brought nearly eight years from the onset of treatment, are barred by the absolute six-year statute of repose imposed by § 15-3-545.

CONCLUSION

In sum, South Carolina's longstanding preservation rules preclude this Court from consideration of the arguments advanced in Plaintiff's motion. Even assuming the issues were preserved, neither argument can revive Plaintiff's untimely action. Accordingly, based upon the foregoing, Plaintiff's Rule 59(e) motion should be denied.

Respectfully submitted,

PIERCE, HERNS, SLOAN & WILSON, LLC
The Blake House
321 East Bay Street
Post Office Box 22437
Charleston, SC 29403


Will Early
Attorney for Defendant MUSC

April 21, 2014
Charleston, South Carolina

CERTIFICATE OF SERVICE

I certify that on this date a copy of Defendant Medical University of South Carolina's Response to Opposition to Plaintiff's Rule 59 (E) Motion for Reconsideration was served on counsel of record by emailing and mailing in the manner prescribed by the applicable Rule of Civil Procedure.

This 21st day of April, 2014.

Mary Honduras

IN THE COURT OF COMMON PLEAS
Case No. 2012-CP-10-2867

Plaintiff,

Defendant.

ORDER

FILED
2015 MAY 29 AM 9:23
JULIE J. ARMSTRONG
CLERK OF COURT
1
1. filed

AND IT IS SO ORDERED!


R. MARKLEY DENNIS, JR.
Presiding Judge

May 26, 2015

IN THE COURT OF COMMON PLEAS
Case No. 2011-CP-10-8318

Plaintiff,

Defendant.

ORDER

FILED
2015 MAY 29 AM 9:22
JULIE J. ARMSTRONG
CLERK OF COURT

AND IT IS SO ORDERED!

R. MARKLEY DENNIS, JR.
Presiding Judge

May 26, 2015

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154



D CRAVENS RAVENEL
PO BOX 8057
COLUMBIA SC 29202-8057

NOTICE OF ENTRY OF JUDGMENT/ORDER PURSUANT TO RULE 77 SCRPC

Order/Mot to alter or amend & for reconsideration is denied

CASE NO: 2011CP1008318

Clair Craver Johnson VS Medical University of South Carolina

This judgment was entered on the 29th day of May, 2015, and notice mailed first class on Tuesday, June 02, 2015, to all counsel of record and/or all parties entitled to receive notice.

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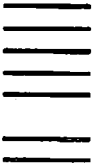
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D. Cravens Ravenel
PO Box 8057
Columbia, SC 29202

NOTICE OF ENTRY OF JUDGMENT/ORDER PURSUANT TO RULE 77 SCRPC

Order/Mot to Alter or Amend & for Reconsideration is denied

CASE NO: 2012CP1002867

Clair Craver Johnson VS John Roberts M D

This judgment was entered on the 29th day of May, 2015, and notice mailed first class on Tuesday, June 02, 2015, to all counsel of record and/or all parties entitled to receive notice.

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable R. Markley Dennis, Jr.
Circuit Court Judge

RECEIVED

JUL 02 2015

SC Court of Appeals

Case No.: 2011-CP-10-8318

Clair Craver Johnson Appellant

v.

The Medical University of South Carolina Respondent

Case No.: 2012-CP-10-2867

Clair Craver Johnson Appellant

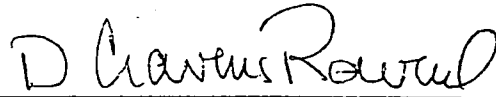
v.

John Roberts, M.D. Respondent

NOTICE OF APPEAL

Motions for reconsideration in Clair Craver Johnson v. Medical University of South Carolina, Case No.: 2011-CP-10-8318 and Clair Craver Johnson v. John Roberts, M.D., Case No.: 2012-CP-10-2867 cases consolidated for discovery were denied pursuant to Rule 77, SCRCP, and judgments entered on the 29th day of May 2015 by notices mailed first class on Tuesday, June 2, 2015 and received by counsel for the plaintiff on June 8, 2015.

Clair Craver Johnson gives notice of her appeal from the orders granting summary judgment to each defendant and from the denial of Clair Craver Johnson's motions for reconsideration.



D. Cravens Ravenel
BAKER, RAVENEL & BENDER, L.L.P.
3710 Landmark Drive, Suite 400
Post Office Box 8057
Columbia, South Carolina 29202
Phone: (803) 799-9091; Fax (803) 779-3423
cravenel@brblegal.com File No.: 10517.0
Attorneys for Plaintiff

July 2, 2015
Columbia, South Carolina

 COPY

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable R. Markley Dennis, Jr.
Circuit Court Judge

Case No.: 2011-CP-10-8318

Clair Craver Johnson Appellant

v.

The Medical University of South Carolina Respondent

Case No.: 2012-CP-10-2867

Clair Craver Johnson Appellant

v.

John Roberts, M.D. Respondent

PROOF OF SERVICE

I, Suzanne Rodriguez, Legal Assistant to D. Cravens Ravenel, an employee of Baker, Ravenel & Bender, L.L.P., attorneys for Clair Craver Johnson, hereby certify that I have, on this 2nd day of July 2015, served counsel below with a Notice of Appeal by mailing copies of same via United States Mail, postage pre-paid and return address clearly indicated on said envelope, to counsel at the following addresses:

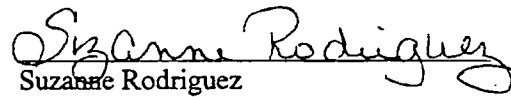
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JUL 02 2015

SC Court of Appeals

James E. Scott, IV, Esquire
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P.O. Box 993
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Charleston, SC 29402
Attorneys for John Roberts, M.D.

William P. Early, Esquire
Pierce Hems Sloan & McLeod, LLC
P.O. Box 22437
Charleston, SC 29413
Attorney for the Medical University of South Carolina

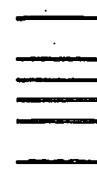

Suzanne Rodriguez

  COPY

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SC Court of Appeals

NOTICE OF ENTRY OF JUDGMENT/ORDER PURSUANT TO RULE 77 SCRPC

Order/Mot to alter or amend & for reconsideration is denied

CASE NO: 2011CP1008318

Clair Craver Johnson VS Medical University of South Carolina

This judgment was entered on the 29th day of May, 2015, and notice mailed first class on Tuesday, June 02, 2015, to all counsel of record and/or all parties entitled to receive notice.

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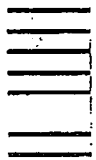
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D. Cravens Ravenel
PO Box 8057
Columbia, SC 29202

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JUL 02 2015

SC Court of Appeals

NOTICE OF ENTRY OF JUDGMENT/ORDER PURSUANT TO RULE 77 SCRCP

Order/Mot to Alter or Amend & for Reconsideration is denied

CASE NO: 2012CP1002867

Clair Craver Johnson VS John Roberts M D

This judgment was entered on the 29th day of May, 2015, and notice mailed first class on Tuesday, June 02, 2015, to all counsel of record and/or all parties entitled to receive notice.

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STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS
Case No. 2012-CP-10-2867

Clair Craver Johnson

Plaintiff,

John Roberts, M.D.

Defendant.

ORDER

FILED
2016 MAY 29 AM 9:23
JULIE J. ARMSTRONG
CLERK OF COURT
1
1, filed

This matter comes before me upon Motion for Reconsideration, filed 2/25/2014, by Plaintiff, by and through counsel. After fully considering said Motion, this Court finds no need for oral argument in this matter and therefore the Motion to Alter or Amend and for Reconsideration is denied;

AND IT IS SO ORDERED!


R. MARKLEY DENNIS, JR.
Presiding Judge

Charleston, South Carolina

May 26, 2015

RECEIVED

JUL 02 2015

SC Court of Appeals

STATE OF MASSACHUSETTS)
COUNTY OF MIDDLESEX)

AFFIDAVIT

1. I, Harold J. Burstzajn, M.D., am a physician currently licensed by the states of Massachusetts and New Hampshire. I am board-certified in psychiatry by the American Board of Psychiatry and Neurology. I serve as an Associate Clinical Professor of Psychiatry, Co-Founder of the Program in Psychiatry and the Law, and Principal Mentor for students at Harvard Medical School. A copy of my current curriculum vitae is attached hereto as Exhibit A.

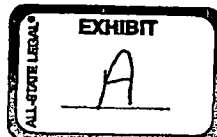
2. This affidavit is provided pursuant to S. C. Code Ann. §§15-36-100 and 15-79-125.

3. Based upon my medical education, knowledge, training and experience, I am familiar with the generally accepted principles and standards of care in the diagnosis and treatment of Bipolar Disorder with psychotic features and a history of head trauma, for which Clair Craver Johnson was being treated.

4. I have, to date, reviewed records of Clair Craver Johnson's education, certain observations by the parents of Clair Craver Johnson over a significant period of time, court records, hospital and physicians' and psychologists' records, all documenting Clair Craver Johnson's emotional condition and the treatment of Clair Craver Johnson by the Medical University of South Carolina hospital and by John Roberts, M.D. and Milton Faust, M.D.

5. I interviewed Clair Craver Johnson in my office for 4 ¼ hours after reviewing the referenced materials.

6. After reviewing the described records and meeting with Clair Craver Johnson, and relying upon my education, knowledge, training and experience, I am of the opinion that based upon a reasonable degree of medical certainty, more likely than not, the treatment provided by



the Medical College of South Carolina hospital, John Roberts, M.D., and Milton Faust, M.D., did not meet the standard of care imposed upon hospitals and physicians under like circumstances. I am of the opinion that the Medical University of South Carolina failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with electroconvulsive therapy (ECT) (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; that Dr. Roberts failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, by failing to conduct an adequate psychopharmacological assessment of alternate medication choices, by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence, and by failing to engage in comprehensive evaluation of clinical and ethical issues such as the appropriate use of substituted decision making and the appropriateness of Ms. Johnson's estranged husband's involvement in her treatment; and that Dr. Faust failed to meet the standard of care by giving inadequate consideration to the foreseeable risks of repeated, extended treatment with ECT (particularly given Ms. Johnson's pre-existing vulnerability to cognitive impairment), by failing to provide or refer Ms. Johnson for meaningful psychotherapy, and by failing to provide systematic ongoing assessment of Ms. Johnson's decision-making competence.

7. I am likewise of the opinion that based upon a reasonable degree of medical certainty, more likely than not, as a direct and proximate result of the negligent acts or omissions on the part of the Medical University of South Carolina, John Roberts, M.D., and Milton Faust, M.D., Clair Craver Johnson sustained the following injuries: prolonged and, to a degree, permanent exacerbation of cognitive impairments, including memory loss; impaired capacity to participate in her divorce proceedings; impairments in the post-traumatic spectrum resulting from the physically and emotionally traumatic experience of extended involuntary treatment with ECT, which produced feelings of helplessness, terror, and personal violation; a prolonged period of confusion and demoralization, resulting in a loss of access to a significant segment of her life experience and a loss of continuity of autobiographical memory; diminished trust in mental health care providers; diminished hope for the future; and loss of the potential benefits of appropriate treatment with psychotherapy, medications, and a meaningful informed-consent process. Had Clair Craver Johnson been properly diagnosed and treated, I am of the opinion that to a reasonable degree of medical certainty, Ms. Johnson more likely than not would not have sustained the injuries described above and her emotional issues would have been managed so as to allow her to function as a productive individual.

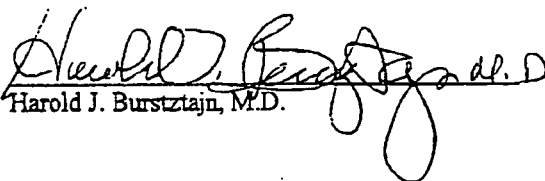
8. Further, I am of the opinion that to a reasonable degree of medical certainty, more likely than not, Clair Craver Johnson did not regain the mental capacity to understand and appreciate the harm she suffered as a consequence of the negligent acts or omissions specified above; particularly the extended involuntary treatment with ECT, until she sought help in reviewing her medical records in June 2010, two years after ECT was concluded. Her capacity to comprehend what was going on in her life, already diminished by mental illness, was further diminished by the physical and emotional trauma and cognitive impairments associated with an

extended period of ECT, which foreseeably resulted in prolonged confusion and demoralization.

She recovered the ability to process her experiences during those years only by reestablishing ties with a supportive community that helped her recreate her autobiographical memory.

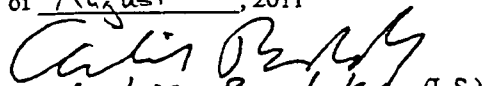
9. This affidavit does not include all of my opinions and I reserve the right to modify and/or formulate additional new opinions should additional, pertinent records be submitted for my review.

Further affiant sayeth not.


Harold J. Burstzajn, M.D.

Sworn to before me this 10th day

of August, 2011


Archie Bradsky (L.S.)
Notary Public for Massachusetts

My Commission expires: June 22, 2012

STATE OF SOUTH CAROLINA
IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON NINTH JUDICIAL
CIRCUIT

CLAIR CRAVER JOHNSON,
Plaintiff

vs. CASE NO. 2012-CP-10-2867

JOHN ROBERTS, M.D.,
Defendant

CLAIR CRAVER JOHNSON,
Plaintiff

vs. CASE NO. 2011-CP-10-8318

MEDICAL UNIVERSITY OF
SOUTH CAROLINA,
Defendant

TELECONFERENCE DEPOSITION
OF
HAROLD B. BURSZTAJN, M.D.

Harvard University Science Building
One Oxford Street
Cambridge, Massachusetts 02138

July 26, 2013
11:00 a.m.

REPORTER: Carol A. Fierimonte, CLNR

A. WILLIAM ROBERTS, JR., & ASSOCIATES (800) 743-DEPO
scheduledepo.com

Page 2

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APPEARANCES:

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On behalf of the Plaintiff

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By: James E. Scott, IV, Esquire
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On behalf of the Defendant, Doctor Roberts

PIERCE HERNS SLOAN & WILSON, LLC
By: William P. Early, Esquire
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(843) 722-7733
On behalf of the Defendant, Medical
University of South Carolina

Page 3

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INDEX

WITNESS DIRECT CROSS REDIRECT RECROSS

HAROLD BURSZTAJN, M.D.

By Mr. Early 4

EXHIBITS

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PROCEEDINGS

July 26, 2013

HAROLD BURSZTAJN, M.D.,

having first shown proper identification

and having been duly sworn, was examined

and testified as follows:

DIRECT EXAMINATION

BY MR. EARLY:

Q. Doctor Bursztajn, we met off the record a

minute ago. My name is William Early. I

am a lawyer down here in Charleston, South

Carolina. I am going to be taking your

deposition today along with my colleague,

Jim Scott. I represent the Medical

University of South Carolina. Mr. Scott

seated to my left represents Doctor

Roberts. And you have been identified as

an expert for the plaintiff, Clair Johnson

in this case and my goal is to find out

your opinions today and what you may

testify about at trial.

Is that your understanding of

your role in this case?

A. Yes.

Q. All right. Because your name is somewhat

Page 5

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unfamiliar, could you please spell it for

the record? Tell me your full name and

spell your last name, if you would.

A. It is Harold J., and then Bursztajn,

B-U-R-S-Z-T-A-J-N.

Q. And Doctor Bursztajn, where are you

currently located right now?

A. We are in the basement of the Harvard

University Science Center in the Media

Services Center, B-4.

Q. All right. And tell me your, your

business or physical address where you get

your mail.

A. It is at my home office which is at 96

Larchwood, that is spelled

L-A-R-C-H-W-O-O-D, Larchwood as the tree,

Drive in Cambridge, Massachusetts. And

our zip code is 02138.

Q. And your date of birth, sir?

A. November 18, 1950.

Q. And are you married?

A. Divorced.

Q. Okay. How long have you been divorced?

A. Oh, gosh, it's been now over six years.

Q. Okay. And what was your wife's name?

Page 6

Page 7

1 A. Patricia Illingworth,
2 I-L-L-I-N-G-W-O-R-T-H.
3 Q. And you are currently -- are you employed
4 by Harvard or are you employed by yourself
5 or by whom are you currently employed?
6 A. I am self-employed.
7 Q. And how long have you been self-employed
8 as opposed to employed by an entity such
9 as a university?
10 A. Since 1982.
11 Q. All right. So you have not been employed
12 by anyone other than yourself since 1982?
13 A. I have not received a salary from anyone
14 since 1982. My function at the
15 university, I donate my time.
16 Q. Okay. I am getting to that in a second.
17 What have you been doing since 1982 as a
18 self-employed, I will assume,
19 psychiatrist?
20 A. Yes. I have been in clinical and forensic
21 psychiatric practice.
22 Q. And if you could just tell me what that
23 entails, what your, what your job duties
24 as a clinical and forensic psychiatrist
25 since 1982, what your job duties are.

1 A. From 1982 to 1986, I saw patients
2 primarily on an inpatient setting. Since
3 then, I see patients in my home office. I
4 also consult to other clinicians, give
5 second opinions, third opinions on
6 patients who have not responded well to
7 treatment, risk management issues. I also
8 do the same for institutions. I also
9 engage in risk management consultation and
10 forensic consultation which includes
11 consulting to attorneys, to judges, and to
12 institutions around issues where
13 psychiatry and the law meet.
14 Q. I am just curious, what kind of consulting
15 would you do for a judge or have you done
16 for a judge?
17 A. I have been asked to give talks to judges
18 about standards for what constitutes
19 forensic psychiatric methodology, what are
20 the standards for opinion formulation and
21 analysis.
22 Q. Have you ever given such a talk to any
23 judges in South Carolina?
24 A. I gave one talk to federal judges which I
25 believe included judges from South

Page 8

Page 9

1 Carolina, but it wasn't in South Carolina.
2 It was in -- it may have been in
3 Tennessee. It was the Southeast Circuit.
4 And there I talked about standards for
5 forensic psychiatric autopsy and I used as
6 an illustration one particular case where
7 I consulted to a Discovery Channel program
8 on doing a forensic psychiatric autopsy.
9 Q. I am sorry. Did you say autopsy?
10 A. Autopsy, yes.
11 Q. Okay.
12 A. Forensic psychiatric autopsy is an autopsy
13 where you cannot go ahead and -- you
14 cannot actually examine the person but you
15 have to do a reconstruction. The reason
16 why you can't examine the person, either
17 the person has been recently dead or the
18 person has been long dead and you are
19 trying to put the pieces together to see
20 how best they fit.
21 Q. Okay. Do you -- I know you said it was a
22 Southeastern Circuit. Do you remember
23 where in Tennessee and when that talk was?
24 A. I don't. It was probably somewhere in the
25 past 15 years. But it was an annual

1 meeting.
2 Q. Doctor Bursztajn, since 1986, I am
3 interested how many patients do you see on
4 average in a week or a month or how ever
5 you want to quantify it?
6 A. My clinical practice constitutes on the
7 average 20 hours of patients and that can
8 be anywhere from eight, eight patients to
9 15 patients a week. It just depends.
10 Q. And how many of those patients are you
11 seeing for expert witness or forensic
12 work?
13 A. None. When I do a forensic psychiatric
14 evaluation, they are not my patients any
15 longer. There is no doctor/patient
16 relationship so I wouldn't count them as
17 being clinical in that sense. Clinical is
18 only when you have a doctor/patient -- in
19 my vocabulary, a doctor/patient
20 relationship.
21 Q. All right. And do you charge those
22 patients that you see, Doctor?
23 A. I do.
24 Q. All right. Do you charge them, I mean do
25 you submit that to their insurance or do

Page 10

1 you charge them specifically or both?
2 A. It is almost exclusively private pay.
3 Q. All right. Okay. What do you charge them
4 per hour?
5 A. It depends. For an initial evaluation, it
6 is \$675 for an hour and 15 minutes. If I
7 am seeing a patient on a standard, yes, an
8 established patient on a treatment basis,
9 it is \$200 for 45 minutes or it is \$100
10 for 15 minutes or less.
11 Q. All right. Is this psychotherapy work or
12 what type of work are you doing with them?
13 A. It is psychiatric work which includes both
14 psychotherapy and psychopharmacology, as
15 well as an ongoing evaluation.
16 Q. Okay.
17 MR. RAVENEL: Will, let me
18 interrupt. Something is going on. We are
19 getting a lot of background right now.
20 Somebody is talking in the background.
21 MR. EARLY: Okay. Nobody else
22 is in the room.
23 MR. RAVENEL: It may be on our
24 end. Let me go see if I can get the
25 technician to check it.

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1 A. I do. And what I did was I brought with
2 me an updated C.V. which includes one more
3 publication, something which was in press
4 which has now been published, because it
5 hasn't gotten up in the web yet, but it
6 has gotten up on the PDF.
7 Q. Okay.
8 A. So I have a copy of that.
9 MR. EARLY: Why don't we do this?
10 For housekeeping, if we could go ahead and
11 mark what you brought, your current C.V.
12 that includes that publication that you
13 just referenced as Exhibit 1 or A.
14 THE WITNESS: Yes.
15 MR. EARLY: Or whatever is
16 easiest.
17 (Document marked as Exhibit 1
18 for identification.)
19 Q. And just for the record, Doctor Bursztajn,
20 what publication are you referencing that
21 is included on that C.V. which is Exhibit
22 1 that is not on the one that I have?
23 A. Let me take a look and just make sure.
24 Let's see. It looks like my office is
25 ahead of me. They actually did get it up

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1 MR. EARLY: I will too. There
2 is an ice machine that is making a lot of
3 noise.
4 MR. RAVENEL: All right.
5 (Brief recess.)
6 MR. EARLY: Back on the record,
7 please. If you hear something again, just
8 stop me and let me know. I will go get
9 whomever. Madam Court Reporter, can you
10 read back the last question or his
11 response? I forgot where I was.
12 (Record read back as requested.)
13 MR. EARLY: All right. Thank
14 you.
15 Q. Doctor Bursztajn, do you regularly
16 prescribe your patients drugs?
17 A. I do prescribe medications to patients on
18 a regular basis, yes.
19 Q. All right. I have a C.V. of yours and I
20 don't know the date of it. I think I have
21 got -- actually, what I have got has got a
22 URL or a website looking thing on the top
23 and the bottom. I had a notebook
24 overnighted to you guys yesterday. Do you
25 have that?

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1 on the web. I thought they didn't, but it
2 is the same one.
3 Q. Just so I know, which one was that that
4 was recently added?
5 A. Number 81 on the publications list, the
6 Journal of the Royal Society of
7 Medicine.
8 Q. The Vulnerabilities --
9 A. Mm-hmm, yes.
10 Q. Okay. Other than -- so what I have there
11 in the notebook and what is Exhibit 1 is
12 the most current, up-to-date C.V.?
13 A. Yes.
14 Q. All right. If we could just flip through
15 it real quickly, there were a couple of
16 things I wanted to ask, Doctor Bursztajn.
17 A. Okay.
18 Q. Your current position, I know you said you
19 were not paid by anyone but you donate
20 time. Can you tell me what you mean by
21 that?
22 A. I am an Associate Clinical Professor of
23 Psychiatry at the Beth Israel Department
24 of Psychiatry and the Massachusetts Mental
25 Health Center at Harvard Medical School.

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Page 15

1 Q. And what is your -- what does that mean?
2 What do you do there?

3 A. I teach, I mentor, I consult, I help
4 people to -- students and faculty as best
5 as I can.

6 Q. How much of your time do you donate doing
7 that per week or per month?

8 A. It varies. Anywhere between four hours to
9 eight hours of time per week.

10 Q. And you receive no remuneration for that
11 time donation?

12 A. I have donated my time since 1982 to the
13 medical school.

14 Q. Okay. And prior to 1982, what was your
15 role at Harvard?

16 A. Well, beginning in 1972, I came there as a
17 student, then I received a fellowship,
18 then I was first an instructor in
19 pediatrics, then internal medicine, then I
20 was in residency training. I became an
21 instructor in psychiatry and when I -- I
22 was the Chief Resident in psychiatry, the
23 program in psychiatry and the law and one
24 of the founders of the Harvard Medical
25 School program in psychiatry and the law

1 at the Massachusetts Mental Health Center
2 in 1982.

3 Q. And Doctor Bursztajn, just because I am
4 not familiar with that, is that a degree a
5 student gets in medical school or a sub
6 degree or is that a B.S. degree at
7 Harvard? What is Forensic Psychiatry in
8 the Law?

9 A. It is the program, Forensic Psychiatry in
10 the Law is a program which is risk
11 management consultation and research at
12 the interface of psychiatry and the law.
13 And we have students at all levels ranging
14 from undergraduate medical students to
15 residents to postgraduate to senior
16 faculty who wish to go ahead and continue
17 to learn. It is an ongoing workshop for
18 exploring difficult clinical risk
19 management and forensic problems at the
20 interface of psychiatry, ethics and the
21 law.

22 Q. All right. Well, how many different
23 classes are offered in that program, if
24 you will?

25 A. Well, we don't have -- it is a weekly

Page 16

Page 17

1 seminar which meets on a weekly basis and
2 then participants are encouraged to keep
3 in contact with each other throughout for
4 ongoing consultation and research
5 collaborations.

6 Q. All right. And how many -- do you teach
7 that every week?

8 A. Every week, except in July and August we
9 don't have formal meetings because too
10 many people are away. But from September
11 through, through July, usually July 7th,
12 the first week in July, we do meet on a
13 weekly basis.

14 Q. All right. Do you use a presentation
15 program such as PowerPoint to aid your
16 lectures and seminars?

17 A. As well as possible but occasionally I do
18 succumb to those, yes.

19 Q. Okay. Do you have copies of those dating
20 back in your hard drive somewhere?

21 A. I don't. Generally speaking, what happens
22 is the presentations, any specific
23 presentations which get to the point of
24 being a PowerPoint eventually became a
25 paper, and when the paper is published

1 there is no more need for the PowerPoint
2 per se. I find myself, although I must
3 say I do use PowerPoint occasionally,
4 especially for photographs, the regular
5 use of PowerPoints discourages discussion
6 and exploration and learning in a complex
7 fashion. I mean a PowerPoint can be
8 useful but it is not -- it is an aid to
9 teaching. It is not a substitute for
10 teaching.

11 Q. All right. Is the section of your C.V.
12 titled Presentations, would those be the
13 lectures or the titles of these lectures
14 that you have given in this Psychiatry in
15 the Law seminars and classes?

16 A. No. Because I don't -- those are outside
17 of there. Those are presentations in a
18 variety of different institutions ranging
19 from Grand Rounds at hospital and surgery,
20 for example, or plastic surgery, to
21 teaching at various, various institutions
22 across the country. So no, those are
23 outside of there.

24 Q. Okay. Well, do you have a list of any of
25 those presentations you offer in that

Page 18

1 class memorialized anywhere?

2 A. No.

3 Q. All right. Looking at your C.V., Doctor

4 Bursztajn --

5 A. Yes.

6 Q. You have a, beginning on about page three

7 or four, the bottom, it is titled

8 Bibliography.

9 A. Yes. I think that is on page number six

10 in my -- I see. You are using -- let me

11 use this one. I see.

12 Q. I apologize. I see it now.

13 A. Yes, okay.

14 Q. What is the significance of that section?

15 Were those things that you penned with

16 others?

17 A. There are a variety of articles which have

18 been published in peer-reviewed journals,

19 blindly peer-reviewed journals since my

20 first article in 1977 through today.

21 Q. All right. And these are in chronological

22 order?

23 A. Yes.

24 Q. Obviously.

25 A. Yes.

Page 20

1 Electroconvulsive Therapy, have you

2 offered any peer-reviewed articles dealing

3 specifically with Electroconvulsive

4 Therapy?

5 A. Looking through my articles here, let's

6 see here, the issues relevant to ECT

7 therapy are discussed; even if the word

8 ECT is not mentioned, in a variety of

9 these articles.

10 For example, looking at this

11 here, number nine, number ten, number 12,

12 number 13, number 16, number 19, number

13 20, number 22, number 23 and number 24,

14 number 33, number 38, number 41, number

15 42, number 43, number 55, number 60,

16 number 62, number 65, 66, number 68,

17 number 76, number 78, number 80. And

18 then in terms of books that I have written

19 and that is on page 15, numbers two

20 through five.

21 Q. Okay, Doctor. My question was did you

22 have any of those articles, and you have

23 expanded to books, dealing with

24 Electroconvulsive Therapy. And the ones

25 that you just told me that I have circled

Page 19

1 Q. All right. Do any of these articles under

2 your section of Bibliography have any

3 bearing on the opinions that you are

4 rendering in this case?

5 A. Well, the totality of my work does

6 specifically deal with the issues of

7 clinical decision making and informed

8 consent and dealing with complex patients

9 where there is an issue of involuntary

10 treatment, where there was an issue of

11 risks and benefits to be considered in

12 psychiatry, and where there was an issue

13 of informed consent process. We can go

14 through these specifically, but there is

15 -- the bulk of these articles do focus

16 very much on the issues which I believe

17 are at the heart of the matter in this

18 particular case. Would you like me to go

19 through them individually?

20 Q. Well, there are 70 something of them.

21 A. Pick any one of them.

22 Q. I don't know if we have time to go through

23 each one, and I was hoping to get a little

24 smaller answer than that. But how about

25 with regards to ECT specifically,

Page 21

1 are dealing with Electroconvulsive Therapy

2 or are they a -- tell me what you meant by

3 that.

4 A. I meant by that that they deal with a

5 variety of issues in the treatment of

6 patients who are depressed and who are

7 potential candidates for Electroconvulsive

8 Therapy and where there is an issue of

9 diminished capacity and where there is

10 also an issue of the treatment being

11 involuntary. None of these articles is

12 exclusively about ECT. None of these

13 books is exclusively about ECT.

14 Q. Have you ever authored a book, article or

15 treatise involving Electroconvulsive

16 Therapy specifically?

17 A. Not exclusively, no.

18 Q. All right. Are you going to render an

19 opinion in this case that the involuntary

20 or the decision by the decision makers to

21 use involuntary Electroconvulsive Therapy

22 beginning in December of 2003 in and of

23 itself was a deviation from the standard

24 of care?

25 A. Relative to the lack of informed consent

Page 22

1 and the failure to explore alternatives
2 prior to instituting such a process, yes.
3 **Q. All right. Is it in and of itself a**
4 **deviation from the standard of care to**
5 **involuntarily give someone**
6 **Electroconvulsive Therapy?**
7 **A. Not by itself.**
8 **Q. Okay. And in this case, what makes that a**
9 **deviation from the standard of care, that**
10 **decision -- let me preface my question --**
11 **that decision to give the plaintiff in**
12 **this case involuntary Electroconvulsive**
13 **Therapy?**
14 **A. The failure to do an adequate evaluation**
15 **for alternatives, the failure to institute**
16 **treatments to restore the patient to**
17 **competency, continuing to proceed with**
18 **Electroconvulsive Therapy without**
19 **adequate, an adequate informed consent**
20 **process, an adequate process of monitoring**
21 **and re-evaluation.**
22 **Q. Anything else?**
23 **A. That is some of what -- let me just take a**
24 **quick look at my original, my original**
25 **notes here. Yes.**

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1 explore with the patient, support the
2 patient and minimize the potentially
3 traumatic effects of involuntary ECT;
4 proceeding with ECT in a context of an
5 extended ECT, in the context where there
6 was a potential conflict of interest among
7 the people who gave so-called substituted
8 judgment; not exhausting reasonable
9 medical choices prior to instituting a
10 course of 80 plus ECT treatments from 2003
11 to 2008; proceeding with such a course of
12 ECT without giving Ms. Johnson the
13 opportunity to benefit from a
14 comprehensive program of psychotherapy;
15 proceeding with ECT, including long-term
16 bilateral ECT, without sufficient
17 monitoring of the foreseeable risk of
18 cognitive impairment, even when Ms.
19 Johnson was complaining about it; and then
20 insufficient response to such impairment
21 when it obviously was occurring. And
22 finally, there seems to be no
23 consideration given to the foreseeably
24 traumatic experience of forced ECT or the
25 terror Ms. Johnson was likely to

Page 23

1 Instituting Electroconvulsive
2 Therapy in a patient who would be
3 foreseeably vulnerable to some of the
4 known and recognized side effects of ECT
5 without considering alternative treatment
6 methods and instituting alternative
7 treatment methods which would not have had
8 these risks; the presentation of
9 Electroconvulsive Therapy as an inevitable
10 choice of treatment when it wasn't; and
11 then continuing it well beyond the
12 generally accepted number of treatments
13 including the use of ECT on an ongoing
14 maintenance basis without exploring
15 alternatives; a failure to perform an
16 adequate assessment of decision making
17 competence while instituting involuntary
18 ECT; proceeding with involuntary ECT which
19 by itself is a foreseeably traumatic
20 process to a patient who is already
21 feeling helpless, hopeless and worthless
22 by reason of having a mood disorder with
23 depressive and manic components to it;
24 without adequately providing the patient
25 with ongoing psychotherapy which could

Page 25

1 experience under these circumstances.
2 **Q. All right. Those are the, your opinions**
3 **in this case?**
4 **A. Yes, they are.**
5 **Q. Okay. All right. Do you have a --**
6 **A. I should also add that in exploring the**
7 **informed consent forms which have been**
8 **signed in this case, they are absolutely**
9 **inadequate relative to the kind of**
10 **informed consent process for ECT, which**
11 **both the hospital guidelines indicate as**
12 **well as the generally accepted guidelines**
13 **for ECT such as the NICE, N-I-C-E,**
14 **Guidelines which are the British National**
15 **Health Service Guidelines for ECT,**
16 **especially given the fact that what we**
17 **have here is 80 plus ECT's over a course**
18 **of almost five years.**
19 **Q. All right. Well, let me -- are those all**
20 **your opinions in this case, Doctor**
21 **Bursztajn?**
22 **A. There may be more specifics under each**
23 **opinion which we can go into, but I think**
24 **that is the gist of it.**
25 **Q. Okay. And I do plan to go into each of**

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1 them. I just wanted to see if I could get
2 you to state them all first and then kind
3 of pick back through them as we can go
4 through them as you just stated. Are
5 there any others that you have as we sit
6 here today in July of 2013?
7 A. Let me just double-check my notes to make
8 sure that I have articulated all the
9 general headings of each of these opinions
10 and then, as you say, we can go into the
11 specifics of each opinion.
12 Q. Okay. Since you have referenced notes,
13 did you bring any with you?
14 A. I did, the ones which were sent to you
15 this morning so you should have them also.
16 Do you have them?
17 Q. I haven't received anything today.
18 A. Okay. You should have received them
19 because they were sent this morning.
20 Q. I got something late yesterday from Mr.
21 Ravenel's office that I hadn't seen before
22 but I certainly haven't seen anything
23 today.
24 A. I think what you got late yesterday may be
25 it. I don't know if it was sent today or

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1 in addition to what you just told me,
2 encompass all of your opinions in this
3 case as we sit here today on July 26,
4 2013?
5 A. Yes. And some of this may be redundant
6 also, but this was just a way of making
7 sure that I wasn't wasting your time and
8 my time doing the deposition, basically.
9 Q. Sure. It sounded like some of them ran
10 together, and I am going to go through
11 them.
12 A. Sure.
13 Q. But I kind of jumped out of order just so
14 I don't lose my place. Tell me what your
15 rate is for your testimony in deposition
16 and trial, if you've got different rates?
17 A. No. My time is all the same forensically.
18 It is \$500 per hour for any time, and
19 expenses are billed at cost.
20 Q. All right. And that includes travel time?
21 A. Up through -- it gets capped so if I have
22 to go ahead and travel and be out-of-state
23 for the day, the most that the client will
24 go ahead and pay is for ten hours of my
25 time or \$5,000 a day, but it doesn't go

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1 yesterday, but it should have been sent to
2 you.
3 MR. RAVENEL: Will?
4 MR. EARLY: Yes.
5 MR. RAVENEL: Cravens, I have
6 Tricia Phyfer, who is my paralegal, sent,
7 I believe, to both of you this morning at
8 9:53 some additional notes that he, that
9 Doctor Bursztajn produced to me.
10 MR. EARLY: Okay. I will tell
11 you --
12 MR. RAVENEL: They are just his
13 notes.
14 MR. EARLY: Let's go off the
15 record for just a second.
16 MR. RAVENEL: All right.
17 (Brief recess.)
18 MR. EARLY: Let's mark that as
19 Exhibit 2, please.
20 (Document marked as Exhibit 2
21 for identification.)
22 MR. EARLY: Thank you.
23 Q. Doctor Bursztajn, I have briefly looked at
24 what was e-mailed to me this morning. And
25 do those, what you have memorialized there

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1 beyond that.
2 Q. All right. Are you Board certified
3 currently?
4 A. In Psychiatry.
5 Q. How about in Neurology?
6 A. I am not certified in Neurology. I have
7 never taken that exam. But I am certified
8 by the American Board of Psychiatry and
9 Neurology in Psychiatry.
10 Q. I am sorry. Could you repeat that one
11 more time? I lost you with your accent.
12 A. No problem. I am certified by the
13 American Board of Psychiatry and Neurology
14 in Psychiatry.
15 Q. Oh, I got you. But you are not Board
16 certified in the field of Neurology, is
17 that fair?
18 A. Yes.
19 Q. Have you taken any boards other than that
20 which you just told me that you are now
21 certified in?
22 A. In my younger days I took the specialty
23 boards in forensic psychiatry, and I was
24 certified in that as well.
25 Q. Did you let that lapse or what happened?

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1 A. Yes. I didn't need to repeat it because I
2 had been, quote, qualified enough after
3 that.
4 Q. All right. And you -- do you currently
5 hold any positions that allow you to admit
6 patients to hospitals? Do you have any
7 admitting privileges?
8 A. I do not have any admitting privileges.
9 When one of my patients needs to get
10 admitted to a hospital, I ask one of my
11 younger colleagues who works exclusively
12 in hospitals to go ahead and do that
13 admission. I continue to consult to that
14 colleague during the admissions process
15 and during the hospitalization as a whole.
16 Q. Who is that colleague?
17 A. Oh, it's anyone. It depends on the
18 hospital, it depends on the patient, it
19 depends on the time of year. So --
20 Q. Okay. I understand. We have been
21 provided some bills, Doctor Bursztajn, and
22 I think they are tabbed in the notebook
23 that I sent you. At least I hope my staff
24 tabbed them. If they didn't, I apologize.
25 A. No, they did. It is a well-tabbed

1 notebook. Thank you, that helps.
2 Q. You're welcome. Can you tell me, based
3 upon that, I can't tell what checks have
4 been going and invoices, could you tell me
5 basely if you're currently owed any money
6 by the plaintiff's counsel and what you
7 have billed?
8 A. I know I spent about 120 -- I had invoiced
9 about 125 hours beginning from August of
10 2010. And beyond that, there is also time
11 I have not invoiced which I have not
12 totaled up yet so I am not sure how much
13 additional time that will be. But there
14 has been about 125 hours of time invoiced
15 since the end of August of 2010.
16 Q. And can you estimate how much time you
17 spent since August, the last invoice?
18 A. Again, this is just a rough guess because
19 -- but I would think somewhere maybe an
20 additional, an additional 35 to 45 hours
21 of additional time.
22 Q. So roughly 160 to 170 hours in this case?
23 A. Yes, as an estimate.
24 Q. All right. And at your rate of \$500 an
25 hour, that is approximately 80 to \$85,000?

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Page 33

1 A. Yes.
2 Q. Okay. Currently, Doctor Bursztajn, what
3 is your split between, speaking about your
4 income, between the work you do seeing
5 patients versus your forensic work?
6 A. It is about 70 percent income forensic,
7 about 30 percent income clinical.
8 Q. Do you know how much you made in the
9 calendar year 2012 based upon your
10 forensic work?
11 A. No.
12 Q. Have you ever been disciplined by any
13 board or hospital?
14 A. No.
15 Q. Have you ever been sued?
16 A. The only time that someone filed a lawsuit
17 against me was when they also filed a
18 lawsuit against a judge and both the
19 prosecutor and the defense attorney; and
20 it was by a prisoner, a man had committed
21 murder and I didn't -- when I examined him
22 I didn't think he was -- I thought he was
23 sane, so he got very upset and he decided
24 that the judge, the prosecutor in New
25 Hampshire and the defense attorney and

1 myself were all part of a big conspiracy.
2 So he filed a lawsuit, but it was
3 dismissed.
4 Q. Any other suits against you or any
5 hospital based upon your alleged conduct,
6 Doctor Bursztajn?
7 A. No.
8 Q. Have you ever testified in South Carolina
9 before?
10 A. No, I don't believe so. Although again,
11 you know, I have been doing this since
12 1982, but I don't believe so.
13 Q. Have you ever testified for Mr. Ravenel or
14 anybody in his firm?
15 A. Not as far as I know.
16 Q. Have you ever testified in a case
17 involving Electroconvulsive Therapy before
18 this one?
19 A. I have been consulted in such cases but I
20 don't believe I have ever testified in
21 cases where the issue of ECT and informed
22 consent was a primary issue.
23 Q. What was the issue in any ECT case that
24 you may have been consulted with in the
25 past?

Page 34 1 A. Guardianship issues and whether or not 2 someone was appropriate for guardianship 3 in ECT, and whether or not involuntary ECT 4 should be ordered by the Court. 5 Q. Are you a member of any professional 6 organizations or associations? 7 A. At this point, although I participate in 8 several, I don't think I am a member of 9 any professional organization. 10 Q. Have you ever been a member of the 11 American Psychiatric Association, APA? 12 A. I used to be. 13 Q. Do you subscribe to any trade journals in 14 your field of medicine? 15 A. Fortunately, one of the benefits of being 16 a faculty member at Harvard Medical School 17 is I have access to any journal I want 18 through the medical school library system 19 so I don't need to subscribe. The medical 20 school does the subscriptions instead of 21 me. 22 Q. All right. Do you or have you in the past 23 performed Electroconvulsive Therapy on any 24 of your patients? 25 A. The only time that I can think where I may	Page 35 1 have been involved in that, although I 2 wasn't the primary person doing the ECT, 3 was very early on in my career, but not 4 since then. 5 Q. Have you ever had any training in 6 Electroconvulsive Therapy? 7 A. Part of standard residency training and 8 post residency was training in 9 Electroconvulsive Therapy. Actually, 10 beginning in medical school we were 11 exposed to it. 12 Q. Have you consulted with any physicians at 13 Harvard or anywhere else regarding this 14 case? 15 A. No. 16 Q. Does Harvard Medical Center have a 17 Electroconvulsive Therapy department? 18 A. There is no specific Electroconvulsive 19 Therapy department, but there are 20 physicians at Harvard Medical School in 21 our Department of Psychiatry who 22 regularly, who do administer 23 Electroconvulsive Therapy to carefully 24 sectioned and carefully monitored 25 patients.
Page 36 1 Q. Is that true today? 2 A. Yes. 3 Q. And is there a machine or machines at 4 Harvard in the hospital system itself 5 where they perform those therapeutic 6 treatments? 7 A. Yes. 8 Q. Do you know the manufacturer of those 9 machine or machines? 10 A. No. 11 Q. Do you know any of the physicians that 12 conduct Electroconvulsive Therapy 13 treatments at Harvard? 14 A. I believe there are several that do, yes. 15 I do know them, yes. 16 Q. All right. When you say several, is that 17 two or is that ten? Can you be more 18 specific? 19 A. Well, two come immediately -- one comes 20 immediately to mind and I think there may 21 be several other colleagues. I am just 22 not sure at this point who does what, how 23 often, how and so on. But I know of at 24 least one person who does it on a regular 25 basis.	Page 37 1 Q. All right. Can you tell me who that is 2 and any others that you know, physician or 3 physicians at Harvard that are currently 4 performing Electroconvulsive Therapy? 5 A. Dr. Kerry Bloomingdale is the person who I 6 know who regularly performs 7 Electroconvulsive Therapy. 8 Q. Any others? 9 A. None immediately come to mind. But I am 10 sure if you gave me enough time to think 11 about it, I could probably think of a few 12 others. 13 Q. Okay. Have you read Doctor Breggin's 14 deposition in this case? 15 A. Yes. 16 Q. Do you agree with his opinion that Clair 17 Johnson's manic symptomatology that 18 required hospitalizations in the past were 19 induced by her drug and alcohol problem? 20 A. Again, I haven't analyzed that so I don't 21 either agree or disagree with his opinion 22 as far as that is concerned. That has not 23 been the focus of my analysis. 24 Q. All right. Let's talk a little bit about 25 this case. Who were you first contacted

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1 by in this case? And what I have in front
2 of me and you is a series of letters. The
3 first one I have, I will tell you, is
4 tabbed as Letter Bursztajn 82310, which is
5 a cover letter from Mr. Ravenel to you.
6 A. Okay.
7 Q. Do you see that?
8 A. Yes.
9 Q. Whom were you first contacted by in this
10 case?
11 A. You know, I am not sure if it was by Mr.
12 Ravenel or by the client -- or his client.
13 I am just not sure. I believe it was Mr.
14 Ravenel but I wouldn't swear by it.
15 Q. Okay. Is that written anywhere in maybe
16 one of your bills, or would you have that
17 anywhere?
18 A. No. I know that my first substantial
19 contact was with Mr. Ravenel.
20 Q. All right. It is my understanding, after
21 deposing Ms. Maia, who is a friend of the
22 plaintiff --
23 A. Yes. She may have actually contacted my
24 office initially. I may have spoken with
25 her briefly over the phone.

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1 Q. It was Exhibit 2. Carol should have it.
2 A. All right. I think this is it but I am
3 just going to go through here and -- you
4 know what, I hope that everything I have
5 reviewed has made it into it because that
6 is what I wanted to do. It is possible I
7 may have omitted something, but hopefully
8 not. So --
9 Q. All right. Since I am looking at you on
10 video, what you have in front of you does
11 not look like what I have in front of me.
12 MR. EARLY: Madam Court Reporter,
13 could you hand him the most recent exhibit
14 that we just marked?
15 COURT REPORTER: Yes, he has it.
16 A. Let me show it to you. So there are the
17 notes and then there is an index.
18 Q. It may be out of order.
19 A. Okay. Is this any better?
20 Q. What I am looking at says List of
21 Materials Received as of July 25, 2013.
22 A. Yes. This should be somewhere here. Hold
23 on. Let's see. Yikes. You know, I don't
24 think that made it in here actually. It
25 should have but --

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1 Q. All right. Do you remember the substance
2 of that conversation?
3 A. No. I think it was primarily logistics.
4 I know I would have sent her my Curriculum
5 Vitae, which is what I usually do on
6 initial contact.
7 Q. Okay. Do you know how she found you?
8 A. No.
9 Q. Exhibit 2, which is I believe what I had
10 not seen, was going to be one of my
11 questions, what all have you reviewed in
12 this case.
13 A. Yes.
14 Q. And that looks like it is, in the first
15 portion of that exhibit, a letter dated
16 July 25, 2013, or yesterday.
17 A. Let me just see here. Yes, mm-hmm, yep.
18 Q. Is that the sum and substance of
19 everything you have reviewed in this case?
20 (Witness perusing document.)
21 A. You mean the index of materials here? I
22 -- let me just double-check here. I am
23 going to -- I just want to make sure I am
24 looking at the same thing that you're
25 looking at, so let me just make sure.

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1 Q. Look in the body of your Exhibit 2. Flip,
2 flip that exhibit that you have in your
3 hand, the other one.
4 A. Yes.
5 Q. Flip to the next page and see if that has
6 it, the exhibit that is laying down right
7 now, the Exhibit 2.
8 A. You know, no. Unfortunately, I don't
9 think it is there.
10 MR. EARLY: Madam Court
11 Reporter, just to help Doctor Bursztajn, I
12 think he just stacked up some records and
13 underneath that stack is an exhibit. So
14 you may want to check on that so it
15 doesn't get misplaced right there.
16 THE WITNESS: Okay.
17 MR. EARLY: Off the record,
18 please.
19 (Discussion off the record.)
20 MR. EARLY: Back on the record,
21 please.
22 Q. Doctor Bursztajn, we were off the record a
23 second ago, but the list of materials
24 received as of July 25, 2013, that was
25 apparently e-mailed to me this morning, is

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1 that the sum and substance of all the
2 materials you have reviewed in this case
3 in forming your opinion?
4 A. It is the sum and substance of all the
5 materials that I have reviewed and
6 analyzed, other than all the literature
7 that I reviewed and analyzed which I
8 haven't kept track of, but I have reviewed
9 and analyzed a variety of background
10 literature.
11 Q. All right, right. What I meant is the
12 factual information pertaining to the
13 details of this case, this list is the sum
14 and substance of all the materials that
15 you have been provided by either Ms. Maia
16 or Mr. Ravenel regarding the plaintiff,
17 Clair Johnson?
18 A. Yes, Mr. Early.
19 Q. Okay. And have you requested any, any
20 further material or data that you have not
21 received that you feel like you need in
22 rendering any opinions in this case?
23 A. Well, just any additional discovery that
24 will be developed in the course of
25 discovery. For example, if you proceed to

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1 updated on that.
2 Q. Other than any expert or fact witnesses
3 and their deposition testimony or reports,
4 there is nothing that you have requested
5 Mr. Ravenel to obtain from either myself
6 or Mr. Scott or our clients at this time,
7 correct?
8 A. Yes.
9 Q. All right. Okay. Well, let's kind of go
10 back to where we were.
11 My notebook that you have in
12 front of you, the first report I have
13 would be dated 11/1/10 and it is called
14 Analysis. Do you see that?
15 A. Let me just go to it. Give me one second.
16 Q. I am sorry. It says Analysis, 11/1/10
17 Initial. There are two different
18 documents on 11/1/10.
19 A. Let me just find it to be sure.
20 Q. Okay. Take your time.
21 MR. EARLY: I tell you what,
22 Doctor Bursztajn, both of us on our end
23 would like to take a quick restroom break.
24 THE WITNESS: No problem.
25 MR. EARLY: Okay. Five minutes.

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1 retain your own experts and they have
2 their reports, I would like to read them
3 and think about them and see what their
4 point of view is and see where the
5 differences may be between us. If there
6 are any additional facts that emerge
7 subsequent to this deposition, anything
8 that any party receives, please send it
9 along so that I receive it eventually so I
10 can go ahead and update my opinion.
11 Q. I understand that. But is there anything
12 right now as we sit here today that you
13 feel like you need based upon reviewing
14 this list in Exhibit 2 that you would need
15 to form or assist your opinions in this
16 case?
17 A. Not at this point in time.
18 Q. All right. Have you asked Mr. Ravenel to
19 request any additional documents other
20 than what any experts that I or Mr. Scott
21 may hire or give?
22 A. No. Unless there are any additional
23 factual witnesses that may emerge, I would
24 like to go ahead, any expert or factual
25 witness that may emerge, I do want to be

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1 THE WITNESS: No problem.
2 (Brief recess.)
3 MR. EARLY: Back on the record.
4 Q. Doctor Bursztajn, we are back on the
5 record. I had asked you to look for what
6 is tabbed Analysis 11 or November 1, 2010,
7 and it has got the word "initial" under
8 it. Do you see that?
9 A. You know, I think is it 2011 maybe that we
10 are looking at? I have an April 1, 2011,
11 not 2010.
12 Q. Well, keep going back in the notebook a
13 couple more tabs.
14 A. It was April 2011.
15 Q. I got that yesterday. But if you keep
16 going back, chronologically it says
17 November 1, 2010 -
18 A. The only -
19 Q. Analysis Initial.
20 A. The only thing I have here is one page but
21 I think that the page behind it is left
22 out. So no, it is not in here.
23 Q. Keep going, keep going.
24 MR. RAVENEL: There is an April
25 1, 2011.

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1 A. 2011, yes. There is a 2011 one but --
2 Q. Keep going.
3 A. It may be misfiled here because I don't
4 see it. You know, I don't know if it made
5 it into the notebook. What I have is an
6 April 1, 2011 one and I have a letter from
7 --
8 MR. RAVENEL: What is that there?
9 THE WITNESS: No. Maybe I am
10 missing it but I don't see it here, no.
11 It never made it into this notebook.
12 MR. EARLY: Okay.
13 Q. Well, I have a letter from you dated
14 November 1, 2010, and it says Initial
15 Analysis of Merit. And I think it was
16 essentially cut and pasted into the April
17 of 2011 portion of that where you were
18 just referencing, that letter as well.
19 A. I see.
20 Q. So maybe we can look at that together.
21 A. Sure, yes. Yes, I have that. I have the
22 April 1, 2011 one.
23 Q. And it says "draft" on it?
24 A. Yes, yes.
25 Q. All right. If you will look, Doctor

1 Bursztajn, at the bottom of that, the
2 first page of that letter, the last
3 sentence says, "I have also treated and
4 performed forensic evaluations of numerous
5 victims of trauma, including traumas
6 caused by human agency," A-G-E-N-C-Y,
7 "such as medical iatrogenesis."
8 Did I read that right?
9 A. Yes.
10 Q. All right. Have you ever tested anyone or
11 done any type of testing that you believe
12 resulted from trauma that you believe was
13 resulted from Electroconvulsive Therapy
14 prior to Clair Johnson?
15 A. Yes.
16 Q. On how many occasions have you done that?
17 A. Over the course of the past 30 some odd
18 years, it is infrequent so, you know,
19 somewhere between five to seven times.
20 Q. And what was the context of that testing
21 done in, why were you testing those
22 particular individuals?
23 A. To check for their competency, to check
24 for their level of impairment, to check
25 for reasonable accommodations for their

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1 level of impairment, to consult to other
2 physicians about what kind of treatment or
3 therapy might be helpful.
4 Q. These were patients who had already
5 undergone Electroconvulsive Therapy?
6 A. Yes.
7 Q. Were any of these done in the litigation
8 context?
9 A. No.
10 Q. And were the tests that you performed on
11 Clair Johnson, all of those tests, same
12 tests performed on these five to seven or
13 eight or how many patients you have done
14 this on in the past?
15 A. Yes.
16 Q. All right. And what is the purpose of
17 that testing as it relates to trauma as
18 you state in this sentence?
19 A. First, to evaluate whether or not the
20 patient may be either misreporting, either
21 underreporting or exaggerating their level
22 of impairment. Secondly, to evaluate what
23 the cause of their impairment was. Third
24 of all, to go ahead and to make
25 recommendations as to whether there was a

1 need for guardianship, whether there is
2 some other accommodation that needs to be
3 made, and what kind of treatment or
4 therapy the person may be best responsive
5 to or most helped with.
6 Q. All right. And you had indicated that
7 part of the testing was to determine what
8 the cause of the impairment was.
9 How do you determine through this
10 testing that the cause of the impairment
11 was due to Electroconvulsive Therapy
12 versus some other type of either trauma or
13 nontraumatic experience?
14 A. By reviewing, my integrating the results
15 of the unstructured and structured
16 interview and the psychological testing
17 with a review and analysis of all the
18 available medical and in some instances
19 legal records.
20 Q. And have you ever conducted any brain
21 imaging studies such as either a CT scan
22 or MRI on any of these patients?
23 A. I have in several instances made a
24 recommendation. I haven't conducted the
25 study myself. I made a recommendation

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1 that such neuroimaging studies be
2 obtained.
3 **Q. All right. And you presumably contacted a**
4 **radiologist for that or a**
5 **neuroradiologist?**
6 **A. Or simply the referring physician who was**
7 **the treating physician.**
8 **Q. Okay. And have you reviewed either any of**
9 **the reports or the images themselves from**
10 **any of those patients?**
11 **A. I have reviewed the reports. The images**
12 **themselves, although I have reviewed them,**
13 **I don't rely on my review of them. I**
14 **would rely on the report itself.**
15 **Q. All right. You are not a radiologist,**
16 **correct?**
17 **A. Yes.**
18 **Q. And you are not a neurologist, is that**
19 **fair?**
20 **A. Yes.**
21 **Q. And are you qualified to render any**
22 **opinions that any, anything you see on**
23 **either a CT or MRI resulted from trauma**
24 **that you believe is associated with**
25 **effects from Electroconvulsive Therapy?**

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1 the bottom of page two.
2 **A. That is the standard shorthand in the**
3 **State of Massachusetts for letting the**
4 **examinee know that I do not have a**
5 **doctor/patient relationship with them, I**
6 **won't be prescribing any medications, I**
7 **won't be treating them in any way, that**
8 **anything that they say to me will not have**
9 **the protection of confidentiality, that it**
10 **also says who retains me and it informs**
11 **the patient that once the decision is made**
12 **to have me present my testimony I will**
13 **need to testify honestly about anything**
14 **that they say to me, so that the usual**
15 **protections of confidentiality in the**
16 **doctor/patient relationship which are even**
17 **higher in a psychiatric, psychiatric**
18 **relationship, will not apply in this**
19 **instance.**
20 **Q. I understand that a LAMB Warning was given**
21 **to both Ms. Mala and Clair Johnson.**
22 **A. Yes.**
23 **Q. Okay. Looking at page three of this draft**
24 **analysis, you, E, midway through the**
25 **pages, talk about relevant literature.**

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1 **A. I am competent to integrate reports from**
2 **radiologists or neuroradiologists into a**
3 **forensic neuropsychiatric opinion as to**
4 **what the cause is of someone's structural**
5 **deficits.**
6 **Q. All right. You are not going to do this**
7 **in this case by looking solely at either**
8 **the scan or the radiology report that was**
9 **done on Ms. Johnson, are you?**
10 **A. Correct.**
11 **Q. All right. Have you seen any of the**
12 **imaging scans themselves for Ms. Johnson**
13 **either done in 2002 or the one most**
14 **recently that was ordered by Expert**
15 **Breggin?**
16 **A. Yes.**
17 **Q. And you have actually seen the scans?**
18 **A. Yes.**
19 **Q. All right. And you are not going to**
20 **render any opinions based upon those scans**
21 **themselves, I believe you just told me,**
22 **correct?**
23 **A. Yes.**
24 **Q. All right. Doctor Bursztajn, what is a**
25 **LAMB Warning? I see reference to that in**

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1 **A. Yes.**
2 **Q. And did you pull and read all 51 of those**
3 **articles in preparing for this report and**
4 **your opinions in this case?**
5 **A. They form part of the background and I**
6 **have considered them as background.**
7 **Q. All right. Number eight is an article**
8 **that you either wrote or co-wrote on page**
9 **four, at the top of page four. Do you see**
10 **that?**
11 **A. Yes.**
12 **Q. Can you give me briefly the gist of that**
13 **article?**
14 **A. Yes. That it is not just a matter of**
15 **cognition or anything, but also in some**
16 **instances such as, for example, when**
17 **someone is feeling overwhelmingly**
18 **depressed or helpless and hopeless and**
19 **worthless, they may not be able to become**
20 **sufficiently competent to give meaningful**
21 **informed consent to treatment. By**
22 **meaningful informed consent, when it is**
23 **the standard of being able to understand**
24 **and appreciate the risks, the benefits,**
25 **and the alternatives of a recommended**

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1 treatment. It is not just thinking but
2 feeling, which makes -- it is not just a
3 problem with thinking but can also be a
4 problem with overwhelming emotions,
5 overwhelming feelings.

6 **Q. All right. You are not going to testify**
7 **or state to a jury that Ms. Johnson was**
8 **depressed or helpless or feeling hopeless**
9 **when she presented to the hospital and was**
10 **an inpatient in a manic state, are you?**

11 **A.** Beginning -- there is -- the simple answer
12 is she was never appropriately evaluated
13 for that, but it is a reasonable inference
14 that at that point in time she may well
15 have been.

16 **Q. Even when she was manic?**

17 **A.** Even when she was manic, she was not
18 competent.

19 **Q. Okay. Understand. And you agree that she**
20 **was rendered incompetent by at least two**
21 **physicians on those occasions when she was**
22 **given involuntary ECT at the Medical**
23 **University of South Carolina, correct?**

24 **A.** We agree and I think it is a reasonable --
25 what I disagree with is the process of

1 evaluation. But I think it is a
2 reasonable inference that she was
3 incompetent when she was manic. What I
4 fail to see in the evaluation is any
5 appropriate evaluation for competence by
6 either of these two physicians, or any
7 attempt to make her or to restore her to
8 competence prior to involuntary ECT.

9 **Q. Okay. Just so I understand that, you are**
10 **not disagreeing that she was incompetent**
11 **during that time period. You just**
12 **disagree with the process by which these**
13 **physicians determined that she was**
14 **incompetent. Is that fair?**

15 **A.** Yes. And the fact that they took no steps
16 once they made the determination, short of
17 ECT, to try to bring her back to
18 competence prior to instituting ECT.

19 **Q. Okay. All right. Other than the**
20 **medication regimen that she had tried and**
21 **been tried on in the past, what else**
22 **should they have done to try to, as you**
23 **put it, restore her competency prior to**
24 **the ECT when she was an inpatient for her**
25 **manic symptoms?**

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1 **A.** First of all, they could have initiated a
2 course of medication which had not been
3 tried before such as Klonopin, for
4 example, on an acute basis which can at
5 least in some instances control a manic
6 episode. Also, Ativan can be used for
7 control of an acute manic episode. There
8 is a variety of -- they could have also,
9 tried again to use medication which had
10 not previously been successful, because it
11 was a different setting, by combining it
12 with psychotherapy. Most importantly, to
13 the extent that there was a fundamental
14 issue whether there was some conflict of
15 interest in helping hospitalize, in the
16 hospital where her brother-in-law, I
17 believe, was the Chair of the Board of
18 Trustees and where her husband had
19 admitting privileges, and given the fact
20 that there was obviously some family
21 stress which ultimately culminated in a
22 divorce, she could have been offered the
23 option of being transferred to a different
24 hospital where there would not have been
25 the same fundamental conflict of interest

1 which would have been a foreseeable
2 stressor, which was a foreseeable stressor
3 which, if she was already depressed and
4 somewhat paranoid, would have made her
5 feeling more helpless, more hopeless, more
6 frightened and, therefore, more paranoid.
7 So certainly, those are some of the simple
8 steps which could have been taken to
9 restore her to competence prior to
10 instituting involuntary ECT. The
11 evaluation --

12 **Q. Okay.**

13 **A.** The evaluation itself should have taken
14 those factors into account. And this
15 simply did not happen, from what I can
16 see, and from everything I have reviewed
17 so far.

18 **Q. All right. Klonopin and Ativan are what?**

19 **A.** They are benzodiazepines which can be used
20 to control overwhelming fear and terror
21 which often compounds any other kind of
22 effective instability, resulting in a
23 manic episode.

24 **Q. All right. And you had indicated they**
25 **should have combined or tried to combine**

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1 this with psychotherapy. You are aware
2 that Ms. Johnson was seeing an outside
3 psychiatrist at this time, correct?

4 A. She was. But from what I can tell, that
5 was relatively -- there was no meaningful
6 psychotherapy which addressed the
7 fundamentally terrifying issues to her of
8 -- this is someone who had been adopted as
9 a child to begin with -- of being
10 abandoned and being divorced.

11 Q. Well, you do agree that she was seeing an
12 outside psychiatrist at this time,
13 correct?

14 A. Yes, Doctor Roberts.

15 Q. And you had mentioned that her
16 brother-in-law was the Chair of the Board
17 of Trustees. Did you -- you read Dr. John
18 Johnson's deposition, correct?

19 A. Yes.

20 Q. And in his deposition he testified under
21 oath that he did not know any of the
22 physicians that were treating Ms. or his
23 now ex-wife at the Institute of Psychiatry
24 at the Medical University of South
25 Carolina, correct?

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1 institution where her husband was on the
2 staff, where there were family
3 relationships, should not be surprising to
4 anyone. It wouldn't be surprising to you
5 in the law firm analogy. The fact that
6 she wasn't -- when she came in manic, it
7 wasn't at least some recommendation made
8 to her parents that she should be
9 transferred to another institution so
10 things could be sorted out is way below
11 the standard of care.

12 Q. Okay. Doctor Bursztajn, in every
13 instance, to be fair, in every instance
14 where Doctor Johnson consented or signed a
15 consent on behalf of Clair to be treated,
16 you agree that the parents also consented
17 and agreed to this same treatment.
18 Correct?

19 A. What I would say is that neither Doctor
20 Johnson nor the parents gave meaningful
21 informed consent, only pro forma informed
22 consent. And they were not informed of
23 this fact that there was a potential
24 conflict of interest which was a stressor.
25 Neither Doctor Johnson was informed of

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1 A. That is what he said. But it doesn't mean
2 that none of them knew him and that they
3 didn't know that he was affiliated with
4 the same institution.

5 If one of my colleagues was to
6 send his obviously somewhat estranged wife
7 to me for treatment, I would refer her to
8 someone else because I would feel that as
9 a colleague I cannot go ahead, I would
10 have a conflict of interest. It is a
11 little bit like if, let's say, someone in
12 your law firm was getting divorced and
13 they asked one of the, asked you, Can I
14 send my wife to you to represent her. You
15 would say no, I have a potential conflict
16 of interest, even if you never met the
17 guy. Let's say you work for a huge law
18 firm, right, you still would say no, they
19 really should seek another firm to
20 represent her. Similarly here. Divorce
21 itself is an extremely stressful and
22 anxiety-provoking time for anyone. For
23 someone who was as vulnerable as Clair
24 was, it was terrifying. The fact that she
25 would not feel safe and secure in the

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1 this, from what I could tell, although
2 eventually he brought it up himself, nor
3 were her parents informed of this.
4 Whereas, at a minimum the people who
5 signed an informed consent form should
6 have been informed that one alternative to
7 ECT was simply to transfer her to an
8 institution where there was no potential
9 conflict of interest, where she could --
10 where there was at least some potential
11 for a meaningful therapeutic alliance to
12 be formed so that meaningful medication
13 and psychotherapy could be tried before
14 resulting to involuntary ECT to either
15 treat her or arguably restore her to
16 competence.

17 Q. Okay. And Ms. Johnson had been to
18 numerous hospitals across South Carolina
19 prior to coming in to MUSC?

20 A. She had had prior hospitalizations at
21 different institutions and in no instance
22 that I can tell was it necessary to use
23 involuntary ECT. This was the first and
24 only occasion that I know of unless you
25 tell me otherwise.

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1 Q. Well, I am not telling you otherwise. But
2 she had been involuntarily hospitalized on
3 numerous occasions at other hospitals
4 throughout the South Carolina area. You
5 are aware of that, correct?

6 A. Yes. And she had always been restored to
7 competence without the need to resort to
8 involuntary ECT, which carries its own
9 risks of a post-traumatic disorder,
10 complicating the mood disorder,
11 complicating, potentially, the bipolar
12 illness that she was suffering from.
13 Never before during any involuntary
14 hospitalization had there been a necessity
15 to use involuntary ECT.

16 Q. Oh, okay. You are not going to testify
17 that ECT was not indicated when it was,
18 when it was first performed on Clair
19 Johnson in December 2003, are you?

20 A. It was not indicated because there were
21 other measures which could have been done,
22 other alternatives which have a more
23 favorable benefit risk ratio, especially
24 when administered on an involuntarily
25 basis.

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1 tell you once I refresh my memory how it
2 contributes to my opinion.

3 Q. All right. Well, did you read it prior to
4 preparing this report?

5 A. Yes.

6 Q. All right. How about number 38,
7 "Long-term Maintenance ECT: A
8 Retrospective Review of Efficacy in
9 Cognitive Outcome?

10 A. Again, I would --

11 Q. What is the gist of that article? Can you
12 tell me without referring to it or not?

13 A. I would need to refer to it to give you a
14 meaningful answer.

15 Q. Do you have these articles pulled already,
16 Doctor? I know you are a member of
17 Harvard Medical Center so you don't have
18 to actually pull them.

19 A. No, I go ahead online and read them
20 online. That saves a lot of paper and a
21 lot of trees.

22 Q. Sure. So you haven't actually printed any
23 of these articles?

24 A. No. I try to go as paperless as I
25 possibly can.

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1 Q. Such as Ativan and Klonopin?

2 A. Such as transfer to another institution
3 and then attempting to treat her with a
4 combination of a variety of different
5 kinds of medications and psychotherapy,
6 while removing the foreseeable stressor
7 that she was in an institution which was
8 her husband's institution, she would
9 identify as being her husband's
10 institution in the midst of a potential
11 divorce hanging over her head.

12 Q. All right. Okay. All right. Looking,
13 keeping in tune with this April 1, 2011
14 report, on page five, number 28 is titled
15 Neuropsychiatric considerations in the use
16 of Electroconvulsive Therapy.

17 Can you give me the gist of that
18 article and in what way it bears on your
19 opinions in this case?

20 A. I would have to consult the article to
21 reconstruct how it contributed to the
22 background, and I don't have the article
23 in front of me. However, if you would
24 like me to, I can simply go ahead and take
25 the article again and then specifically

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1 Q. I understand. The reason I ask is it
2 costs me money to get them and it doesn't
3 cost you any money to get them.

4 A. If you go to the University of South
5 Carolina, they should be able to pull all
6 of these articles to you, for you, without
7 any additional cost. I would guess that
8 for some of them they had the same,
9 substantially, as Harvard Medical School
10 does. There may be a few that they don't,
11 but for most of them they should.

12 Q. All right. In looking at the bottom of
13 page six, Doctor Bursztajn, the last
14 sentence, you refer to some severely
15 impaired mental capacities including
16 reality testing.

17 Can you tell me what you mean by
18 that, Doctor Bursztajn?

19 A. I can, Mr. Early, except I see Carol is
20 having problems. We are having noise
21 coming in again. I don't know if that is
22 a problem. There seems to be some
23 background noise. Would you mind
24 repeating your question maybe because it
25 was very, it came across in a very, with

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1 lots of background noise.
2 **Q.** Sure. I am asking about your last
3 sentence on page six.
4 **A.** Right.
5 **Q.** You say that, talking about Ms. Johnson,
6 she was having some severely impaired
7 mental capacities in and around 2003. And
8 my question is what you are referring to.
9 Is that a symptom or is that a -- what are
10 you referring to there? What do you mean
11 by that?
12 **A.** If I may go ahead and refer to my notes
13 because what I tried to do, I tried to
14 type parts of the medical record so I
15 could easily read it. So do you mind if I
16 refer to my notes?
17 **Q.** Please do. But what I would ask is at the
18 end of the deposition if we could mark a
19 copy of that as well and mark that --
20 **A.** That is Exhibit 2. That is the index of
21 materials that you see.
22 **Q.** Okay. I thought you meant handwritten
23 notes.
24 **A.** No, no, no. What I did was I tried to
25 have typed those passages that might be

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1 **Q.** Notes for Deposition Preparation?
2 **A.** Yes.
3 **Q.** And the one today dated, titled Parties.
4 I don't have anything that says the Index
5 of Materials.
6 **A.** You don't? It should have been sent
7 because I --
8 **THE WITNESS:** Wasn't it sent?
9 **MR. RAVENEL:** Yes.
10 **THE WITNESS:** Yes, it was sent
11 apparently.
12 **MR. EARLY:** Well, I didn't get
13 it, but Mr. Scott did and he printed it
14 off what he got sent and brought it here,
15 which is in front of me, and that is not
16 in that.
17 **THE WITNESS:** Are you sure you
18 printed everything? Was there an
19 attachment maybe that was not printed?
20 **MR. SCOTT:** I am not sure. This
21 was done by my paralegal. I didn't even
22 go into the office this morning so I don't
23 know.
24 **MR. EARLY:** Let's go off the
25 record for one second.

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1 useful as references. So let me look.
2 And it is an annotated index of materials
3 with my annotations.
4 **Q.** Okay.
5 **A.** So let's see. Where was it? There it is.
6 Okay.
7 I am looking at page 29 of my
8 notes, page 29 of the index of materials.
9 **Q.** We are obviously not on the same page
10 because I don't have anything that's even
11 near 29 pages.
12 **A.** Do you have my -- you have my index of
13 materials. Those were in the three
14 documents that were marked and you had
15 received it.
16 **Q.** Is it dated July 25, 2013?
17 **MR. RAVENEL:** Yes.
18 **A.** Yes.
19 **MR. RAVENEL:** Index of
20 Materials.
21 **MR. EARLY:** Okay. All right.
22 **Q.** The only three things I have that are on
23 that date are a list of materials
24 received.
25 **A.** Yes.

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1 (Brief recess.)
2 **MR. EARLY:** Back on the record.
3 Madam Court Reporter, could you
4 -- my last question, I believe, could you
5 please read it back to me?
6 (Record read back as requested.)
7 **MR. EARLY:** Thank you.
8 **Q.** Doctor Bursztajn, on the bottom of page
9 six of the letter that we have been going
10 over, your April 1, 2011 letter to Mr.
11 Ravenel, the last sentence, you indicate,
12 "In or around 2003, she," being Ms.
13 Johnson, "manifested severely impaired
14 mental capacities."
15 And my question I think before
16 the break was what you were referring to
17 there, and then you wanted to look at your
18 notes which I haven't gotten. So would
19 you read me what you are talking about?
20 **A.** What you will be getting is page six of my
21 notes. And it refers to the medical
22 record, to Dr. John Roberts' medical
23 record. And the date on that is September
24 12, 2003. And in his medical record he
25 says that she is grandiose, that she is

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1 hypervigilant and paranoid. Parents and
2 friends worried about her. Afraid that
3 she is unsafe driving. Says she is not
4 taking Concerta, losing and misplacing
5 things.
6 Then later on, if we continue
7 here, we have a note from October 28,
8 2003, which says that she is hypomanic.
9 It is page seven of my notes, so when you
10 get my notes it will be clearer.
11 "Thinks Will's wife (divorce
12 final this month) is one who persecuted
13 her and had her committed from hotel rooms
14 since 1997." So again, she is paranoid at
15 this point.
16 There was a note here on November
17 17, 2003, it is page 47 of Doctor Roberts'
18 notes, which indicates that she is
19 irritable and grandiose, paranoid,
20 delusional, impulsive spending, and so it
21 goes.
22 I can give you a bunch of other
23 examples, but those are illustrative. But
24 they are all in the medical record and you
25 will find them all in the medical record.

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1 she did not have any problems that she
2 related to others from ECT prior to June
3 of 2010, are you?
4 A. I am not testifying as to that way, no.
5 That is not my opinion.
6 Q. All right. In fact, she relayed to
7 physicians and others that she believes
8 she was having problems with ECT as early
9 as early 2009, didn't she?
10 A. Yes.
11 Q. All right. Just for the record, and
12 Doctor, the gentlemen walked in and handed
13 me now your notes so I have them.
14 A. Oh, good. That will save us time, yes.
15 Q. Okay. Great. All right. Looking at page
16 eight.
17 A. Okay.
18 Q. Your examination observations, you had
19 indicated earlier that you met with Ms.
20 Johnson for between four and five hours at
21 some point prior to this letter. Correct?
22 A. Yes. I met with her specifically, I can
23 give you the specific date here, it was --
24 one second. Date of my exam, January 31,
25 2011.

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1 Q. Okay. All right. And those type of
2 symptoms are indicative of a manic
3 patient, are they not?
4 A. Of a hypomanic, a patient suffering from
5 either hypomania or manic impairment or
6 someplace in the spectrum.
7 Q. All right. You weren't referring, when
8 you said mental capacities, to anything
9 referencing her memory, were you?
10 A. No, not at that point, no.
11 Q. All right. Okay. And the vast portion of
12 the next two pages of that letter, I
13 believe and you can correct me if I am
14 wrong, pages seven and at least the top of
15 page eight are dealing with your opinion
16 that she didn't gain enough mental
17 capacities until June of 2010 to
18 appreciate any harm from ECT.
19 Is that a fair statement without
20 going through it all?
21 A. It is a fair statement to say that it
22 wasn't until June 2010 that she could
23 appreciate what harm had been done to her
24 by the ECT.
25 Q. All right. You are not testifying that

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1 Q. Okay. And she came to your office with
2 her friend Anna Maia, correct?
3 A. Yes.
4 Q. Was Mr. Ravenel also present or was it
5 just the two of those ladies?
6 A. It was just Clair Johnson and Anna Maia.
7 Q. Okay. Looking at number two of your
8 examination observations, and I may skip
9 out of order here but you state, "Although
10 Ms. Johnson was made vulnerable to
11 cognitive impairment by bipolar disorder
12 and a history of head trauma," and it goes
13 on from there.
14 You agree with me that bipolar
15 disorder and specifically depression
16 itself can also cause memory loss in and
17 of itself. Agree?
18 A. It can cause some kinds of memory
19 impairment, but not the kind that she was
20 experiencing and that she was reporting.
21 Her pattern of cognitive impairment is
22 much, is not consistent with depression
23 per se. It is consistent with a
24 subsequent brain injury caused by ECT.
25 Q. Would it also be consistent with a chronic

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1 long-term alcohol and illegal drug user?

2 A. It would not be consistent with most forms

3 of long-term alcohol or drug use.

4 Specifically, the areas that she mentioned

5 were much more areas which are in the

6 frontal lobe, in the areas where the ECT

7 would be functioning and, as we understand

8 the mechanisms of the ECT, the ECT, if it

9 is administered for too long and it is

10 given too much, can impair. There were

11 other kinds of memory impairments which

12 would be consistent with long-term alcohol

13 use or many kinds of substance use.

14 Q. That she exhibited in her testing,

15 correct?

16 A. That overall the pattern is much more

17 consistent with the kind of impairment one

18 would expect from 80 plus ECT's.

19 Q. Okay. You will concede that some of the

20 findings from her examinations are

21 consistent with a person who has a history

22 of long-term alcohol and drug abuse, won't

23 you?

24 A. There was some overlap, but as far as the

25 whole is concerned, no. And moreover, the

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1 was manifested in my examination.

2 Q. All right. You will concede that after

3 she became unemployed and even after she

4 was married, that her mother or at least

5 her medical records show that her mother

6 found an illegal drug pipe in her

7 belongings. Do you remember seeing that?

8 A. Yes.

9 Q. All right. Do you have any reason to

10 disagree with that?

11 A. No.

12 Q. All right. Do you agree that long-term

13 depression can also cause physiological

14 changes in the brain?

15 A. That is a matter of controversy at this

16 point. It is certainly a possibility but

17 the kinds of changes which it can -- which

18 could conceivably be attributed to

19 long-term depression are not the kinds of

20 impairments that she was manifesting on my

21 examination and that have also been

22 confirmed by observation of her, of Chip,

23 for example.

24 Q. Of what?

25 A. Of Chip Craver, her brother.

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1 reason why I mentioned her prior history

2 is that prior, since her alcohol and drug

3 abuse was many years ago, you would expect

4 it would have -- she would not have been

5 able to, for example, receive a B.A. in

6 public affairs if the impairments, if she

7 had had the impairments subsequent to ECT,

8 prior to ECT. So overall, it is not

9 consistent. I mean I considered it

10 initially as part of the differential

11 diagnosis, but it is just not likely that

12 the fundamental impairments which she was

13 exhibiting in my office on my examination

14 are the impairments from alcohol and drug

15 use, which she had engaged in many years

16 prior.

17 Q. All right. What is your understanding of

18 the last time or time frame where Ms.

19 Johnson was engaging in illegal drug use?

20 A. That is not clear to me. But what is

21 clear to me is that she, again, was able

22 to be employed in a business and had past

23 accomplishments which were just not

24 consistent with substantial impairment

25 from alcohol and drug use of the kind that

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1 Q. Her brother, sorry?

2 A. Her brother, Chip Craver.

3 Q. All right.

4 A. And they were not consistent with what has

5 been reported in the medical record in

6 terms of prior to 2003. She simply did

7 not have the kind of, these kinds of

8 impairments before the ECT.

9 Q. All right. Looking down at the last

10 sentence, if you will, of number two on

11 that page, page eight, you indicate, "In

12 any case, her ongoing impairments indicate

13 how severely impaired she is likely to

14 have been throughout that course of ECT."

15 Where did you get that

16 information and what evidence did you have

17 that she was severely impaired by looking

18 at her medical records during her course

19 of ECT?

20 A. For one thing, she was judged to be

21 incompetent and in need of involuntarily

22 ECT. If she was not severely impaired at

23 that point in time, why would she be

24 judged as being incompetent and getting

25 involuntary ECT?

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1 We can also go through specific
2 pieces of the record and we can talk about
3 significant pieces of impairment which you
4 saw that.
5 **Q. When you say severely impaired, you are**
6 **talking about her competency and not her**
7 **mental status. Is that fair?**
8 A. Her competency is a function of her mental
9 status or it should be a function of her
10 mental status.
11 **Q. Well, maybe I said it wrong. Memory loss,**
12 **you are not talking about anything to do**
13 **with memory loss at that time, correct?**
14 A. Correct.
15 **Q. Okay. That is what I was getting at.**
16 **Looking at the bottom of that page, on**
17 **number three you indicate that this**
18 **selective impairment is consistent with**
19 **other indications in the record.**
20 What are you referring to there,
21 Doctor Bursztajn? What other indications
22 in her record are you referring to?
23 A. She begins to -- let me just look at the
24 record and I can address that. I am going
25 to look at the index of materials now so

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1 a paranoid state. So what we have here is
2 the first and voluntary administration of
3 ECT to someone who is already feeling
4 helpless and terrified, compounding the
5 helplessness and the terror. She becomes
6 more paranoid at times, not less paranoid
7 with the ECT. That is what I am referring
8 to. We can go to the specific notes if
9 you would like me to in the medical
10 record, but that is what I am referring
11 to.
12 **Q. Okay. Are you testifying that her mania**
13 **was driven by her feelings of helplessness**
14 **and terror because she was going to have**
15 **ECT, and that was the reason that she was**
16 **hospitalized?**
17 A. No. That would be a caricature of what I
18 just said. I am sorry if I
19 miscommunicated it to you so that you
20 heard it that way.
21 What I am saying is that to the
22 extent that her mood swings between
23 depression and mania were indicative of
24 feelings of helplessness, hopelessness,
25 worthlessness and fear, to the extent that

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1 --
2 **Q. I've got it now.**
3 A. Okay. Now, in terms of your question,
4 would you just mind repeating your
5 question one more time because I want to
6 be sure I am answering it specifically.
7 **Q. Well, I guess I'm asking a question that**
8 **you state in your letter, you talk about**
9 **other indications in the records that deal**
10 **with her maintaining difficult --**
11 **maintaining attention, etcetera?**
12 A. No, no, no.
13 **Q. And I am simply asking what you are**
14 **referring to.**
15 A. Well, if you read to page nine, I think
16 the problem is it is consistent with
17 indications in the records that both the
18 ECT itself and its first administration
19 over an extended period of time
20 constituted a significant traumatic
21 experience for Ms. Johnson, involving
22 feelings of helplessness and terror. And
23 the record is filled throughout her ECT
24 course of feelings of helplessness and
25 terror which often manifest themselves in

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1 she presented herself as being delusional.
2 **Q. Okay.**
3 A. To that extent, the involuntary
4 administration of ECT compounded those
5 feelings and made things worse, not
6 better. And this should have been clearly
7 part of the ongoing evaluation. And there
8 were notes in the record here, if I may go
9 ahead and refer to them, which go ahead
10 and state -- I am looking at page 34 of my
11 notes.
12 **Q. What page?**
13 A. 34, page 34.
14 **Q. Okay.**
15 A. And if you read that last sentence there,
16 "She has been undergoing ECT with a fair
17 to poor response. Her insight into her
18 treatment on this is very impaired."
19 So what we have here is not that
20 the ECT is helping her, but it raises a
21 question which would need to be evaluated,
22 is the ECT actually hurting her. If you
23 go down further, on December 12, 2006,
24 "Angry over ECT, it is forced and it is
25 not helping," so the patient is telling

Page 82 1 you it is not helping. The designated 2 examiner says it is a fair to poor 3 response. What we have here -- 4 Q. Well -- 5 A. -- as we go through this course is the 6 fact that the patient is receiving massive 7 doses, repeatedly, of ECT without any 8 clear indication, clear indication that it 9 is being helpful to her, and there is some 10 question which the patient feels it is 11 actually being worse, and the fact that it 12 is involuntary is going to be a 13 foreseeable trauma and that is not being 14 addressed by psychotherapy, that is not 15 being addressed by trying to transfer her 16 to another setting where she might be less 17 frightened, given her husband and her 18 husband's connections to the hospital she 19 is in. Nothing is being done to address 20 this except more ECT and more involuntary 21 ECT. This is a problem and it is a very 22 very very serious problem. 23 Q. Well -- 24 A. Look, if you were basically advising the 25 hospital from a risk management point of	Page 83 1 view or from a -- and they said to you, 2 you know, we have someone who is married 3 to someone on our staff and, by the way, 4 his brother is the Chair of the Board of 5 Trustees and she is really complaining, 6 and she has herself brought up in 2003 the 7 idea that there was a conflict of interest 8 there, it was a conflict of interest, 9 wouldn't you advise them at that point to 10 recommend that she be transferred to 11 another hospital and another setting to 12 see whether she might have a better 13 response than this. I mean -- 14 Q. Doctor, I am going to let you talk about 15 the conflict of interest, but I was simply 16 asking you to refer to any records that 17 you referred to or that you were talking 18 about on number three of page eight. 19 A. Right. 20 Q. And so if you could just answer my 21 question, I will try to get through it a 22 lot faster. 23 A. Okay. 24 Q. Since you wrote that, is there any 25 indication that Doctor Faust knew that
Page 84 1 Clair Johnson's husband might have been 2 associated with the medical university in 3 any way when he saw her? 4 A. It should have been his business to find 5 out if he didn't know. That is not the 6 issue. The issue isn't did he know or 7 didn't he know. The issue is should he 8 have known. It is part of a family 9 history that the psychiatrist takes when 10 you are treating a patient as to a patient 11 going through a divorce as to what her 12 spouse's or ex-spouse-to-be's job is or 13 what the connections may be and why isn't 14 the patient responding. Most patients 15 should respond extremely well between six 16 to 12 sessions of ECT. She is not 17 responding extremely well. What is the 18 problem here? 19 The evaluation is not being done. 20 I don't see any evaluation being done for 21 why she hasn't responded with -- I mean I 22 have had patients who have responded 23 within three sessions to ECT. Why hasn't 24 she responded to the ordinary course of 25 ECT? That evaluation is not being done.	Page 85 1 If you look at the NICE Guidelines, that 2 evaluation needs to be done when the 3 patient isn't responsive to a limited 4 number of ECT's. You don't go up to 80 5 without doing the evaluation. 6 Q. All right. Let's go further in the letter 7 because I don't want to get too bogged 8 down in extraneous stuff. But if you look 9 at number four, you indicate Ms. Johnson 10 self reports an examination consistent 11 with a persistent failure on her part for 12 her treating clinicians to obtain her 13 informed consent. 14 Is that a self report she gave 15 you at the examination in January of 2011 16 or is that something you saw in the 17 records? 18 A. It is something which the records failed 19 to evaluate for even, and it is primarily 20 based on my observations of how helpless 21 she appeared to be when she talked about 22 the involuntary nature of the ECT and when 23 she talked about the boundary violations 24 committed by Doctor Roberts and her 25 treating clinicians in treating her in a

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1 hospital where she was protesting there
2 was a conflict of interest. These were
3 boundary violations fundamentally. A safe
4 place was not created for the patient.
5 Again, that is the -- that is fundamental.
6 To treat a patient who is feeling so
7 frightened that she is paranoid and so
8 helpless, you need to treat her in a safe
9 setting. If she is complaining of a
10 conflict of interest and there is a
11 reasonable conflict potential for someone
12 perceiving it as being a conflict of
13 interest, you are going to transfer her to
14 another institution where that won't
15 exist, that won't get in the way of the
16 therapeutic alliance. That was never,
17 from what I can tell, considered. It
18 never happened.
19 **Q. All right. Did her parents to your**
20 **knowledge ever raise any conflict issues**
21 **during their discussions with the doctors**
22 **or their consents?**
23 **A.** They were not in a position to do so.
24 Most lay people are not. It is remarkable
25 --

1 **Q. Most what?**
2 **A.** Most lay people -- I mean lawyers would
3 be. You know, if -- I am sure if this was
4 your loved one, you would be. But to the
5 extent that people are not lawyers for
6 hospitals, they wouldn't have enough
7 knowledge to be able to raise it as an
8 issue.
9 What is amazing is that she
10 herself did raise it as an issue as early
11 as 2003.
12 **Q. All right. Again, are you aware of any**
13 **situation where Doctor Johnson consented,**
14 **when either of her parents did not consent**
15 **to her having involuntary ECT, yes or no?**
16 **A.** There was -- I can't answer that question
17 as a yes or no. What I can say is that
18 neither Doctor Johnson or her parents gave
19 any reasonable consent, only pro forma
20 consent for ECT. So whenever he gave pro
21 forma, so did they. But there was no
22 meaningful informed consent either with
23 Doctor Johnson or with her parents.
24 **Q. And the basis of that is what? Have you**
25 **reviewed the medical records in this case?**

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1 **A.** I have in detail.
2 **Q. All right. And tell me the basis of them**
3 **not getting any informed consent or giving**
4 **any informed consent?**
5 **A.** Any meaningful informed consent is a
6 process, any pro forma. The only informed
7 consent that I could mention or informed
8 consent that I could find were either very
9 brief notations saying informed consent
10 obtained over the telephone, that is not,
11 to me informed concept, or a very long,
12 very detailed form which is signed which
13 maybe has what, about a thousand words or
14 so where alternatives is mentioned once at
15 the very beginning and then it is not
16 mentioned at all. There is no mention
17 that this may be a potentially stressful
18 situation for her given the fact that she
19 is complaining of a conflict of interest.
20 There is no mention made of the potential
21 of transferring her to another institution
22 where she might be more responsive to
23 medication and treatment. So I haven't
24 seen in this record any meaningful
25 informed consent that is along the

1 meaningful informed consent process. And
2 neither Doctor Johnson nor her parents
3 should feel that they are responsible for
4 signing forms when they were not informed
5 of the alternatives, meaningfully of the
6 alternatives to her receiving involuntary
7 ECT, as well as the risks of involuntary
8 ECT which can be compounding a manic
9 episode with post-traumatic episode unless
10 the involuntary nature of the ECT is
11 adequately, the meaning of it is
12 adequately explored with the patient,
13 which it never was in this instance. I
14 mean there was an absence here in the
15 record of anyone talking with the patient
16 or the patient's family, the patient's
17 parents or Doctor Johnson about what the
18 risks of the ECT being involuntary might
19 be and why any post-traumatic
20 complications should be, could be treated,
21 should be treated and at least should be
22 considered. But they never are.
23 **Q. What about the consent form itself**
24 **deviates from the standard of care? I**
25 **think you had indicated that earlier.**

Page 90 1 A. There was not sufficient mention other 2 than one word, in a very long form, about 3 alternatives. No specific alternatives 4 are identified, other than in some general 5 terms, medication and psychotherapy. It 6 fails to mention that, for this particular 7 patient, one alternative would be a change 8 of setting, transferring her from a 9 hospital where she was complaining of a 10 conflict of interest to an institution 11 where there would be no conflict of 12 interest. There was not sufficient 13 elaboration of the potential for 14 medication and psychotherapy to treat her 15 condition. The risks of the ECT being 16 involuntary rather than voluntary are not 17 sufficiently, are not mentioned at all, in 18 fact. The fact that one alternative might 19 be to try to restore her to competency so 20 that she could decide whether or not she 21 should undergo ECT is not detailed in any 22 meaningful manner. I mean this is as pro 23 forma as it gets. 24 Q. All right. Other than the -- 25 A. It is documentation rather than an	Page 91 1 informed consent process. 2 Q. All right. Other than the consent forms, 3 you are telling me you don't see anywhere 4 in the medical record where Doctor Faust 5 explained to the family, including her 6 parents and her ex-husband, the risks 7 including memory loss and alternative 8 treatments to ECT in the medical record? 9 A. Well, Doctor Faust explains the risks. He 10 does so, at least based on the 11 documentation, in a perfunctory manner. 12 The risks of ECT being voluntary rather 13 than involuntary, I don't see Doctor Faust 14 explaining at all, that involuntary ECT 15 carries its own special risks beyond 16 voluntary ECT. The alternative of 17 transferring her to another institution, 18 from what I can tell from the 19 documentation and from Doctor Faust's 20 deposition, he never explains to the 21 family. 22 Now, if you can show me 23 otherwise, I would be willing to consider 24 it. Maybe I have overlooked something in 25 this haystack, but I don't see it.
Page 92 1 Q. All right. Have you ever given informed 2 consent to a patient who is about to have 3 ECT? 4 A. Yes. 5 Q. All right. On how many occasions and what 6 were the circumstances? 7 A. Oh, in my career, since 1979, easily, 8 gosh, easily over 50 times. 9 Q. Well, didn't you testify earlier that you 10 had never given a patient ECT before? 11 A. I myself have not administered it, but I 12 have been asked by the person who has 13 administered it since I knew the patient 14 best to go over the risks, benefits and 15 alternatives of ECT since I was the 16 treating physician or the attending 17 physician in a unit where a patient was 18 being given ECT or one of my own patients 19 received ECT. That is one of the things 20 -- 21 Q. What would be the -- I am sorry. I 22 thought you were finished. 23 A. That is okay. Please go on. I don't mean 24 to be long-winded here so go ahead. 25 Q. When is the last time you have given an	Page 93 1 informed consent for an ECT therapy? 2 A. Sometime in the past five to seven years, 3 five to eight years maybe. 4 Q. All right. Do you know where the consent 5 form that MUSC was using back in 2003, 6 where they got the language from or what 7 it was modeled after? 8 A. I do not. But the problem isn't with the 9 form per se. The problem is with how it 10 is being used as a substitute for 11 meaningful informed consent. 12 Q. Well, you didn't indicate earlier that you 13 had a problem with the form itself so I am 14 asking -- 15 A. Well -- go ahead. 16 Q. Let me finish my question, if you would? 17 A. Absolutely. I am sorry about that, 18 Mr. Early. Please correct me. 19 Q. That is okay. Were you critical of the 20 form itself? And my question was do you 21 know what our form or MUSC's form was 22 modeled after? And if you so, great. If 23 you don't, that is fine too. My question 24 is if you know. 25 A. I don't know. And my criticism is only in

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1 the context of the overall informed
2 consent process. If this form had been
3 accompanied by an extended discussion of
4 the risks of involuntary ECT, if it had
5 been accompanied by a discussion of the
6 likelihood that it was best for this
7 patient given her own perceptions of there
8 being a conflict of interest that she
9 should be transferred to another
10 institution, there would be no conflict
11 with the form per se.

12 But there was no such
13 conversation. The form itself as a whole
14 could certainly use improvement, but it is
15 not about the form. It is about the
16 process.

17 Q. You keep using the term "process". I am
18 sorry. Did you read Doctor Faust's
19 deposition where he used the term
20 "process" when he described his relaying
21 the risks and benefits to patients
22 including Clair Johnson?

23 A. Yes, I did. And let me just check one
24 thing if I may. Give me one second.

25 Q. Certainly, Doctor.

1 A. Okay. Please go ahead. Mm-hmm.

2 Q. My question was did you read Doctor
3 Faust's deposition where he described the
4 word, where he used the term "process"
5 that you continue to use in relaying the
6 risks, benefits and alternatives of ECT to
7 his patients including Clair Johnson?

8 A. He did use that word, but I did not see in
9 his deposition nor his notes with Ms.
10 Johnson any meaningful process which
11 addressed specifically the risks of
12 involuntary ECT or the fact that, given
13 her perceived conflict of interest, it
14 would be best to transfer her to another
15 institution prior to considering, and
16 seeing whether that would help restore the
17 competency prior to administering ECT.
18 Again, I may have overlooked it; and if I
19 have, please let me know.

20 Q. Well, was Doctor Faust ever asked to
21 explain his process that he relayed to
22 Clair Johnson in his deposition?

23 A. I would not trust my memory as to what
24 questions were asked by the attorney of
25 Doctor Faust. I would need to look at the

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1 deposition per se to refresh my memory.
2 If Doctor Faust now testifies that he did
3 in fact advise that she should be
4 transferred to another institution, that
5 he did in fact inform the parents and the
6 ex-husband of the risks of proceeding with
7 involuntary ECT and the conflict of
8 interest situation, then I would wonder
9 why he didn't document it because that is
10 something, it is so vital in this case,
11 you would need to document it. I mean the
12 failure to document it itself would be
13 below the standard of care because these
14 are vital points in this particular case.
15 These are vital for the informed consent
16 process.

17 Q. Okay.

18 A. So you know, whether he was asked, why
19 wouldn't he volunteer that part of his
20 informed consent process was to recommend
21 that she be transferred to another
22 institution because of the potential
23 conflict of interest that she was raising
24 and which was actually there and
25 reasonably there, and why wouldn't he

1 mention the fact that part of his informed
2 consent process was to inform the parents
3 and Doctor Johnson of the risks of
4 involuntary ECT or the risks of extended
5 ECT or massive ECT? I don't see the
6 documentation there.

7 Q. All right. Doctor Bursztajn, you used the
8 term "apparent collusion" in speaking with
9 or about Dr. John Johnson and the
10 physicians in this case.

11 Are you going to testify that
12 there was in fact collusion to do harm to
13 Clair Johnson in this case between any
14 physicians?

15 A. Well, not in any legal sense. I am not an
16 attorney, I am not a judge, and I would
17 not make the judgment. But it was
18 apparent, but Ms. Johnson herself felt,
19 that there was, so you see. And so when a
20 patient feels that is so then the
21 patient's feelings need to be explored and
22 addressed because there would be a -- it
23 was apparent to Ms. Johnson; and if it was
24 apparent to Ms. Johnson, then that is a --
25 and she was complaining about it, right,

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1 so that is something which would have
2 needed to have been addressed in the
3 course of treatment, given the potential
4 conflict of interest that she herself was
5 raising.

6 **Q. Okay. Let's assume for the sake of just a**
7 **hypothetical, if you would, that Ms.**
8 **Johnson was transferred to another**
9 **hospital in South Carolina. Would you**
10 **have any problem with them doing**
11 **involuntary ECT after getting consent from**
12 **both her now ex-husband and her parents**
13 **back in 2003?**

14 **A.** They would -- before proceeding
15 immediately, I would have a problem of
16 them proceeding immediately to ECT
17 because, given the trauma that Ms. Johnson
18 had experienced in the previous setting,
19 it would take some time to create a
20 therapeutic alliance with her, it would
21 take some time for medications to begin to
22 work and for her to feel that she was in a
23 safe setting. The way I think of it and
24 the way psychiatrists who I have taught
25 and how all my colleagues think of it, but

1 certainly the way I think of it is that
2 any psychiatric intervention is only as
3 good as the intervention itself
4 interacting with the setting in which it
5 is given, is it a safe setting, and a
6 mindset of the patient. And the setting
7 of this particular hospital, given the
8 potential conflicts of interest with the
9 patient, if anyone listened to the
10 patient, an intervention, especially an
11 involuntary intervention was not likely --
12 was likely to -- was foreseeably going to
13 have some very serious harmful effects on
14 the patient's mindset which already was
15 vulnerable and the patient's ability to
16 have a therapeutic alliance to be able to
17 trust the physicians who she was working
18 with. To be even more specific, if I may,
19 I have in my practice patients who have
20 been transferred to me by psychiatrists
21 who are treating a couple in couple's
22 therapy and one of the patients does
23 become, did become hypomanic. And the
24 reason why they transferred that patient
25 to me is because they felt that they were

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1 the physician for their husband, there
2 would be a potential conflict of interest
3 for that patient. When they tried to
4 treat that patient with medications,
5 medications were not working. When I
6 treated that same patient with the same
7 medications when there was no -- the
8 patient knew that I was their, my interest
9 was their interest, the medications
10 worked. We established a therapeutic
11 alliance. We were able to do some
12 meaningful therapy, and low and behold,
13 not only did the medications work but it
14 worked in a lower dosage than it had been
15 previously prescribed at times. So you
16 see, in psychiatry it is the intervention
17 plus interacting with the mindset of the
18 patient and setting, the amount of trust
19 that is in the doctor/patient or the
20 institution/patient relationship.

21 **Q. Okay. I am not sure you answered my**
22 **question, Doctor.**

23 **If Ms. Johnson would have been**
24 **transferred, if she would have**
25 **hypothetically been transferred to another**

1 **facility in South Carolina before she ever**
2 **got ECT at MUSC, assume all that, can you**
3 **assume that for me?**

4 **A.** I can assume that. But are you also
5 assuming that she was receiving
6 appropriate, subsequently an appropriate
7 trial of medication and psychotherapy for
8 some extended period of time?

9 **Q. All right. I am speaking simply of the**
10 **conflict which you keep going into,**
11 **dovetailing from other questions. But if**
12 **she would have been transferred as you**
13 **said she should have been done, if she**
14 **should have been transferred to another**
15 **hospital in South Carolina where the law**
16 **requires her husband and parents and in**
17 **this case both of them gave consent, if**
18 **she would have been transferred to another**
19 **hospital, would it have been a deviation**
20 **from the standard of care to get consent**
21 **from her husband, now ex-husband, and her**
22 **parents, and go through with involuntary**
23 **ECT?**

24 **A.** It would not, it would have been a
25 deviation and it would not be meaningful

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1 informed consent unless she first felt she
2 received in that institution an adequate
3 and comprehensive evaluation and then
4 adequate trial of medication and
5 psychotherapy before recommending
6 involuntary ECT.
7 **Q. All right. So we stop it here. What**
8 **evaluation should have been done that**
9 **wasn't done in your opinion?**
10 **A.** The evaluation would have included
11 exploring her concerns about her marriage,
12 the potential conflict of interest
13 situation that she had felt herself placed
14 in previously, the helplessness that she
15 felt when being hospitalized at her
16 husband's institution, and a medication
17 trial would be part of that evaluation to
18 see whether she could now respond the way
19 she had responded in her previous
20 hospitalizations to a combination of
21 medication and psychotherapy before trying
22 ECT, before especially on an involuntary
23 basis.
24 **Q. All right. Do you know how she ended up**
25 **at the Medical University of South**

1 **Carolina, Doctor Bursztajn?**
2 **A.** I would have to consult the medical, the
3 records for that. I don't want to go
4 ahead and rely on my memory.
5 **Q. Do you know whether her parents, her**
6 **friends including herself requested that**
7 **she be transferred to that institution in**
8 **Charleston, South Carolina?**
9 **A.** Again, even if they did, they should have
10 been told that this was contraindicated,
11 given the potential conflict of interest
12 at that point in time.
13 **Q. Well --**
14 **A.** Given the status of her marriage, given
15 the status of her marriage which was very
16 shaky to say the least, given her concerns
17 about it, given her fears of abandonment
18 and helplessness.
19 **Q. Okay. All right. Let me -- I am going to**
20 **try to trudge through the main opinions**
21 **you gave early on. If you could to the**
22 **extent you can, I know you have covered a**
23 **lot with regards to the conflict of**
24 **interest and I am not trying to limit your**
25 **answer but just answer my question, we**

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1 might be able to get done a little
2 quicker. Now, let me find my -- okay.
3 Beginning on -- and I am going to ask you
4 about your testing in a second.
5 But beginning on page 13 of that
6 same letter that you sent Mr. Ravenel back
7 in April of 2011, do you see where you
8 have corroborative data?
9 **A.** Page -- which page are we on now? Yes,
10 13, right.
11 **Q. Thirteen.**
12 **A.** Page 13, right. Okay.
13 **Q. Okay. Looking at that, I want to make**
14 **sure what I am looking at is the same**
15 **thing that you are looking at. You talk**
16 **about some preexisting vulnerability. Is**
17 **that the gist of that opinion?**
18 **A. Yes.**
19 **Q. All right. And some of that, you include**
20 **a childhood head injury regarding falls in**
21 **gymnastics and being hit by a baseball.**
22 **Are you aware of any treatment or medical**
23 **scans that she had as a result of those**
24 **falls or that instance where she was hit**
25 **by a baseball?**

1 **A.** No. The only brain imaging that I am
2 aware of is the brain imaging which was
3 done in 2002, which showed brain atrophy
4 more advanced than would be expected for
5 her age, which would be consistent with
6 that. But none at the -- but none at the
7 time.
8 Now, I should also mention that
9 when she was a child, even the CT scans
10 that were used were used much less and
11 brain imaging was used much less than it
12 was by 2002.
13 **Q. Okay. But do you know whether even she**
14 **went to see a doctor at all for the fall**
15 **or falls and the time she was hit by a**
16 **baseball?**
17 **A.** I don't believe she did. But again, I
18 would have to refresh my memory on that.
19 **Q. All right. And the CT that you refer to**
20 **was done in 2002. That, at least her**
21 **neurologist who consulted with her in**
22 **Columbia Palmetto Baptist indicated that**
23 **was consistent with drug use, did he not?**
24 **A.** It can be consistent with drug use as
25 well, yes.

Page 106 1 Q. All right. And that in and of itself, 2 that particular scan was ordered by the 3 physicians at MUSC during the pre-ECT 4 workup of Clair Johnson. You agree with 5 that? 6 A. Yes. 7 Q. And that CT scan in and of itself would 8 not be a contraindication for 9 Electroconvulsive Therapy. You agree with 10 that, at least you say that in your 11 record? 12 A. Yes. It is not an absolute 13 contraindication, but it is an indication 14 for proceeding carefully, establishing a 15 baseline, potentially doing some new or 16 psychological testing to establish a 17 baseline to begin with so that you can 18 closely monitor the patient as you 19 proceed. And then once you exceed the 20 NICE Guidelines, that is the National 21 Institute Center for Excellence, the 22 British which were available at that point 23 in time in 2003. And they basically are a 24 nice and relatively unbiased set of 25 guidelines. More biased guidelines were	Page 107 1 put out by people who do ECT, but this was 2 the National Health Service, the British, 3 which doesn't have a dog in the fight, 4 basically, about ECT. Once you begin to 5 go beyond 12, I mean once, if she doesn't 6 have a clear, ongoing positive response 7 after about between six to 12 ECT's, that 8 would be a very good indication for 9 stopping the ECT at that point. It 10 certainly is below the standard of care 11 not to continue to monitor her, especially 12 in light of this prior vulnerability shown 13 in the CT scan. I mean just to not 14 continue to not do any serious monitoring 15 other than simply, you know, meeting with 16 her, that is not good enough. You have to 17 begin to do some, some monitoring. The 18 problem with her self reports are — 19 Q. We are never going to get through this. 20 A. That there would be, to the extent of her 21 memory would be affected by the ECT 22 itself, they would not be reliable. She 23 could not report impairment unless you 24 were to go ahead and either do new 25 psychological testing or, as I did, give
Page 108 1 her a series of checklists where she could 2 recognize impairment which she might not 3 be able to recall herself. 4 Q. All right. You used the term 5 "monitoring". What wasn't done that 6 should have been done in your opinion just 7 with regards to monitoring, simply with 8 monitoring? 9 A. Yes. She should have been given a series 10 of checklists, of cognitive symptoms 11 checklists so that even if she might not 12 remember what her impairments are, she 13 could recognize — even if she couldn't 14 recall her impairments, she could 15 recognize her impairments. Many mental 16 status exams could have been done. Serial 17 neuropsychological testing could have been 18 done. And none of this was done. 19 Q. All right. Mental status exams were not 20 done, in your opinion, based on what you 21 have seen? 22 A. Not adequate formal mental status exams. 23 What was done was perfunctory and 24 unsuitable for a patient as vulnerable as 25 this patient is and was.	Page 109 1 Q. And her vulnerabilities are based on her 2 childhood head trauma, hit by the baseball 3 and falling, and migraine headaches. 4 Anything else, any other vulnerabilities 5 that this patient had? 6 A. She did have a history of substance usage 7 including alcohol, so that is an 8 additional vulnerability. So you have 9 three sets of vulnerabilities. She was, 10 had also been prescribed stimulants which 11 potentially is another vulnerability but 12 more arguably so. So you have at least 13 three clear sets of vulnerabilities here 14 which require careful, thoughtful, timely 15 monitoring by repeated testing, by 16 structured interviews with the patient, 17 not simply when you talked with her and 18 she doesn't say there is anything wrong or 19 says I didn't see anything wrong. That is 20 not good enough. That is not — that is 21 not — that is not monitoring, not for 22 this patient anyway. 23 Q. Is it possible — is it possible to do the 24 type of monitoring that you are suggesting 25 on a patient that is delusional and

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1 suffering the type of acute mania that Ms.
2 Johnson presented to MUSC with on numerous
3 occasions?

4 A. During the acute manic episode it is
5 difficult but not impossible. I have had
6 something to do with patients who are
7 acutely manic. But she was not always
8 manic, right. So subsequent, subsequent
9 to each episode, that could have been
10 done. It could also have been done on an
11 outpatient basis by Doctor Roberts when
12 she was relatively stable and euphenic.
13 So there is a -- there were times and
14 places where it wasn't difficult to do and
15 it should have been done. There were
16 other times where it was difficult to do
17 but still should have been done.

18 Q. All right. Are you aware of any instance
19 where Ms. Johnson was admitted as an
20 inpatient at MUSC where she was not
21 presenting in a state where she was
22 acutely manic?

23 A. I am not aware of any such instance, but I
24 am aware of plenty of instances where she
25 was discharged and she wasn't acutely

1 manic and then the testing still could
2 have been done.

3 Q. All right. Looking at paragraph B or on
4 yours it would be two.

5 A. Yes. Page 14?

6 Q. Well, I am looking at one of your other
7 letters. But give me a second, I can
8 compare them.

9 A. Okay.

10 Q. All right. You say, "ECT was not an
11 inevitable choice of treatment," but you
12 are not, again, saying that ECT was not
13 indicated based upon her symptoms.
14 Correct?

15 A. I am saying that involuntary ECT was not
16 indicated based on her symptoms.

17 Q. All right. You don't believe that she was
18 a -- you don't believe when she presented
19 in -- well, she wasn't given involuntary
20 ECT on her first admission to MUSC, was
21 she?

22 A. She wasn't. That assessment was not made.
23 But for all intents and purposes, the ECT
24 was given to someone who was impaired
25 enough so it should have been given. An

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1 assessment should have been made for
2 whether she was competent to consent.

3 Q. Now, I guess I am talking about something
4 different. You were aware that she
5 presented at MUSC for the first time about
6 three months prior to her ever getting an
7 ECT, correct?

8 A. Yes.

9 Q. All right. Doctor Bursztajn, do you have
10 a -- are you going to opine at trial that
11 the use of bilateral ECT was a deviation
12 from the standard of care in this case
13 simply because of the choice of the
14 electrode placement?

15 A. Not simply because of the choice of the
16 electrode placement.

17 Q. Well, are you going to opine that the use
18 of bilateral ECT in this case was a
19 deviation from the standard of care?

20 A. For it to be administered in the context
21 of an involuntary basis for as long as it
22 was without looking at reasonable
23 alternatives, yes.

24 Q. All right. Are you aware of the efficacy
25 of unilateral Electroconvulsive Therapy on

1 patients suffering from acute mania?

2 A. The issue of efficacy, although there were
3 some studies out there, I haven't seen
4 anything which is conclusive or
5 definitive. I think there is a tremendous
6 amount of variability based on the
7 individual patient.

8 Q. All right.

9 A. The reports I have seen show a great deal
10 of variability.

11 Q. Okay. And have you -- I lost my train of
12 thought.

13 You have not looked at the
14 efficacy of unilateral placement of
15 electrodes on a patient who has suffered
16 from acute mania, is that fair?

17 A. No. I have looked at various reports. I
18 haven't seen any studies which I would
19 consider to be reliable and definitive for
20 this, for this patient such as Clair
21 Johnson. What I have seen at this point
22 is either some metrologic problems in
23 those studies or they would not apply to
24 Ms. Johnson.

25 Q. Ms. Johnson did have a favorable or

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1 positive outcome from ECT during her
2 initial or first couple of courses of
3 treatment.
4 You agree with that, correct?
5 A. It is unclear whether whatever gains she
6 made were due to the ECT or due to a
7 variety of changes in her medication and
8 her social situation. To attribute the
9 favorable outcome to the use of ECT is a
10 stretch.
11 Q. Why do you say that? What about her
12 social situation changed in December of
13 2003?
14 A. Well, for one thing, even though she was
15 placed in a setting where she was
16 frightened, she was removed from daily
17 contact, from, from living, from a life
18 situation where there was constant
19 conflict with now her ex-husband.
20 Secondly -- let me consult my notes here.
21 Q. Well, do you think she was living with her
22 ex-husband then, Doctor Bursztajn?
23 A. No, I didn't say then. I said constant
24 conflict is not the same as living with.
25 But it was a conflictual situation with

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1 her.
2 No, she wasn't he living with
3 him. I didn't think that, no.
4 Let's just take a look here.
5 Okay. I mean she is someone who responds
6 to hospitalizations. She has responded to
7 previous hospitalizations without ECT.
8 The fact that she eventually responded to
9 this hospitalization with ECT doesn't mean
10 that it is the ECT that causes the
11 response to the hospitalization. If
12 anything, arguably, it made her less
13 responsive to the hospitalization itself.
14 Q. Anything else about her social situation
15 that you just referred to other than what
16 you just said?
17 A. Well, that is the elephant in the room.
18 Q. All right. Number three, "The ongoing
19 assessment of decision making competence
20 was called for in Ms. Johnson's case."
21 Is there anything else about that
22 particular opinion that you haven't
23 already stated in this deposition?
24 A. I believe I have stated the gist of it.
25 Q. All right. Number four, "Insufficient

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1 consideration appears to have been given
2 to the choice of substitute decision
3 makers and to the clinical and ethical
4 implications of that choice."
5 Other than her parents and her
6 now ex-husband at the time, what other
7 substitute decision makers could have been
8 considered?
9 A. There were some instances -- well, first
10 of all, her husband shouldn't, should not
11 have been considered as a substitute
12 decision maker. It boggles the
13 imagination that, given their
14 estrangement, he would be and, again,
15 especially for someone who is feeling
16 helpless and who obviously will have some
17 potential abandonment issues. There was
18 some conflict with her father and, again,
19 whether or not it would help if her
20 parents were substitute decision makers
21 was something that should have been
22 assessed and evaluated rather than just
23 simply assumed. And there are times where
24 one proceeds to get a guardian ad litem,
25 the Court appoints a guardian. Someone

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1 like yourself, for example, is appointed
2 or someone like Mr. Scott or Mr. Ravenel.
3 That could have been considered in this
4 particular case as well. And I certainly
5 have consulted in more than one
6 guardianship case where, even though the
7 family is well meaning and well
8 intentioned, the family dynamics are such
9 that there is a counter indication to the
10 family being the guardian. Without, you
11 know, without in any way devaluing anyone
12 in the family, that evaluation should have
13 been done. And I just don't see any such
14 evaluation. Why not? I don't understand.
15 I mean I have looked at the depositions, I
16 have looked at the medical records. And
17 again, if you can tell me why that wasn't
18 done or at least not documented, that
19 would be very helpful.
20 Q. Well, I guess I am not sure what you are
21 saying. I am asking what other substitute
22 decision makers other than her mom, her
23 dad and her current husband at the time
24 should have been considered.
25 A. And I answered, a guardian ad litem such

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1 as yourself or Mr. Scott or Mr. Ravenel or
2 anyone else who has an interest in mental
3 health and the law.
4 **Q. Do you know who her guardian ad litem was**
5 **that was appointed by the Court in her**
6 **family court case which was running**
7 **concurrent at this same time was?**
8 **A. I don't remember off the top of my head.**
9 **Q. Okay. Are you familiar with the South**
10 **Carolina Law for alternative substitute**
11 **consenters?**
12 **A. I -- I am in terms of having reviewed it**
13 **but I couldn't recite it and I would not**
14 **rely on my memory for the black letter of**
15 **the law. I am sure that -- but if you**
16 **wanted to give it to me, I can simply**
17 **comment on it, recognize it and comment on**
18 **it.**
19 **Q. Well, would you -- well, without doing**
20 **that, would you expect the physicians at**
21 **MUSC to follow that law when it comes to**
22 **the hierarchy of who should be the**
23 **substitute alternate consenters for Ms.**
24 **Johnson?**
25 **A. They need to do an evaluation to see what**

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1 the hierarchy is and then follow the law.
2 But you have to do an evaluation before
3 you can go, the family dynamics before you
4 can interpret the law.
5 **Q. All right. This evaluation you are**
6 **talking about is different than the**
7 **evaluation we were talking about a little**
8 **while ago. Is this just an evaluation**
9 **with regards to the substitute consenters?**
10 **A. There needs to be a specific evaluation as**
11 **to what is the best interests of this**
12 **patient clinically. That is, you know, as**
13 **a clinician, your duty is to the patient.**
14 **If you feel that if you need to do an**
15 **evaluation when you are applying for**
16 **guardianship to see who would be in the**
17 **best position to be a substitute decision**
18 **maker and protect the patient's best**
19 **interests at the same time, that**
20 **evaluation needs to include a**
21 **comprehensive evaluation of family**
22 **dynamics such as, Gee, are these people**
23 **getting a divorce right now, are they at**
24 **least estranged and separated from each**
25 **other right now, is it a good idea to have**

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1 her estranged husband be one of the
2 substitute decision makers?
3 I don't believe that South
4 Carolina law tells the clinician that an
5 estranged husband has to be the substitute
6 decision maker. You could prove me wrong
7 on that.
8 **Q. All right. Have you reviewed the South**
9 **Carolina Substitute Consenter, the Act**
10 **that I am referring to?**
11 **A. I believe I have, yes. That is one of my**
12 **long -- one of my special interests is**
13 **guardianship issues, as you know from my**
14 **publications nationally, and I served on**
15 **the ABA Mental Health Law and Disability**
16 **Commission. So yes, that is one of the**
17 **laws I have reviewed.**
18 **But again, if you can recite it**
19 **to me, I can recognize it and then I can**
20 **go ahead and give you my opinion as to**
21 **whether or not the clinicians followed the**
22 **law or not.**
23 **Q. All right. So you have given opinions as**
24 **to clinicians not following the law**
25 **before?**

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1 **A. I have given an opinion that clinicians**
2 **have done an inadequate assessment of**
3 **family dynamics before so as to have**
4 **someone be appointed a guardian who**
5 **shouldn't be a guardian.**
6 **Look, if you have a, for example,**
7 **a father who abuses a daughter, the**
8 **daughter gets sick, you don't have the**
9 **guardian, the father be appointed a**
10 **guardian. That is not the law.**
11 **If you have a husband who is**
12 **estranged from the a wife and the wife is**
13 **worried about being abandoned to him, you**
14 **don't nominate him to be the guardian.**
15 **That is not the South Carolina**
16 **law, is it? I mean if it is, please let**
17 **me know. I would be interested to write**
18 **about it.**
19 **Q. Well, do you know whether the South**
20 **Carolina law addresses the spouse in the**
21 **process of separation in the context of**
22 **this South Carolina Alternative Adult**
23 **Health Care Consent Act, do you know or**
24 **don't you know?**
25 **A. I simply don't remember off the top of my**

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1 head. But I would be shocked if it
2 precludes a clinician from doing an
3 evaluation on this specific point. I mean
4 if it does, please show me.
5 **Q. Well, I am not suggesting it precludes an**
6 **evaluation. But if it does, if it does**
7 **talk about an evaluation and it gives a**
8 **hierarchy of who should be the substitute**
9 **consent, you would not follow the law in**
10 **that context?**
11 **A. Oh, no. That is a misleading question.**
12 **Of course you follow the law, but you have**
13 **to do an evaluation to know whether or not**
14 **what the hierarchy should be and whether**
15 **there should be an exception to the**
16 **hierarchy or not. And if an evaluation**
17 **wasn't done, whether there is good reason,**
18 **there is every indication that such an**
19 **evaluation should have been done. Not to**
20 **do it is below the standard of care. And**
21 **you can't hide behind the law to say that**
22 **the law does not command you to practice**
23 **below the standard of care. South**
24 **Carolina law doesn't do it, any law that I**
25 **know doesn't do it, not in the United**

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1 **mania, correct?**
2 **A. Yes. But on none of those occasions did**
3 **she subsequently need ECT.**
4 **Q. Well, what other medications other than**
5 **Lamictal could have prevented her acute**
6 **mania and recommitments to the hospital,**
7 **if you will?**
8 **A. Well, once she had been traumatized by**
9 **this 80 plus ECT dosages, medication**
10 **management foreseeably became much more**
11 **difficult because now you have a**
12 **combination of not just a bipolar disorder**
13 **but also a post-traumatic disorder**
14 **secondary to the involuntary ECT that she**
15 **suffered. So I am not surprised that**
16 **subsequently she was not as responsive to**
17 **medication management. At the same time,**
18 **even at the time that she was**
19 **hospitalized, as I mentioned, Ativan and**
20 **Klonopin could have been tried on an acute**
21 **basis and it could have been also a re-try**
22 **in other institutions and safe settings of**
23 **other medications that did not previously**
24 **work because they might work this time**
25 **around if she felt safe enough.**

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1 States anyway.
2 **Q. All right. Let's move on from number four**
3 **to number five. You are talking about**
4 **conflict of interest in this particular**
5 **paragraph. It goes on to page 16.**
6 **Is there anything with regards to**
7 **your opinion on the conflict of interest**
8 **that you haven't already articulated in**
9 **this deposition?**
10 **A. I believe you have the gist of it.**
11 **Q. Well, if there is anything you haven't**
12 **told me already I would certainly like to**
13 **hear it now before trial.**
14 **A. Absolutely. And again, I think I have**
15 **said the gist of my opinion.**
16 **Q. All right. Okay. Number six, you talk**
17 **about reasonable medication choices as**
18 **alternatives and you give in the first**
19 **sentence an example of Lamictal.**
20 **A. Yes.**
21 **Q. You are aware now since you wrote this**
22 **letter to Mr. Ravenel that Ms. Johnson was**
23 **in fact taking Lamictal and,**
24 **notwithstanding that, was hospitalized on**
25 **several subsequent occasions for acute**

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1 Again, the effect of any
2 psychiatric intervention including
3 medication, it is a combination of the
4 medication, the substance, the setting,
5 the therapeutic alliance, and the mindset
6 of the patient. And this was simply not
7 considered.
8 **Q. All right. Are you going to tell the jury**
9 **that her most recent hospitalizations for**
10 **acute mania in Columbia, South Carolina**
11 **resulted from post-traumatic stress**
12 **disorder versus her underlying chronic**
13 **bipolar disorder dating back to her teens?**
14 **A. Again, I would need to go ahead and review**
15 **and analyze those in detail to be**
16 **definitive. But there is no question that**
17 **her risk of subsequent decompensation and**
18 **recurrent hospitalizations has increased**
19 **due to the involuntary ECT creating a post**
20 **traumatic, creating trauma and a**
21 **post-traumatic stress disorder spectrum**
22 **for someone who is already vulnerable due**
23 **to bipolar illness.**
24 **That at the time she was**
25 **hospitalized, she was in an unhappy**

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1 unstable marriage initially. Now she is
2 divorced so she doesn't have that hanging
3 over her head anymore. But what she does
4 have is the trauma of ECT. Basically, one
5 psychosocial stressor has gone out of her
6 life which would foreseeably tip over a
7 patient vulnerable to bipolar in an
8 essentially manic episode; namely, the
9 threat of divorce and abandonment is not
10 gone from her life. But what you have
11 instead is the helplessness, the
12 hopelessness and the horror which was
13 attendant to her experience with
14 involuntary ECT and the subsequent loss of
15 memory that she has suffered as well,
16 which together create significant trauma
17 which continues to be an ongoing
18 destabilizing stressor and makes her much
19 more difficult to manage on an outpatient
20 basis over extended periods of time.
21 **Q. All right. I guess my question is now**
22 **limited to, Doctor, I guess part of your**
23 **job is to give some causation opinions.**
24 **Are you going to testify that the cause of**
25 **her recent hospitalizations, and if you**

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1 trauma of helplessness and hopelessness
2 and lack of trust engendered by the
3 involuntary ECT in a setting where she was
4 getting divorced, where she was estranged
5 from her husband and she was hospitalized
6 in her husband's hospital, and her
7 brother, where her brother-in-law was the
8 Chair of the Board of Trustees.
9 **Q. All right. How about the ones prior to**
10 **her ECT, what caused her to be**
11 **hospitalized for those?**
12 **A. Her bipolar disorder, complicated by the**
13 **growing estrangement from her husband was**
14 **a major factor, and her growing fears of**
15 **abandonment by him.**
16 **Q. All right. How about prior to her getting**
17 **married, what caused those**
18 **hospitalizations for acute mania?**
19 **A. Ongoing fears of, a combination of fears**
20 **of abandonment which she self medicated by**
21 **alcohol and drug use and subsequently**
22 **became overwhelmed and became bipolar,**
23 **became manic. She always has had some**
24 **bipolar vulnerability, mood instability**
25 **but --**

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1 are that is fine, I just want to know, are
2 caused by her post-traumatic stress
3 disorder or her underlying bipolar
4 disorder; and if so, which ones?
5 **A. Well, it is her post-traumatic stress**
6 **disorder which causes it because she is**
7 **vulnerable by reason of bipolar disorder.**
8 **So her post-traumatic stress disorder,**
9 **given her bipolar vulnerability, tips her**
10 **over into a manic state.**
11 **Q. All right. Can you say to a reasonable**
12 **degree of medical certainty,**
13 **notwithstanding her post-traumatic stress**
14 **disorder, that she would not have required**
15 **those hospitalizations recently with her**
16 **underlying bipolar condition?**
17 **A. More likely than not, with appropriate**
18 **treatment of bipolar disorder, without the**
19 **post-traumatic complication, she would be**
20 **and she should be stabilized by now so**
21 **that she would not require repeated**
22 **hospitalizations.**
23 **Q. Well, why did she have to have those**
24 **hospitalizations recently, Doctor?**
25 **A. Because she is still experiencing the**

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1 **Q. So in your opinion --**
2 **A. Yes.**
3 **Q. So in your opinion, Doctor Bursztajn, it**
4 **has always been some external factor and**
5 **nothing to do with the underlying disease**
6 **component of Clair Johnson that has caused**
7 **her to have these multiple**
8 **hospitalizations. Is that your opinion?**
9 **A. No, that is a misunderstanding of my**
10 **opinion. I am distinguishing between a**
11 **vulnerability and a proximate cause. A**
12 **stressor with most bipolar patients tends**
13 **to be the proximate cause and it is**
14 **certainly Ms. Johnson's case that is true.**
15 **There is a vulnerability that is there, a**
16 **vulnerability to a variety of different**
17 **stressors. And in Ms. Johnson's case, it**
18 **is the stressor to which she is vulnerable**
19 **to the most is abandonment, helplessness,**
20 **hopelessness, which is what you would**
21 **expect given her life history. She tries**
22 **to self medicate, using stimulants and**
23 **using drugs and alcohol. It doesn't work**
24 **for her. It makes things worse.**
25 **Q. All right. So just if I can put that in a**

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1 nutshell, the proximate cause of her 2 hospitalizations prior to her getting 3 married were drugs and alcohol, and the 4 proximate cause of her hospitalizations 5 during her marriage were the way she was 6 treated by her husband, and the proximate 7 cause of her hospitalizations after her 8 ECT treatments are now post-traumatic 9 stress disorder. Is that what you are 10 saying? 11 A. No. Again, that is a misunderstanding 12 throughout. Overwhelmingly, she is very 13 vulnerable to overwhelming feelings. 14 Before her marriage, the feelings of, the 15 fear of abandonment and helplessness and 16 hopelessness resulted in drug use and 17 together they resulted in her becoming 18 manic and needing to be hospitalized. 19 During her marriage, the ongoing fear of 20 abandonment and the stress in the 21 relationship with her now ex-husband was a 22 major precipitating factor. And then 23 subsequent to her hospitalization in 2003, 24 even though the divorce is now done, the 25 major factor is the trauma that she	1 experienced during this protracted course 2 of first involuntary ECT both in an 3 inpatient and then in an ongoing 4 outpatient basis in a situation where 5 anyone would be foreseeably feeling 6 terrified by, especially someone that is 7 vulnerable as she is to mood, she has a 8 mood disorder basically. Mood disorders 9 are triggered into either major, manic or 10 depressive phases by external stressors. 11 The stressors are foreseeable. If they 12 are not addressed adequately through a 13 combination of psychotherapy, changes in 14 social intervention and then appropriate 15 medication management, the patient becomes 16 unstable. 17 To give you an example, if I may, 18 but I can stop here if you want me to. I 19 mean I don't need to -- 20 Q. Well, I don't want you to cut you off. I 21 do want you to answer my question. We've 22 only paid for a certain amount of time: 23 When did she start experiencing 24 symptoms that you relate to post-traumatic 25 stress disorder?
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1 A. If I may consult my notes, where did I put 2 that? I would need to check the specific 3 points in time where she begins to 4 complaint of conflicts of interest. But I 5 think at that point what you have is 6 someone who is clearly experiencing a 7 degree of trauma due to the setting that 8 she is in. So again, I -- let's see here. 9 Where does that begin? 10 This isn't the passage I was 11 looking for, but one place in my notes is 12 on December 17, 2003. I am in the middle 13 of the page and it is page 214 in the 14 hospital records. The resident discusses 15 with Clair Johnson she plans to live with 16 her husband, but the resident is aware of 17 the husband's separation and divorce plans 18 and knows that CJ is unaware of these 19 plans. Now, at that point in time you 20 have a situation where a patient who had 21 been previously terrified -- oh, here it 22 is. 12/9/03, page 197. 23 "Patient was agitated, reporting 24 a conflict of interest in her 25 hospitalization." At that point in time,	1 you have clear manifestation of how 2 frightened she is, she is agitated about 3 this potential conflict of interest. A 4 few days later on December 17th, she is 5 saying that she is planning to live with 6 her husband, even though the resident 7 knows that her husband plans to separate 8 and divorce from her. 9 Now, if that doesn't create a 10 situation which would undermine trust, I 11 don't know what will. So certainly, by 12 December 9th of 2003, we have clear 13 evidence of a post-traumatic stress 14 element due to the involuntary nature of 15 the ECT which her husband has, husband who 16 is planning to divorce, has signed coming 17 into play. Unfortunately, this was never 18 further explored or pursued with her. 19 Q. What was never explored or pursued with 20 her? 21 A. The meaning, what it meant for her that 22 her husband, that the staff knew about her 23 husband's planning to divorce her when she 24 didn't, what it meant for her that her 25 husband, who was planning to divorce her,

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1 was signing the consent form for her
2 involuntary ECT — what is it — and for
3 her to have complaints of a conflict of
4 interest that went unheeded, unexplored
5 and unaddressed. This was never explored
6 with her that I can see.

7 **Q. Doctor Bursztajn, we just talked about a**
8 **series of external factors. Isn't it**
9 **prudent medical practice to suppress as**
10 **many external factors that are causing**
11 **stress on Ms. Johnson during her**
12 **hospitalization as possible and then later**
13 **have a family meeting like subsequently**
14 **occurred?**

15 **A.** It is not prudent to go ahead and to have
16 a, if you are aware that a husband is
17 planning to, if the wife is estranged from
18 the husband, to go ahead and have the
19 estranged husband who is planning divorce
20 sign the consent form for her ECT. It is
21 not only imprudent, it is reckless.

22 **Q. All right. You are taking what she says**
23 **during her medical records of December of**
24 **2003 at face value. Does that mean that**
25 **you are believing everything she says in**

1 **December of 2003 or just taking bits or**
2 **pieces that support your opinion?**

3 **A.** I am not simply choosing bits and pieces
4 to support my opinion. I have considered
5 the record as a whole. I am focusing on
6 those elements which are most relevant,
7 relative to what we have here and her
8 presentation, which was not simply bipolar
9 disorder but someone who has a bipolar
10 vulnerability which under stress becomes
11 manic, with the stress, with the stress of
12 involuntary ECT, where her estranged
13 husband is chosen as being the substitute
14 decision maker, the helplessness that she
15 experienced in that process.

16 **Q. Doctor Bursztajn, are you suggesting that**
17 **the substitute decision maker for this**
18 **course of ECT treatment that you are now**
19 **talking about was her husband or her**
20 **parents?**

21 **A.** It is the reality, even if it was her
22 parents, the fact that her husband was
23 involved, the fact that she was in her
24 husband's institution where his brother
25 was the Chairman of the Board of Trustees

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1 made it, as she says herself, clearly a
2 conflict of interest. That is what I am
3 saying. It is a conflict of interest
4 which compounded her helplessness and her
5 fear.

6 **Q. All right. And she was aware of that,**
7 **Clair Johnson was aware of that and**
8 **related that to others in 2003?**

9 **A.** Yes.

10 **Q. All right. So there is a cause of action**
11 **in 2003, Clair Johnson was aware of it for**
12 **a conflict of interest?**

13 **A.** She was not aware that it would produce
14 post-traumatic stress disorder, but she
15 was aware that this was a conflict of
16 interest. You have to be a clinician who
17 understands the nature of therapeutic
18 alliance and the importance of a
19 therapeutic alliance for the effective
20 management of bipolar illness through a
21 combination of medication and
22 psychotherapy to be able to understand the
23 causal connection. She did not have the
24 capacity to understand the causal
25 connection. And moreover, she was sick,

1 she was —

2 **Q. Well, I had asked you a second ago to tell**
3 **me when you first see symptoms of**
4 **post-traumatic stress disorder, and this**
5 **is the record that you pointed me to in**
6 **December of 2003.**

7 **A.** Yes. She knew something was terribly
8 wrong about this conflict of interest.
9 But could she go ahead and know that this
10 was a cause of action in her state of
11 mind, no. She knew she was terrified of
12 it. She felt terrified of it.

13 **Q. Was she disabled mentally in December of**
14 **2003?**

15 **A.** She, she still was impaired sufficiently
16 in 2003 so as not to be able to engage in
17 any kind of self diagnosis.

18 **MR. EARLY:** Okay. I tell you
19 what, let's take a quick break. And I am
20 really just going to ask you about your
21 testing after the break and then look
22 through my notes. But I am going to pass
23 the baton to Mr. Scott and have him ask
24 you some questions. He has been sitting
25 over here jumping on his hands.

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1 THE WITNESS: Very good,
2 gentlemen. Let's proceed.
3 (Brief recess.)
4 MR. EARLY: Back on the record.
5 Q. Doctor Bursztajn, we took a brief break.
6 Again, Will Early here. We been talking
7 for many hours about your opinions and
8 your criticisms of the Medical University
9 of South Carolina. I think we have
10 indicated off the record I am going to ask
11 you questions for about 15 minutes and
12 leave this deposition open and I may have
13 some more, and Mr. Scott certainly will.
14 A. Sure.
15 Q. But have you now given me verbally all of
16 your criticisms that you have with regards
17 to anything to do with fault or
18 malpractice or deviations from the
19 standard of care with regards to any
20 personnel at MUSC from the president all
21 the way down to the janitor?
22 A. Let me just check my notes so --
23 Q. Okay.
24 MR. RAVENEL: There is some
25 question about the janitor.

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1 afternoon, only has eight, and if you've
2 got nine then we're looking at you've got
3 more than what I've got.
4 A. Oh, yikes, let's see here. Let's look and
5 see. Can you bear with me to page 17?
6 Page 17.
7 Q. Okay.
8 MR. SCOTT: I've got nine.
9 A. Nine, it is nine unless --
10 MR. SCOTT: And then eight --
11 Q. I was looking at the wrong part of the
12 report. You are correct.
13 A. Okay.
14 Q. You had eight in the previous section?
15 A. Yes, yes, yes. It is between pages --
16 let's see. It gets enumerated, yes, pages
17 13 to 17, pages 13 to 17.
18 Q. Pages 13 to 17?
19 A. Yes, under C.
20 Q. Okay.
21 A. Now, let me just check two other places
22 real quick.
23 Q. Well, before you do that, have we talked
24 about all of those areas? I think we have
25 but I want to make sure you tell me that

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1 THE WITNESS: The ice machine.
2 MR. RAVENEL: Yes.
3 A. Let me just check my notes. Well, you
4 know, if you go through the draft of my
5 report, I don't know if we went through
6 all the points from one to nine, but I
7 think those points plus there is a set of
8 notes, let me just check those. I
9 summarize --
10 Q. Well, let's make sure we are on the same
11 page. Which report, because I have gotten
12 three and I got one late yesterday, so
13 which report are you talking about?
14 A. Well, first it is the draft report that
15 was sent, I believe, on April the 1st,
16 2011.
17 Q. Right.
18 A. Okay. And I am just going to check two
19 other places to be sure that I am not
20 leaving something out which you have every
21 right to know about. So can you give me a
22 couple seconds?
23 Q. Okay, right. Before you do that, Doctor
24 Bursztajn, my draft report from April 1st
25 of 2011, which again I got yesterday

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1 we have on the record.
2 A. I think we have also. I think there are
3 details that we could go into and go into,
4 but I think that we have the gist of it.
5 Again --
6 Q. Okay.
7 A. Let me just double-check to make sure that
8 -- we talked about causation and my
9 opinion about causation. We talked about
10 --
11 Q. Where are you looking?
12 A. Now I am looking at my affidavit that was
13 filed which you should have a copy of.
14 Q. Yes.
15 A. Yes. So here I think so. We talked about
16 that. We also talked about why I don't
17 think that Clair Johnson had the capacity
18 to understand the harm that was being
19 caused to her as a result of this, I am
20 sure, 2010, in any meaningful way.
21 Q. We did.
22 A. Let me just make sure there is nothing
23 else I have omitted here. One more page I
24 need to find. I am just looking now at
25 Exhibit 2, the notes for deposition

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1 preparation.
2 **Q. Okay. I've got it.**
3 A. We talked about one, we talked about two,
4 we talked about three. We talked about
5 four, we talked about five. We talked
6 about six, we talked about seven. We
7 talked about eight and how it is a
8 deviation from the hospital policy itself
9 it is also a deviation from what NICE,
10 that is the National Institute for the
11 Center of Excellence, but we talked about
12 it, the National Health Service, what the
13 British Guidelines recommend. And we
14 talked about nine, so I think we have
15 covered it at this point.
16 **Q. Okay. Well, let me just have a few**
17 **follow-ups. In looking back at Exhibit 2,**
18 **your notes --**
19 A. Yes.
20 **Q. On number eight --**
21 A. Yes.
22 **Q. Which hospital standard or what hospital**
23 **standard was violated in your opinion?**
24 A. I am just going to look at this. I have
25 the standard with me so let me make sure I

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1 assessment so you can inform the
2 consenter. If you don't do the proper
3 monitoring and assessment, you can't
4 properly inform the consenter. That is
5 important.
6 Let me just look at one other
7 thing here. Yes, okay. I think -- I
8 believe that that was it but let me just
9 check to make sure there was nothing else
10 that I was referring to here.
11 **Q. Okay.**
12 A. Yes. Now, I was referring, I was
13 referring to that. And then also number
14 six actually on that, this is on page
15 under E, Concept for ECT, number six, a
16 consideration of reasonable treatment
17 alternatives. I just don't see that on an
18 ongoing basis, do you? I mean if you do
19 then let me know, but I just don't see it
20 on an ongoing basis. So that would be E,
21 the top of the letter, E6.
22 **Q. Okay. But it is not important what I see.**
23 **It is important to me what you see and**
24 **what you don't see.**
25 A. Yes. But those were the two places,

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1 am referring to the specific standard
2 then.
3 **Q. Okay.**
4 A. Let me not leave you in the dark here.
5 **Q. Okay.**
6 A. Yes. If he look at E, Consent for ECT,
7 informed consent for ECT is a process
8 which is not concluded with the signing of
9 the formal consent document but continues
10 throughout the ECT course. That consent
11 was only done in a very perfunctory
12 fashion at best. I mean I think that this
13 violates the hospital standard, as I
14 understand the standard.
15 **Q. Yes. But you said that dealing with**
16 **number eight on your Exhibit 2 --**
17 A. Yes.
18 **Q. What does that have to do with cognitive**
19 **assessment?**
20 A. Let's see here. Let me just check that
21 here. Good question, very good question.
22 Yes, because, you see, the consent, well,
23 part of informing the consenter about a
24 perceived need for an unusually large
25 number of treatments is you need to do the

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1 mm-hmm.
2 **Q. Okay. Finally, a couple of follow-ups.**
3 **And you had mentioned earlier that early**
4 **on in the decision one of the opinions you**
5 **gave that I don't think you have written**
6 **but you said it was continued well beyond**
7 **the generally accepted number of**
8 **treatments.**
9 **What in your opinion or where are**
10 **you getting any data that show what the**
11 **generally accepted number of treatments,**
12 **specifically maintenance treatments are?**
13 A. Although there was no absolute number, the
14 NICE Guidelines clearly indicate that to
15 go beyond 12 treatments requires a very
16 careful evaluation as to why you would go
17 beyond 12 treatments including even if the
18 term "process" is spread out and these
19 treatments were spread out. But you have
20 80 plus treatments over the course of, you
21 know, less than five years. That is a
22 lot.
23 **Q. Doctor Bursztajn, you read Doctor Short's**
24 **deposition where he talks about six to 12**
25 **treatments per course?**

1 A. Yes.
2 **Q. Are you referring to total number of**
3 **treatments or treatments per course?**
4 A. I am referring to total number of
5 treatments. For maintenance ECT, again,
6 according to NICE Guidelines, alternative
7 steps should be considered to maintenance
8 ECT per se, and especially once you get
9 beyond the standard six to 12 treatments.
10 I know he talks about it per course, but
11 the reality is once -- maintenance ECT is
12 not an actual -- actually, 80 ECT's is not
13 the usual, not standard care, and simply
14 not indicated simply to prevent the
15 recurrence of depression. You have to do
16 an evaluation.
17 **Q. But there is nothing that you have seen in**
18 **either NICE or the MUSC standards or**
19 **anywhere else that talks about a number, a**
20 **specific number, where you go over that it**
21 **is a deviation or you stay under that.**
22 **When I am talking about a number, I am**
23 **talking about a total lifetime treatment**
24 **number, correct?**
25 A. There was no specific number per se, but

1 there is clear statements in the NICE
2 Guidelines that you have to seek
3 alternatives to maintenance ECT.
4 **Q. All right. I think you answered this**
5 **earlier. I've got like two or three more**
6 **questions for today.**
7 A. Mm-hmm.
8 **Q. You told me earlier that you don't have**
9 **any opinion that Clair Johnson suffered**
10 **any physiological brain injury or damage**
11 **as a result of ECT, do you?**
12 A. There is a reasonable likelihood that she
13 did in fact suffer some neuropsychiatric
14 impairments due to a combination of the
15 ECT and the post-traumatic stress disorder
16 subsequent to her involuntary ECT and her
17 protracted course of ECT.
18 **Q. All right. Do these physiological brain**
19 **changes --**
20 A. Any neuropsychiatric impairments take
21 place because they are all physiological
22 brain changes. They don't occur without
23 the brain being involved physiologically.
24 We all have a brain and when we exhibit
25 neuropsychiatric impairments, it is due to

1 physiological changes in the brain.
2 **Q. In your opinion, is a CT scan sufficient**
3 **to see those physiological changes if they**
4 **exist?**
5 A. It may give you false negatives. You may
6 overlook changes which are not apparent in
7 a CT scan because they are too subtle to
8 be picked up by a simple CT scan.
9 **Q. Well, but can you see them if they exist**
10 **on a CT scan?**
11 A. If you -- you can certainly. If you see
12 progression of atrophy in the context of
13 ongoing neuropsychiatric impairment, then
14 that progression in the context of ongoing
15 neuropsychiatric impairment is consistent
16 with too much ECT being given on an
17 involuntary basis and combined with the
18 post-traumatic stress disorder, which
19 follows. PTSD itself can produce
20 physiologic changes in the brain. That
21 has been documented, documented by
22 neuroimaging.
23 **Q. All right. If those -- I am sorry. If**
24 **those changes do exist, you would agree**
25 **with me that that would be a question**

1 **better answered for either a radiologist**
2 **or a neuroradiologist?**
3 A. No. Because neuroradiologists are not
4 experienced in combining neuroradiology
5 reports with neuropsychiatric impairments.
6 They don't do neuropsychiatric testing,
7 they don't evaluate people for impairment.
8 They simply look at the image and what is
9 on the image.
10 **Q. Well, how about the degree of components**
11 **simply of the physiological changes**
12 **between one CT and another CT, would you**
13 **agree with me that that degree of change**
14 **would be better appreciated by**
15 **radiologists or neuroradiologists than**
16 **somebody like yourself?**
17 A. No.
18 **Q. You don't agree with that?**
19 A. I don't agree with that.
20 **Q. Okay. All right. Finally, for today at**
21 **least, are you going to opine that Clair**
22 **Johnson suffered anything other than**
23 **memory loss and now PTSD, which I heard**
24 **for the first time yesterday, as a result**
25 **of her ECT treatments?**

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1 A. I am going to opine that the
2 neuropsychiatric impairments which I found
3 on my examination and which she reported
4 and on her cognitive symptom checklists
5 are primarily due to a combination of the
6 PTSD that she suffered due to the
7 involuntary ECT and the massive dosages of
8 ECT that she received.
9 MR. EARLY: And we will go over
10 those tests when we reconvene because we
11 don't have time to do that right now.
12 Doctor, I appreciate your time. It is
13 3:00 Eastern Time. I appreciate your
14 time.
15 Just for the record, Cravens, we
16 are agreeing to leave this deposition open
17 based on several circumstances, correct?
18 MR. RAVENEL: Yes, yes. I mean
19 I don't want to do it but I think it is
20 the only reasonable thing to do under the
21 circumstances. I hate to give you all
22 more time to go think of more questions
23 but --
24 THE WITNESS: That is okay.
25 MR. RAVENEL: That's the way it

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1 is and I think it is only reasonable for
2 me to permit that and so that I am going
3 to -- yes, the answer to your question is
4 yes.
5 MR. EARLY: Okay. All right.
6 Thank you.
7 (At which time the matter was
8 concluded at 3:02 p.m.)
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2 HAROLD B. BURSZTAJN, M.D.
3 CASE: Johnson vs. Roberts
4 DATE TAKEN: July 26, 2013
5 ERRATA SHEET
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