

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

Daniel D. Hall, Circuit Court Judge

Appellate Case No. 2019-000359

RECEIVED

MAR 06 2020

SC Court of Appeals

David Miller,.....Appellant,

v.

ENT & Face PA, and Brian Wilson, MD,.....Respondents.

RECORD ON APPEAL

Volume II

Johnson & Davis, P.A.

Hutson S. Davis, Jr. Esquire
S. Harrison Williams, Esquire
10 Pinckney Colony Road
Victoria Building, Suite, 200
Bluffton, SC 29909

Lindemann, Davis, & Hughes, P.A.

Andrew F. Lindemann, Esquire
5 Calendar Court, Suite 202
Columbia, SC 29206

ATTORNEYS FOR RESPONDENTS

McGowan, Hood & Felder, LLC

Whitney B. Harrison
1517 Hampton Street
Columbia, South Carolina 29201

Chad McGowan
Eve Goodstein
1539 Health Care Drive
Rock Hill, South Carolina 29732

ATTORNEYS FOR APPELLANT

INDEX

Volume I

Verdict Form and Order

Verdict.....	1-2
Form 4 Order denying JNOV.....	3-7

Pleadings

Complaint.....	8-15
Answer.....	16-18

Motions , Supporting Memoranda, and Other Filings

Plaintiff’s Motion and Memorandum in Support of Motion for Judgment Notwithstanding the Verdict and New Trial Absolute	19-27
Exhibit A—Excerpts from Plaintiff’s Trial Exhibit 1.....	28-35
Exhibit B—Excerpts from Horning Deposition.....	36-38
Exhibit C—Excerpts from Wilson Deposition.....	39-41
Defendants’ Memorandum in Opposition to Plaintiff’s Motion for Judgment Notwithstanding the verdict and New Trial Absolute	42-49
Exhibit A—Deposition excerpts of Joshua Horning, M.D.....	50-52
Exhibit B— Deposition excerpts of Ronald H. Blum, M.D.....	53-54
Exhibit C—Deposition excerpts of David A. Miller.....	55-57
Exhibit D—Deposition excerpts of Brian Wilson, M.D.....	58-59
Plaintiff’s Exhibit 1—Wilson & ENT records.....	60-85
Notice of Appeal.....	86

INDEX

Volume II

Transcript

Trial Transcript.....87-558

STATE OF SOUTH CAROLINA)	
)	COURT OF COMMON PLEAS
COUNTY OF YORK)	2017-CP-46-00302
)	
)	
)	
)	
DAVID MILLER,)	
)	
PLAINTIFF,)	
)	
vs.)	TRANSCRIPT OF RECORD
)	
ENT & FACE, P.A., ET AL,)	
)	
DEFENDANTS.)	
_____)	

January 28 - February 1, 2019
York, South Carolina

B E F O R E:

THE HONORABLE DANIEL HALL, JUDGE.

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

CHAD MCGOWAN, ESQ.
EVE GOODSTEIN, ESQ.
WHITNEY HARRISON, ESQ.
Attorney for the Plaintiff

HUTSON DAVIS, ESQ.
HARRISON WILLIAMS, ESQ.
Attorney for the Defendants

SHIRLEY BROOM
Circuit Court Reporter

I N D E X

(PW) - Denotes Plaintiff's Witness
(DW) - Denotes Defense Witness

	<u>Page No.</u>
Jury Qualifications.....	8
Jury Selection.....	36
 Introductory Remarks by the Court.....	 60
Opening Statement by Mr. McGowan.....	65
Opening Statement by Mr. Davis.....	86
 <u>(PW) DAVID MYSSIOREK, M.D.:</u>	
Direct Examination by Mr. McGowan.....	96
Cross-Examination by Mr. Davis.....	121
Redirect Examination by Mr. McGowan.....	143
 <u>(PW) DAVID MILLER:</u>	
Direct Examination by Ms. Goodstein.....	149
Cross-Examination by Mr. Davis.....	197
 <u>(PW) RONALD BLUM, M.D.:</u>	
Direct Examination by Mr. McGowan.....	214
Cross-Examination by Mr. Davis.....	244
 <u>(PW) JOEY WILLIAMS:</u>	
Direct Examination by Ms. Goodstein.....	252
 <u>(DW) BRIAN WILSON:</u>	
Direct Examination by Mr. Davis.....	270
Cross-Examination by Mr. McGowan.....	297
 <u>(DW) JOSHUA HORNIG, M.D.</u>	
Direct Examination by Mr. Davis.....	331
Cross-Examination by Mr. McGowan.....	389
Redirect Examination by Mr. Davis.....	426
 Closing Argument by Mr. McGowan.....	447
Closing Argument by Mr. Davis.....	471
Closing Argument by Ms. Goodstein.....	501
 Charge by the Court.....	510
 Verdict.....	531

E X H I B I T S

<u>NO.</u>	<u>DESCRIPTION</u>	<u>ID.</u>	<u>EVD.</u>
(Plaintiff's Exhibits)			
1	Medical Records		50
2	Medial Records Dorn VA		50
3	Medical Records Johnson VA		50
4	Medical Records Carolina Blood		50
5	Medial Records Rock Hill Radiation		50
6	Medical Records PMC		50
7	Medical Bill Summary		50
8	Demonstrative	58	
9	Deposition of Dr. Wilson	300	
10	Photograph of Mr. Miller		50
11	Deposition of Brian Wilson, M.D.	330	
12	Deposition of Joshua Hornig, M.D.	362	
(Defendant's Exhibit)			
1	Progress Note 4/16/2013		148
2	Dr. Brian Wilson's records of David Miller		276
3	Progress Note		440
4	Progress note - 4/19/2013		440
5	Progress Note - 4/19/2013		440
(Court's Exhibits)			
1	Note	530	
2	Note	530	
3	Note	530	
4	Note	530	
5	Note	530	

All Exhibits were retained by the Clerk of Court for York County.

1 break tomorrow morning that you elect a foreperson from
2 among yourselves. And when you elect that foreperson, you
3 come back in the courtroom and for the remainder of the
4 trial, the foreperson will keep this seat up here on the
5 front row all the way here on the end. The foreperson has
6 no greater say in how the case is to be determined, they're
7 simply someone for which the Court can communicate with the
8 jury back and forth if we need to do that. So sometime
9 tomorrow morning when you take a break, go ahead and elect a
10 foreperson from among yourselves. When you do that tomorrow
11 morning, if you'll just simply write that name and number on
12 a piece of paper and hand it to the bailiff and he'll give
13 that to me for the Court.

14 Anything further from the Plaintiff?

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

16 THE COURT: From the Defense?

17 MR. DAVIS: No, sir.

18 THE COURT: Ladies and gentlemen, it's now time for
19 opening statements.

20 Mr. McGowan.

21 OPENING STATEMENT BY MR. MCGOWAN

22 MR. MCGOWAN: May it please the Court, Your Honor.

23 I want you to imagine a government hospital built in
24 the 1970s. This is the Dorn VA, it's in Columbia, and it's
25 March of 2016. And we're sitting in an office with Mr.

1 Miller and he's there with his physician. And David is very
2 tense because he's been waiting for the results of a biopsy
3 that happened a couple of weeks before.

4 David was told by the VA that he has to come to the VA
5 to have a conversation with an ear, nose and throat
6 specialist. He was told that he could not be given the
7 results over the phone. The biopsy was of a tonsil that had
8 been troubling David for years. It's the same tonsil that
9 three years ago, Dr. Wilson told him was fine and was not
10 cancer. And it's the same tonsil that Dr. Wilson assured
11 David was nothing to worry about.

12 Now, whether we like it or not, healthcare is a
13 business, we make a deal with a doctor. And part of what
14 the deal is, the doctor has to put our interest first and do
15 those things that are medically required by the standard of
16 care to keep us safe. When we come in with something that
17 could be cancer, the doctor -- the deal is that the doctor
18 has to do what is necessary to rule it in or rule it out.
19 It's very simple. That's what this case is about.

20 You don't have to be a doctor to know some things about
21 cancer. First, simply put, if the looks of it and the
22 report of it and the symptoms and the examination tell the
23 doctor that this could be cancer, the standard of care
24 requires that the cancer be ruled in or ruled out, period.

25 And now, the way you rule it in or you rule it out

1 depends on the kind of cancer that you're talking about.
2 There might be different ways to do it for different
3 situations, but in this particular cancer, everybody in the
4 world says that the way you rule in or rule out tonsil
5 cancer is with a biopsy. You take a small tissue sample,
6 you send it to the lab, they look at it and tell you if it's
7 cancer or not. That's what's done. It's done in offices.
8 It's done in surgical suites. It's done in dermatology
9 offices, ENT offices. It's done all the time everywhere in
10 the U.S. and around the world when you're trying to figure
11 out if something's cancer. It's simple. It takes about
12 five minutes, local anesthetic, very minimal blood loss.

13 You don't do x-rays. You can, but they don't tell you
14 if you have cancer or not. You don't do MRIs. You can, but
15 they don't tell you if you have cancer or not. You don't do
16 CTs. Again, a biopsy, that's what you do. And there's
17 going to be absolutely no dispute about any of that from
18 Defendant Wilson, from the doctor down in the Charleston,
19 from Dr. Myssiorek, who you'll hear from in a minute.
20 That's just the way you do it.

21 Now, looking at a suspicious spot with your eyes or
22 poking it with your finger, that's not a biopsy. That
23 doesn't do it. So at the Dorn VA in March of 2016, David
24 Miller is now told that he has Stage 4 tonsil cancer and
25 it's spread to his neck and his lymph nodes and surgery is

1 not an option. There's too much stuff going on in there.
2 Chemo and radiation are the only hope to beat this cancer
3 down. His questions are the same ones that you may have
4 right now. How did this happen? Why wasn't this caught?
5 And how did this possibly get missed?

6 Well, for answers, we have to go back to the beginning,
7 to the visits with Dr. Wilson in 2013. Now, David Miller is
8 a Marine Corp veteran and he was disabled in a plane crash.
9 That disability has gotten worse over time, so that entitles
10 him to VA benefits. And he has the type of VA benefit that
11 he could get all of his healthcare through the VA if he
12 chose to.

13 For this particular thing, he thought -- he had this
14 spot on the right side develop. And it wasn't so much pain
15 as it was a fullness, like a cracker was stuck in the back
16 of his throat. He'll tell you about that. It didn't hurt,
17 it was just kind of a lump that he could feel with his
18 finger. He said it felt like a pig's nose. He's a farmer,
19 so he knows that. And then if you looked at it, it was like
20 the end of a cigar.

21 So with this odd feeling, he says, I don't want to go
22 to the VA. I know how long that can take and I know what to
23 expect with the VA, so I want to go to a private doctor and
24 get this looked at immediately. It had existed for about
25 three weeks and he worried enough about it that he went to

1 see Dr. Wilson. He had a lot of folks in his family get
2 cancer. His momma had cancer. He had some aunts that had
3 cancer. And he was worried about it.

4 So what did he do? He went to the ENT in town, in Rock
5 Hill, Dr. Wilson. He had this big office across from the
6 hospital. It looked legitimate to him. He thought he was
7 going to get good care. So he went to see Dr. Wilson. He
8 made an appointment and he reported to the doctor's office
9 what was troubling him and described it to the nurse and the
10 doctor like anybody would when they go and see a doctor. He
11 said it didn't hurt, but it felt full and like something was
12 back there. He also stuck his finger back there to touch
13 it, said it feels unusual, the texture is different. And he
14 said it looked like the end of a cigar. And he shared all
15 that with the doctor.

16 And Dr. Wilson examined him and made a note of what he
17 saw. And he also saw this spot and made a note. And this
18 is actually from Dr. Wilson's records. So this is actually
19 Dr. Wilson's writing. And what he did is he wrote these
20 little scratch marks on this part of the record.

21 Now, Dr. Wilson was told by Mr. Miller he was worried
22 it could be cancer. And so Dr. Wilson says well, I share
23 your concern for cancer. It was only on one side. It was
24 only on the right side. It looked red. And all this led
25 Dr. Wilson to believe that it could be cancer. So

1 unbeknownst to David, but well known to Dr. Wilson, the only
2 way you rule out cancer in this situation is a biopsy.
3 That's not what happened. That biopsy never occurred by Dr.
4 Wilson. And that's called the standard of care. What is
5 required under the situation is called the medical standard
6 of care. And it is when cancer is on the table, rule it in
7 or rule it out. And for this kind of cancer, only a biopsy
8 will do. David Miller did not know this then. Dr. Wilson
9 did know that then. So simply put, if the ENT suspects
10 cancer, he has to do a biopsy. It is that simple. Every
11 doctor that testifies will agree to that simple proposition.

12 So what did he do? Well, he, obviously, didn't do that
13 biopsy, otherwise we wouldn't be here and David Miller would
14 not have the Stage 4 cancer that he was found to have in
15 2016. So how do we know that Dr. Wilson said gosh, this
16 could be cancer? Well, he put it in his records. This is
17 actually in evidence. And what he put in the problem list
18 was malignant neoplasm of tonsil. That's medical speak for
19 cancer. Malignant neoplasm means cancer.

20 Now, Mr. Miller didn't see his record. This was Dr.
21 Wilson's record. So he clearly knew at this point when it's
22 in his record that malignant neoplasm of the tonsil could be
23 one of his problems. Similarly, on his bill, he put problem
24 list, malignant neoplasm of tonsil. And when he decided to
25 order an MRI, he put that on the request, neoplasm malignant

1 tonsil. Clearly, Dr. Wilson thinks it could be cancer, but
2 he ordered an MRI. That's not what you do. You get a
3 biopsy. Anyway, clearly, Dr. Wilson had a concrete concern
4 for this cancer and he just didn't do what you're supposed
5 to do.

6 So what did he do? He did order an MRI, that's okay.
7 I mean, it's not what you do, but okay, fine, didn't hurt
8 anybody. Sometimes before you start treatment or you do
9 further, you want to see if it's spreading already or if
10 it's a big tumor or something, but you cannot rely upon that
11 MRI to say there's no cancer. That's just not the way it's
12 done. So the MRI did not show anything remarkable. Now, if
13 you look at those scans today in retrospect, you can see
14 some asymmetry, but it's nothing that you would think was
15 cancer back then, which is why you don't use MRIs.

16 So, Dr. Wilson, on the first visit orders his MRI.
17 What he should have done right then and there, sample, five
18 minutes, local anesthetic, send it off to the lab and be
19 done with it. That's what should have happened, but that's
20 not what happened.

21 Dr. Wilson schedules this MRI. David Miller goes to
22 get it. He comes back about a week later. And at this
23 visit, he still has the spot, still there, still bothering
24 him. And on that visit, the MRI results were not shared
25 with Mr. Miller. That wasn't going to happen until the

1 third visit. But what Dr. Wilson did is gave him some
2 Keflex, an antibiotic, and sent him away, said come back in
3 three weeks. So David Miller did just that. What he should
4 have done at that second visit is say, you've still got this
5 lump here, it's a problem, why don't we just take some
6 tissue and send it off and see what it says. That's not
7 what happened.

8 Anyway, about two weeks into that three-week period,
9 David had some heart issues, he gets some stents put in. He
10 goes down to the VA to get some stents put in. He comes
11 back to Rock Hill and sees Dr. Wilson at the appointed time
12 at that three-week visit. Now, that thing is still there.
13 It's still a lump. It doesn't hurt. It's not causing any
14 problems other than it's just there. It's still the
15 fullness.

16 And it was that third visit that Dr. Wilson went over
17 the MRI results with Mr. Miller. Now, this was in Dr.
18 Wilson's office. It was not in an exam room. It was
19 actually in his office on the desk. And Mr. Miller was
20 talking with Dr. Wilson. Dr. Wilson said, Well, there's
21 nothing here that makes me worry about the C word. And Mr.
22 Miller goes, The C word, you mean cancer? And he goes, Yes.
23 So there's no reason to worry about cancer, that's what Dr.
24 Wilson said. There's no cancer here, there's nothing to
25 worry about. He says, We could go in and take those tonsils

1 out at some point, but unless it's an emergency or critical
2 situation, there's no reason to do that. So there's no exam
3 of any kind. It's in an office, not an exam room, and the
4 point was to go over the MRI results.

5 So Mr. Miller takes this and says great. I was worried
6 about cancer. The doctor's done what I think -- what I
7 guess he's supposed to do and tells me I don't have cancer.
8 So he's very happy with that result. And he'll tell you
9 about how happy he was to hear that in 2013.

10 It's a huge relief. He shared that relief with his
11 friend, Joey. Joey is sitting here with him. Joey Williams
12 has known David Miller since they were 12 years old.
13 Literally, grew up together. They were in the Marines
14 together. They live about 40 miles apart. Joey at one
15 point had cancer, David helped him out with that, and Joey
16 returned the favor. They're just buddies, literally, for
17 life. They've known each other since they were 12. And
18 Joey was there every step of this way and will tell you what
19 was going on.

20 If David had been told that it was cancer, obviously,
21 he would have dealt with it, he'll tell you. And if he was
22 told that it could be cancer, that this didn't rule it out,
23 then he would have gone further. After all, he decided to
24 go outside of the VA system and seek that care independently
25 from Dr. Wilson. But he was told, he had a test that looked

1 legit to him, that everything was fine.

2 Mr. Miller then, after that, went about his life. He
3 says this is a lump. It's a benign thing. You know, if
4 I've got to worry about it later, I will, but it's not
5 cancer, so I'm not really worried about it. He kept going
6 back to the VA for his normal healthcare. He'd get his
7 prescriptions refilled. He would not normally see a doctor
8 unless it was something complicated like a heart issue. The
9 VA systems uses a lot of nurse practitioners and physician's
10 assistants. There's nothing wrong with that, that's just
11 the way they do their business. And Mr. Miller would see
12 these folks on the by and by.

13 It came to October of 2015, about two and a half years
14 after his visit with Wilson and he actually had a sore
15 throat. It's October. He had some inflammation, a little
16 sore throat that he reported to the non-urgent, sort of
17 emergency room at the VA. That's where you go in for kind
18 of routine stuff like this. And he reported that and they
19 diagnosed him at that point with acute tonsillitis. The
20 right side was more swollen than the left. They gave him
21 some antibiotics and that cleared up that. The lump was
22 still there, but the pain from the sore throat actually went
23 away.

24 Come January, this thing had started getting bigger.
25 It started growing slowly and progressively over time. And

1 before January of 2016, he would have a problem breathing
2 sometimes when he was laying back. It kind of clogged up
3 his airway. So he said this thing's getting -- I've got to
4 get this checked out. So he reports it to the nurse
5 practitioner at his yearly visit in January at the VA. And
6 she looks at it and says, Yeah, we need to get that looked
7 at, something's going on there. Let's refer you to an ENT.
8 And she writes a referral to an ENT that says this tonsil
9 has been bothering him for years. Let's check this out and
10 get that done.

11 During this whole time, David thought, based on what
12 Dr. Wilson told him, it was a completely benign swelling in
13 the tonsil. He was of the mind that when you're older and
14 get your tonsils out it's kind of a bigger deal than when
15 you're a kid, so he was putting it off because he didn't
16 think it was any big deal. He was told it was not cancer
17 and nothing to worry about.

18 So the ENT checks him out and says yeah, you got
19 something going on back there, schedules a biopsy. It's on
20 February 11th, he sees that ENT. The ENT finds the right
21 tonsil was enlarged and there was a mass in his neck to go
22 with it. The ENT orders a CT to figure out what's going on,
23 which occurs five days later. The CT shows a mass in the
24 tonsil and in the neck. And then he gets referred to the
25 surgeon to have that biopsy done. The surgeon writes in his

1 notes, which we'll see, a three-year history of enlarged
2 right tonsil, minimally responsive to antibiotics, now
3 affecting speech as well. That's what the surgeon writes.

4 The plan is to schedule this biopsy, which now happens
5 March 1st. This procedure was done, like they all are,
6 local anesthetic, estimated blood loss is like two
7 milliliters is what they said, hardly complicated. The
8 biopsy is done and the results come back as oral cancer.
9 This result was communicated to the ENT and the ENT had
10 another appointment set up with Mr. Miller in March and
11 that's when he's told that he has Stage 4 cancer that has
12 now spread in his throat and neck.

13 He's immediately referred to a dentist because the
14 treatment for this involves radiation. And the dentist has
15 to make sure your teeth are in good shape because the
16 radiation can kill your whole jaw bone. That's call
17 osteoradionecrosis. Bone radiation death, essentially. So
18 they've got to make sure your teeth are in good shape
19 because if you lose a tooth after the radiation, your jaw
20 can get infected and just the whole thing dies, then you
21 don't have a jawbone. So he gets sent over to the dentist.
22 It took 30 days to get him into the VA dentist. That's one
23 of the issues with the VA, he has Stage 4 cancer and it took
24 him 30 days to get an appointment with the VA dentist.

25 So anyway, Stage 4 means a couple of things. First, it

1 means it's going to be a whole lot tougher to treat. It
2 will require chemo and radiation. Surgery is not an option.
3 To remove this from the neck, it's just not an option. If
4 it had been caught three years earlier, the testimony is it
5 would have been Stage 1, confined, small, take out the
6 tonsil, no radiation, no chemo, Stage 1, if that. It would
7 have required a simply tonsillectomy. The nodes would have
8 been clear, tumor very small and it would not have spread
9 like it did over that two-and-a-half, three-year period.
10 Well, how do we know that? Well, because an oncologist,
11 cancer specialist is going to come in and talk to you about
12 how that works.

13 The other thing about Stage 4 is not only the
14 treatment, it's the prognosis. Now, cancer that has spread
15 is much more likely to come back and come back harder to
16 treat. It's called metastasis. At the time of the
17 diagnosis, the survival rate from a Stage 1 was greater than
18 70 percent. Stage 4, less than 30 percent. That's a big
19 difference. And what that means is that more likely than
20 not, Mr. Miller is going to pass from this metastasize of
21 this recurring cancer.

22 So March of 2016, the VA formally diagnosed him with
23 that tonsil cancer. David was shocked by this, as he was
24 explicitly told that he didn't have anything to worry about.
25 Once that shock wore off, he went about getting treatment.

1 He gets a dental evaluation and then he goes to see the
2 oncologist, radiation oncologist, that's a radiologist who
3 shoots radiation and a regular chemo oncologist, who gives
4 him chemotherapy. The treatments help, but they also cause
5 extensive damage to the body.

6 There are only three ways to treat cancer, surgery,
7 chemo and radiation. Surgery, you cut out the cells.
8 Chemo, you poison them, and radiation, you burn them.
9 Doctors can fancy it up, but that's what's happening. Now,
10 the same radiation that burns the cancer cells burns the
11 patient. And the same chemo that kills the cancer cells,
12 that poisons the cancer cells poisons the patient. You're
13 going to hear about all those treatments.

14 His chemo was a six-week course. Everything you'd
15 expect from chemo, hair loss, fatigue, all of that happened
16 with that. He also had to undergo radiation. Now,
17 radiation is -- I didn't much about it until this case
18 started. But he had 35 treatments of radiation. And they
19 did quite the number on his neck, his throat, his tongue,
20 salivary glands. And that was then and continuing to this
21 day.

22 Now, the doctors do the best they can to only burn the
23 cancer. It can't be helped that normal cells will get
24 burned as well, so they try to focus that radiation as well
25 as they can. This starts with the patient getting what's

1 called a mask. And I hope nobody goes through this, but if
2 you've done radiation oncology, one of the things the doctor
3 will first do is take one of these out, warm it up and make
4 it pliable and they then will press it over your face and
5 your torso to make a mask that they can then bolt you to the
6 table so that you don't move. Because if you move during
7 radiation, cells that shouldn't get burned will get burned.
8 So this is the way the doctors help try to avoid the
9 extraneous damage from this. But you still have to go
10 through this process.

11 And these holes inside this are where you're supposed
12 to be bolted to the radiation treatment table. And that
13 radiation treatment, it looks like an x-ray machine. We'll
14 hopefully be able to describe it to you. You're strapped
15 down and this thing will go around and it's shooting
16 radiation. It's just burning you. It doesn't feel so bad
17 at the time. Sometimes you get a metallic taste in your
18 mouth and it taste really awful. But it's the effects that
19 happen later that are really the bad stuff.

20 Now, part of the effects of this is -- the early effect
21 of radiation is, essentially, a sunburn. Your skin gets red
22 and it looks like you've been burned by the sun because
23 that's the same stuff that burns you. The next step of that
24 is the skin can come off, you just get frankly burned. At
25 the same time, the structures inside your mouth get burned.

1 The mucus membranes in your throat, your salivary glands get
2 burned, your taste buds get burned. And all of this is
3 cumulative. So the first one does it a little, the second
4 one more, the third, fourth, thirty-fourth, thirty-fifth, it
5 gets bad at the end. And a lot of those effects are and
6 were permanent for David Miller.

7 So right now, what he has is he's got no salivary
8 glands, so permanent dry mouth. He has no taste buds, can't
9 taste anything. He's got scarring on his neck from all of
10 this. He's got -- during the course of this, just -- he
11 said it was just -- he'll describe it. It's something else.

12 This is what David looked like April of 2016. That was
13 about a week or two before the radiation started, maybe a
14 month. And his hair didn't come in right, turned gray, he
15 lost it, the beard. This is what all that treatment did to
16 him. It's what the treatment did. He'll tell you about all
17 that. The oncologist will tell you about that. Joey will
18 tell you about all that.

19 He can't enjoy food anymore. No taste whatsoever.
20 Permanent cotton mouth. He can't eat certain foods,
21 anything that's dry, breads, cookies, cake, meat. It has to
22 be something with moisture in it, soups and Ensure and all
23 that kind of thing. He's losing his gums because radiation
24 will kill those, too. Constant fear of losing a tooth
25 because if he loses a tooth, then the jaw is going to go.

1 His hair before, you saw it. Now, it is what it is.

2 And all this is from the radiation and the chemo and
3 not due to the cancer. It was due to the fact that the
4 cancer got out of hand at Stage 4 because it was Stage 1,
5 and this is what happened. You'll hear evidence about all
6 that.

7 It was not caught because Dr. Wilson didn't do what
8 literally every ENT on the planet would have done, which is
9 do a biopsy. Why did he not do it? I don't know. We have
10 to gather some information about why that happened.

11 So this is a lawsuit, we're in court, we're suing.
12 Nobody should be surprised by that. Who's the Defendant?
13 Dr. Wilson and his practice. Why are we suing them?
14 Because in 2013, cancer was on the table, it was likely and
15 he didn't rule it out with a biopsy. More than that, if he
16 was not going to rule it out by doing the right test, he
17 should have told Mr. Miller, listen, man, you could still
18 have cancer. Because if he had been told that, Mr. Miller,
19 just like he went to Brian Wilson to begin with, would have
20 gone to another doctor and said listen, buddy, this may be
21 cancer and this guy's not helping me out. But that's not
22 what Dr. Wilson did and that's why we're suing.

23 So legally, what do we have to do. We have to prove
24 three things: A standard of care, a breach of that standard
25 of care -- this is fancy legal language -- and that that

1 breach caused or substantially contributed to injury.
2 Standard of care just means what would a normal doctor do in
3 this circumstance. Easy peasy, every doctor says do a
4 biopsy. We know he didn't. So breach and standard we think
5 will be easy to prove. That it caused the injury we
6 complain of. We're claiming damages for the fact that the
7 cancer went from Stage 1 to Stage 4, chemo and radiation and
8 all the aftereffects and the bills only associated with
9 that.

10 Now, there's going to be a cancer specialist who comes
11 in. Our first witness will be an ENT specialist, ear, nose
12 and throat, otolaryngologist. He's going to testify today.
13 The witness tomorrow will be an oncologist.

14 As far as damages from all of this, you're going to
15 hear from David and his friend, Joey, who was with him
16 literally every step of the way, about all of the damages
17 that have been wreaked up him by virtue of the way this
18 thing got the way it is. And this is court, so the only
19 thing you can do is convert all of this hassle, all of this
20 pain, all of this inconvenience, all of these treatments,
21 all these permanent impairments to doing something like
22 eating into money.

23 And at the end of the trial, we're going to ask you for
24 a lot of money for that. We're going to ask you for eight
25 million dollars for what happened here, for the chemo, the

1 radiation, the scars, the permanent dry mouth.

2 We're also going to ask you to answer two questions in
3 the affirmative, whether this meets a legal definition of
4 reckless, which we'll get into in this trial, and whether
5 Dr. Wilson has made a misrepresentation related to claim.
6 Those will be, hopefully, two separate questions on the
7 verdict form.

8 So what does Dr. Wilson say about all this? It's
9 pretty open and shut. You thought he could have cancer and
10 you didn't get a biopsy. Well, what he says is that the
11 spot in the right tonsil went away and it just so happened
12 that the Stage 4 cancer was found in the exact same spot.
13 Literally, that's what he's going to say. And that's what
14 they paid -- they've got this fellow coming from Charleston
15 who's going to say it is a pure coincidence that the spot in
16 the right tonsil that Dr. Wilson thought may be cancer went
17 away completely and now it just happened to come up.

18 As evidence for this, he's going to point to his own
19 exam that he says he did on that third visit where he didn't
20 feel anything or see anything. Let's assume that happened.
21 David says it didn't, but let's assume it did. Poking it
22 and looking at it is not how you rule out cancer. Everybody
23 agrees with that, too.

24 This particular cancer, interestingly enough, starts on
25 the inside like a buried nodule, it comes out. It doesn't

1 go -- I mean, outside and go in. So if it's buried in
2 there, that's why you get a biopsy.

3 So what else does Dr. Wilson say? Well, he says that
4 David went to his primary care visits with a nurse
5 practitioner at the VA and they didn't find anything. He
6 didn't mention it and they didn't find anything, therefore,
7 it wasn't there. That's curious. It assumes a couple of
8 things that we'll get into, one of which is the nurse
9 practitioner doing yearly exam and gets scripts refilled is
10 going to be looking at tonsils and all that kind of thing.

11 We also know that the VA charting is something else
12 altogether. And we're going to prove this to you with
13 records that we have. We'll get into all of it. But he was
14 diagnosed for sure, definitively post-biopsy in March of
15 2016 by the VA. And that dental visit on April 12th, they
16 claim they did an oral cancer screen and found no evidence
17 of any pathology. So the VA had him clearly diagnosed Stage
18 4 cancer -- we're going to actually show you a picture of
19 this thing, it's a honker, and that the dentist says he
20 didn't see any evidence of that 13 days later. You're going
21 to have to deal with that, whether the VA records are what
22 they purport them to be. So it was very important for Dr.
23 Wilson to do the right thing when he had the chance.

24 One of the other things you'll notice in the VA records
25 is that every time it was spoken about, Mr. Miller said this

1 has been bothering me for years. The doctors put it in the
2 records it's been going on for years. This has been a
3 problem. It's only recently got worse. You'll see the
4 records from Dr. Thakkar, who's a radiation oncologist.
5 It's actually in evidence, we'll show it to you. And it
6 tells exactly what happened under the same records that
7 we've been over and over, I have and Mr. Davis has, and
8 everybody in this room, except y'all have been over this for
9 years.

10 So what happens next is that you're going to hear from
11 Mr. Davis. And he's going to tell you what Dr. Wilson's
12 side about all this is. We're going to call our first
13 witness. We'll call our witnesses, they'll call theirs.
14 We'll probably be done by Wednesday. That's short for
15 medical malpractice trials, but because it's short, don't
16 take that as being not important because it is vitally
17 important. We're trying to be efficient. Mr. Davis has
18 been doing this for a good long time. I have, too. We're
19 trying to be respectful of you and your time.

20 At the end of this case, the Judge will give you the
21 law to apply to the case. Y'all have to determine the
22 facts. There will be a verdict form, which we'll go over at
23 the end of it. And I hope that you will side with David
24 Miller on this. Thank you.

25 THE COURT: Mr. Davis.

1 MR. DAVIS: May it please the Court, Your Honor.

2 OPENING STATEMENT BY MR. DAVIS

3 MR. DAVIS: Good afternoon. Usually, we say Mr.
4 Foreman or Madam Foreman, but we don't have a foreman, so
5 good afternoon, jury.

6 First of all, I want to tell you that Dr. Wilson and
7 his defense team, me and my partner and my paralegal,
8 appreciate the time that you will spend in taking care of
9 this case and listening to the evidence presented.

10 If you just listened to the opening statement of Mr.
11 McGowan, you're wondering why in the world we're here, you
12 know, because it seems like it's pretty much a slam dunk
13 case. But the reason we're here is because there's a lot
14 more to this case than you've heard from Mr. McGowan. And
15 it matters a lot in the defense of the case.

16 It's a medical malpractice case, and Mr. McGowan
17 focused on this just a little bit. In a medical malpractice
18 case, we have what you'll hear referred to as the standard
19 of care. What that simply means is what an ordinary
20 physician equally trained with Dr. Wilson would have done
21 under the same circumstances.

22 The reason we have that is because most of us know in
23 negligence cases, like running red lights or running stop
24 signs and those kinds of things, we know what the rules of
25 the road are, but in medical cases, we don't know the

1 medical rules of the road for those of us who are lay
2 people. We require experts to come in and tell us what they
3 are.

4 As Mr. McGowan said, you'll hear from his side from the
5 ENT and oncologist. And from our side, you'll hear from the
6 ENT, who is an oncologist and who practices at the Medical
7 University of South Carolina. And they'll tell us -- you'll
8 get to decide. They have different opinions, obviously.
9 And you can weigh that evidence. It doesn't mean you've got
10 to believe everything that any of them say, you can weigh
11 that evidence and believe as much or as little as you'd like
12 to believe.

13 But one thing you should remember throughout all of
14 this, and that is that they'll be only one doctor who
15 testifies in this entire case who actually touched Mr.
16 Miller, who actually saw what Mr. McGowan referred to and
17 the records refer to as the spot on the tonsil, who actually
18 treated this patient for three different visits. That's the
19 only -- even with my expert, that's the only doctor in this
20 case who actually treated and saw Mr. Miller.

21 And you may at the end of the case want to know why
22 that is. And that's perfectly okay for you to consider
23 that. Because in these cases, there's several kinds of
24 evidence. And one of the kinds of evidence, of course, is
25 the medical evidence. And we put those in by agreement,

1 they're here, all of the medical records. And that's one
2 form of evidence. The other form, of course, is testimony.
3 It can come from lay witnesses or expert witnesses.

4 But then there's another kind of evidence that you may
5 want to ask about, too, and that's the evidence that's not
6 here. And when this case is over with, I think you'll find
7 there's significant evidence that's missing from this trial
8 and you'll wonder why it's missing. And that's perfectly up
9 to you to decide why the evidence has not been presented to
10 you. Because in a case like this, the Plaintiff, they have
11 the burden of proof, and they accept it. By filing this
12 paper, the way we practice law, the Plaintiff accepts the
13 burden of proof and says I have a duty to come to this jury
14 and convince them of my case.

15 You've all got better things to do, I presume. You
16 could be somewhere else that you want to be, but you came
17 here because civic duty. And you're being asked to decide a
18 negligence case against a physician, something that's a
19 little bit complicated. In order to do that, I think
20 there's a duty on all of us, but, in particular, it's a duty
21 on the Plaintiff because they have the burden of proof to
22 give you the evidence that you need to make that decision.
23 And I submit when this case is over, there will be some
24 evidence lacking and you won't have the evidence you need to
25 make the decision you need to make for the Plaintiff.

1 It's true that Mr. Miller came in -- as you will see
2 from the records, and the records are clear, Dr. Wilson has
3 very little memory of Mr. Miller. We have to rely on
4 records, but this happened in 2013. So what's in the
5 records is basically what happened at the different sessions
6 of treatment. And you will find, as Mr. McGowan claimed,
7 Mr. Miller came in and he had a spot on his tonsils. He
8 will describe that spot for you. And he will say it was
9 about as big as the end of a cigar, whatever. He describes
10 it in his own terms. But he will also say to you that that
11 spot never went away, that it was always there. That's what
12 Mr. Miller will say.

13 The records will show you that when Mr. Miller came in
14 the first time -- and let's forget this thing about a biopsy
15 for a second, okay, because I think all of us have taken our
16 children for sore throats to the doctor. We've been to the
17 doctor ourselves for a sore throat. We've been to the doctor
18 with red tonsils. They don't do a biopsy on the first
19 visit. You don't go in there and start cutting on somebody
20 because biopsies are -- there is a danger with biopsies.
21 All the physicians who testify in this case will tell you
22 that a biopsy is not a very minor procedure. You will find
23 through Mr. Miller's own testimony that when they did a
24 biopsy at the VA, he got an infection. So it's not
25 something you just do. So Dr. Wilson is looking at this

1 spot. He looked at the spot, observed the spot. Wrote it
2 down. Sure, he was concerned about cancer, it's in the
3 record. And what did he do? He ordered an MRI.

4 Now, you've been told that most people don't do an MRI
5 and that's correct. And the reason is, the physician who
6 testifies from the Medical University of South Carolina will
7 tell you that that's above and beyond the standard of care.
8 That's a higher standard of care to go ahead and order the
9 MRI. Because here's the thing, if you're going to do a
10 biopsy, you want to know what to biopsy. You want to know
11 if there's a mass there, if there's something there that you
12 can take a piece of.

13 Certainly, if you're going to take someone's tonsil out
14 -- and we'll hear testimony from all the experts who will
15 tell you that a tonsillectomy on a 62-year-old person is
16 serious. You don't just do that for the heck of it. You
17 take the time and you worry about it and you find out, there
18 never was a tonsillectomy done for lots of reasons.

19 So the biopsy -- in order to take a proper biopsy, you
20 need a pic, you need a film. They did the same thing at the
21 VA. They took a CT scan. You need to know what to do and
22 Dr. Wilson did that. And the MRI comes back and says you
23 don't have a mass here. You don't anything here to biopsy.
24 There is no mass. He will describe what he called a spot,
25 what Mr. Miller called a spot on his tonsils.

1 But on the second visit when Mr. Miller comes back,
2 that's cleared up. There's less redness and we've got a
3 negative MRI. So Mr. Miller goes on his way. He's told to
4 come back in three weeks, I believe it is. As you've been
5 told, during that time, he had a cardiac event, which took
6 place and he had to have stents.

7 So when he comes back the third time, I believe that
8 even the experts for the Plaintiffs will tell you now he's
9 on what's called a platelet inhibitor or we commonly refer
10 to it as blood thinner, it's called Plavix. And I believe
11 that even the Plaintiff's expert will tell you, at that
12 third visit, you certainly don't do a tonsillectomy and you
13 don't even do a biopsy now because the guy's on a blood
14 thinner.

15 Well, what's he told? He's told that there's an MRI
16 that's negative. It shows no mass there. It's cleared up
17 completely. You can't even see the so-called spot anymore,
18 it's not there. And Mr. Miller is told to go away, go home
19 and to come back if he needs to. He never comes back ever.

20 You will find by his own testimony, the story that will
21 be told to you is that from that point on, he went through
22 almost three years without ever seeing a physician for
23 anything to do with his throat. And he will tell you that
24 all the time, the so-called tip of the cigar, the lesion or
25 whatever it is that Mr. Miller will describe was still on

1 his throat. The whole time, according to the Plaintiff,
2 there's a cancer on the tonsil that's now three years old
3 that hasn't gotten any bigger, it hasn't metastasized. This
4 is a cancer that's just sat there for three years. An
5 expert from the Medical University of South Carolina will
6 tell you that doesn't happen with cancer. Cancer doesn't
7 just sit in one place dormant for three years. It doesn't
8 happen.

9 So yeah, he has a sore throat in October of '15, I
10 believe it is, and he goes to see a person who examines him.
11 And this person who examines him, they don't see any nodule
12 or lesion on his throat and they treat him with an
13 antibiotic. And then he's diagnosed in 2015.

14 You can call it a coincidence if you want to, but if
15 you think of it this way, every person who has a sore throat
16 as a child and later has cancer of the throat, whether it's
17 tonsils or somewhere else, doesn't go back and sue the
18 doctor because they failed to do a biopsy. The point is, in
19 order to believe what the Plaintiff will offer you, you've
20 got to believe that this cancer just stayed in one place,
21 did nothing for three years and then all of a sudden, it
22 showed itself.

23 Dr. Wilson's position is really clear and it's in the
24 record. And that is that Mr. Miller came to see him three
25 times. And on the third time, the spot on his tonsils which

1 he found on his right tonsil was completely cleared up. And
2 told what anybody -- what most of us have heard from our
3 doctors, and that is okay, come back if you have any more
4 problems with it and we'll look at it again. And he never
5 came back.

6 And as I said, it's been mentioned to you before, you
7 bring your common sense into this courtroom. We will --
8 both sides will give you experts and you can hear medical
9 opinions and you can hear medical theories, but sometimes,
10 we have to apply our common sense. And I submit to you this
11 just doesn't make sense. It makes no sense.

12 You will see in the records -- and they can diminish if
13 they want to the value of the medical care or the ability of
14 the Veteran's Administration, but we don't. And there will
15 be records introduced to you of different people of
16 different medical disciplines at the VA, all of whom at one
17 time or another took a look down the throat of Mr. Miller
18 and saw nothing. They didn't see the tip of the cigar, they
19 didn't see the spot, they didn't see the rash all these
20 three years, where he will say that they're all not telling
21 you the truth. Because he will say that every one of them
22 should have seen it because it's been there the whole time.
23 If you want to believe that, it's up to you, but it's a lot
24 of doctors.

25 So as we go through this case, I ask you to just apply

1 your common sense to what we're looking at here, apply your
2 common sense to the fact that on the third visit when Mr.
3 Miller came back to Dr. Wilson, he was in a position where
4 no biopsy could be taken and the tonsils couldn't be
5 removed.

6 But moreover, as a physician, he was in the position of
7 what would I biopsy or what would I remove? You certainly
8 -- a tonsillectomy, as I said, is a dangerous procedure.
9 And who would remove a tonsil in the face of a negative MRI
10 saying you have no mass? An MRI is a very sensitive test
11 that we can run. MRIs are done on lungs, on all the organs
12 of the body to determine if there's a mass there which could
13 be cancer. Sure, you can't rule out cancer with it, but you
14 can rule out the mass that is cancer. And the MRI is
15 negative.

16 Now, you can talk about the fact well, if you go back
17 and look at the MRI now, there might be something there.
18 Well, Dr. Wilson is not a radiologist. And Dr. Wilson has a
19 right to rely on the report that he gets back from the
20 radiologist. And if the report comes back negative, it's
21 negative.

22 So all we ask you to do as the defense team is just
23 apply your common sense, listen to the witnesses as they
24 testify and see what you think about this case. And I think
25 when you do that, we're confident that you will find a

1 verdict for the Defendant in this case. And I appreciate so
2 much you listening to the evidence that is presented. Thank
3 you very much.

4 THE COURT: Lawyers approach.

5 (Whereupon, a bench conference was held in the presence
6 of the jury but outside the hearing of the jury.)

7 THE COURT: Ladies and gentlemen, we anticipate that
8 the first witness is going to take 45 minutes or an hour, so
9 we're going to take a 10-minute break and we will have you
10 back here in court.

11 Do not discuss the case among yourselves at all.

12 Everyone remain seated while this jury is excused.

13 (Whereupon, the jury exits the courtroom at 4:35 p.m.)

14 THE COURT: All right. We'll be in recess about 10
15 minutes.

16 (Whereupon, a short break was taken.)

17 THE COURT: Is the Plaintiff ready?

18 MR. MCGOWAN: Yes, sir.

19 THE COURT: Defense ready?

20 MR. DAVIS: Yes, sir.

21 THE COURT: All right. Let's bring the jury in.

22 (Whereupon, the jury enters the courtroom at 4:43 p.m.)

23 THE COURT: Thank you, ladies and gentlemen.

24 Mr. McGowan, call your first witness.

25 MR. MCGOWAN: Your Honor, the Plaintiff calls Dr.

1 Myssiorek.

2 THE CLERK: Place your left hand on the Bible and raise
3 your right.

4 DAVID MYSSIOREK, M.D.,

5 after being duly sworn, testified as follows:

6 DIRECT EXAMINATION

7 BY MR. MCGOWAN:

8 Q Doctor, let's start off by getting to know you a little
9 bit. Who are you and where are you from?

10 A My name is David Myssiorek. I'm a physician. I'm from
11 New York, born and bred. It's pronounced like the river
12 with a K, but not spelled in anyway close to that.

13 Q Tell us where you got your training. Where did you go
14 to med school?

15 A I started off, I went to college at the University of
16 Buffalo where I measured as a speech therapist working with
17 cancer patients. From there, I went to NYU School of
18 Medicine, graduating in 1980, completed my residency in
19 otolaryngology, what we're going to call here, I guess, ear,
20 nose, and throat. From there, I did one of the first
21 fellowships in head and neck oncology in this country. That
22 was done at Montefiore Medical Center in the Bronx, New
23 York. It was a one-year fellowship where we were treating
24 all forms of head and neck cancer. And that has been the
25 nature of my practice since.

1 Q So you've been treating head and neck cancer as an
2 otolaryngologist and a surgeon for 38 years, 39 years?

3 A I can't count residency, it's not fair to do that.
4 It's about 35 years or so.

5 Q Are you Board certified in any medical specialty?

6 A I am Board certified in otolaryngology. There is no
7 subspeciality board at this time for head and neck. But I'm
8 Board certified in otolaryngology since 1985, and I'm so old
9 that I'm grandfathered in.

10 Q Have you had any appointments where you've taught at
11 medical schools?

12 A I've had every academic appointment that was available.
13 I've been a clinical instructor, an assistant professor, an
14 associate professor, sat on associate professor committees,
15 obtained full professorship at NYU, and I recently changed
16 jobs and I do not have my academic appointment yet, but I
17 will.

18 Q And you're currently practicing?

19 A I'm very currently practicing.

20 Q In the field of otolaryngology?

21 A I am doing otolaryngology with trying to see as many as
22 head and neck patients as I still can.

23 Q Have you, in the course of your career, encountered
24 oral cancers like are at issue here?

25 A I most certainly have.

1 Q Tonsil cancers?

2 A I've been there from the bad old days to the good old
3 days.

4 Q And do cancers like we're talking about here, tonsil
5 cancer, have you treated patients, diagnosed and treated
6 patients just like this?

7 A Yes, sir.

8 Q Have you taught medical people about oral cancers,
9 nurses, medical students, residents?

10 A Back in the 90s, I did a couple of videotapes for
11 companies that were trying to teach the public about oral
12 cancer and the risks of cigarette smoking, et cetera,
13 alcohol abuse. I teach nurses who are willing to listen in
14 the operating room. I find that frequently my nurses know
15 more than I do. I teach medical students, I teach PAs,
16 physician assistants, nurse practitioners. My pride and joy
17 are my residents. Many of them have now gone on to do head
18 and neck fellowships. Frankly, you'll learn, I like to
19 talk, so I don't mind teaching anybody who will listen. Not
20 my children, they don't listen.

21 Q Have you made presentations to other doctors on
22 subjects in the ENT field?

23 A I have I think in excess of 120 presentations,
24 internationally and nationally, on a slew of subjects, many
25 of them cancer, some of them not cancer. And I've written

1 book chapters on cancers. The answer is yes.

2 Q Now, when you go to get Board certified, you have to
3 take what's called the Board exam; is that right?

4 A Yes, sir.

5 Q And part of that is other doctors will pose questions
6 to the, hopefully, to be Board certified doctor, to the
7 student?

8 A I'm a Board examiner.

9 Q So your role in that is what?

10 A Well, my role as the examinee, I was to sit there and
11 sweat and to give as many correct answers as I could. And
12 as an examiner was to make that person sit there and sweat
13 and give me as many correct answers as he or she could.
14 It's much easier being on this side.

15 Q So you were part of the process of getting newer
16 doctors, new ENTs Board certified, giving them the test to
17 see if they qualify?

18 A I like to look at it as making sure the people that
19 shouldn't be certified were not certified. There's got to
20 be a filter somewhere.

21 MR. MCGOWAN: Your Honor, at this point, we would offer
22 Dr. Myssiorek as an expert in the field of ENT or
23 otolaryngology and cancer disorders of the head and neck.

24 THE COURT: Mr. Davis?

25 MR. DAVIS: No objection.

1 THE COURT: I find he is qualified as an expert in each
2 of those areas.

3 BY MR. MCGOWAN:

4 Q Doctor, what did you review in connection with your
5 work on this case?

6 A Not in this particular order, I reviewed Dr. Wilson's
7 notes. There weren't that many for me to review. I
8 reviewed the depositions of Dr. Wilson, Mr. Miller. I did
9 not look at all of the depositions. I did look at the
10 Defense expert, Dr. Hornig's deposition.

11 Q And did you review medical records from the VA?

12 A Thank you. I did review medical records from the VA as
13 much as I possibly could.

14 Q How about the radiation oncologist, Dr. Thakkar?

15 A I saw parts of it. I did not look at the entire thing.
16 At this point, it was going to a different part of the case
17 that really -- in my opinion did not require my particular
18 expertise.

19 Q So your focus is on what Dr. Wilson did or didn't do?

20 A I tried.

21 Q Okay. Have you identified one or more deviations from
22 the applicable medical standard of care in connection with
23 the actions or inactions of Dr. Wilson and his practice
24 related to Mr. David Miller?

25 A I did.

1 Q Is it your testimony that to a reasonable degree of
2 medical certainty, more probably than not that the actions
3 or inactions of Dr. Wilson, his deviation from the standard
4 of care were a proximate cause of the injuries suffered by
5 Mr. Miller?

6 A I definitely did. There were some missteps along the
7 way that did impact strongly on Mr. Miller.

8 Q Okay. What kind of cancer did Mr. Miller had?

9 A Mr. Miller had a subset of head and neck cancer called
10 the squamous cell cancer that happened to locate in his
11 superior right tonsil.

12 Q What does superior mean?

13 A Oh, I'm sorry. The superior part means the upper part
14 as opposed to the inferior part, which is the lower part.
15 It's an area that usually remains very silent unless we pick
16 it up visually. So these things would have to be pretty
17 sizeable before we find them. In fact, nowadays, most of
18 the ones being found in this country are being found by
19 first presenting with a lymph node in the neck rather than
20 the patient complaining of something in their throat.

21 Q Is tonsil cancer relatively common?

22 A I looked up the stat on this one. This year -- well,
23 not this year, but in the last year or so, there's something
24 in the order of 16 and a half thousand new cases in this
25 country of HPV positive squamous cell cancer of the tonsil

1 and tongue base.

2 Q So for his particular subset of cancer, 16,000 some odd
3 people get diagnosed newly every year?

4 A Yeah, and probably going to keep going up.

5 Q Okay.

6 A We're in the middle of -- I'm sorry to interrupt.
7 We're in the middle of an epidemic that is being present,
8 we're not sure how long, but HPV-related cancers are on the
9 rise. And if you look at our statistics, it's one of the
10 few cancers that are growing in incidents because,
11 fortunately, the folks in this country have gotten wise to
12 alcohol and cigarette smoke, so those cancers are declining,
13 but the virally-induced ones are on the rise because you
14 don't know who you kissed 30 years ago.

15 Q What is the standard of care if an ENT suspects a
16 patient might have a cancer in a tonsil?

17 A The standard of care -- and again, there will be
18 mitigating circumstances, but the standard of care, meaning
19 what would any doctor do in any state, in any city with the
20 same patient would be to biopsy this to make sure it's not a
21 cancer. It's not the same as somebody coming in with
22 tonsillitis or a sore throat, which is not at all the
23 presentation that Mr. Miller made way back in March 2013.

24 Q Yeah, so we've heard the argument and I'm sure we will
25 from some of the other witnesses that you don't biopsy

1 everybody who shows up with a sore throat. Is that what the
2 standard of care is?

3 A There wouldn't be enough time. Also, most of us in ENT
4 do not see your standard sore throats. We do get the
5 patients who have gone through several filters first. Sore
6 throat is not what he was complaining about in any event, so
7 making a comparison to children and adults with a sore
8 throat is apples and tangerines.

9 Q You reviewed the deposition of Hornig; is that right?

10 A I did.

11 Q And that was a witness that was called -- is going to
12 be called, presumably, by Dr. Wilson in his defense; is that
13 right?

14 A Yes.

15 Q He's known as an expert witness. You reviewed his
16 transcript and his deposition?

17 A Yes, I did.

18 Q I'm going to show you a section of that and I want to
19 see if you agree. While we wait on that, does an MRI rule
20 out cancer?

21 A I've been trying to think of an instance in which it
22 could. There are some instances where it's helpful in
23 ruling one in, but I don't know of a surgeon that would tell
24 you that he's operating on an x-ray. He's going to be
25 operating on a patient and when the patient has a physical

1 finding, that's what your target is, not what might or might
2 not be on an x-ray film.

3 Q Tell us what a biopsy is and what that entails.

4 A Great question. Because most the people I work with
5 don't really know. A biopsy is simply taking of tissue.
6 The specimen is the specimen. I still use them
7 interchangeably, I probably shouldn't. But a biopsy does
8 not imply taking out a gigantic chunk of tissue. It's
9 taking out a representative piece of tissue.

10 If I recall correctly, the biopsy taking at the VA on
11 Mr. Miller was point five centimeters or five millimeters.
12 I'm just trying to think to give you something. If y'all
13 look at your fingers, my finger is 1.6 centimeter side to
14 side, so you go about half of that. I've got fat fingers.
15 You go about half of that and the specimen wasn't even that
16 big.

17 You don't require a tonsillectomy unless there's
18 extenuating circumstances, such as an extremely deep, but
19 probable mass in the tonsil. But even then, that could be
20 reached with a cup forceps and some topical lidocaine. It
21 takes about five minutes, maybe 10 -- no, it takes about 10
22 because you've got to get consent from the patient. The
23 paperwork, filling out all the forms takes more than the
24 procedure.

25 There's minimal bleeding. If the patient is on a blood

1 thinner, depending on which thinner, if they're on Coumadin,
2 it's a little bit hairier, but if they're on a platelet
3 inhibitor, then the amount of bleeding is not all that much.
4 I happen to be on one myself right now, so I kind of know
5 how much it bleeds. It's annoying as all heck, but I'd
6 rather be annoyed than undiagnosed.

7 Q So the biopsy procedure yields a specimen, which would
8 then be sent to the lab, right?

9 A Correct.

10 Q It takes about five minutes?

11 A To do --

12 Q To do the whole procedure?

13 A It takes the lab a considerably longer period of time.

14 Q Is there any dispute among ENTs that a biopsy is the
15 way you rule in or rule out cancer in a patient where cancer
16 is suspected?

17 A I think the only dispute would be where the biopsy
18 itself is such a threat to the patient that it might not be
19 worthwhile. As a for instance, an astrocytoma in a
20 90-year-old patient would probably not be addressed because
21 -- an astrocytoma is a brain tumor, a specific brain tumor,
22 and you would not open up a 90-year-old's head to get a
23 piece of that. You know what you're dealing with.

24 There's certain places like cardiac malignancies you
25 might have to think twice about opening up, especially in a

1 patient that's got a cardiac condition already. But beyond
2 that, in the head and neck, there are very few places that
3 we can't reach safely.

4 Q In a case like Mr. Miller, with his situation and his
5 presentation, is there any dispute among any ENTs of which
6 -- is it clearly the standard of care that a biopsy is used
7 to rule in or rule out cancer in a patient like Mr. Miller?

8 A Okay. The only -- in this day and era -- you know,
9 maybe 10 years from now, we'll be depending completely on
10 molecular diagnoses, but right now, the standards of care
11 are pathology. You need cells to look at. However, an
12 oncologist will not touch a patient -- a radiation
13 oncologist will not touch a patient unless we've proven that
14 they've got a cancer because the last thing in the world you
15 want to subject someone to, as I'm sure Mr. Miller would
16 probably tell you, is cancer treatment. They're draconian
17 because it's a war. You're trying to beat this war against
18 the cancer. And you don't want to unleash that war on an
19 unsuspecting victim unless they need it.

20 So in this case -- I know it's a round-about answer.

21 And I'm sorry, Mr. Davis, this is my style.

22 You have to weigh the risks of the harm to the patient
23 of the biopsy versus the harm of not doing the biopsy. And
24 I think there's ample evidence what the harm is here.

25 Q All right. Take us through the course of events. And

1 we've got the medical records. We're going to have to go to
2 plan B at some point. I'm going to hand you some of the
3 exhibits that have been put in. And Exhibit No. 1 is the
4 medical records from Dr. Wilson's office, so you'll have
5 those. How did this present, what was reported, what was
6 found, what was the differential diagnosis?

7 A I have my copies. That's what I brought up with me, my
8 copies of Dr. Wilson's records.

9 Q Sure. That's fine. If you need to use the whole
10 thing, it's up there as well.

11 A Is that okay?

12 Q Yeah. Yeah, that's fine.

13 A So, basically, as I understand it from the record, it
14 said Mr. Miller showed up at the doctor's office because he
15 did not -- well, this is not in the record. Unfortunately,
16 I was about to editorialize. Let me stop that.

17 He showed up with a chief complaint of having a mass in
18 his tonsil or a spot in the back of his throat. He did not
19 complain of pain. And according to the medical record,
20 there was no pain at all as a complaint. He actually denied
21 hoarseness, said he was snoring and he did not have trouble
22 swallowing at that time. These are significant complaints.
23 We have a man -- as I alluded to before, we have a man who,
24 basically, has one symptom and it's that he can feel it.
25 Many cancers are pretty painful, but in this particular

1 location, as I said, this can grow silently for quite some
2 time before it starts wreaking real havoc.

3 So when we somebody with a mass -- and this is not an
4 eight-year-old with tonsillitis. This is not some
5 20-year-old who's been out screaming all night and boozing
6 it up. This is a 62-year-old guy who doesn't smoke, he has
7 a remote history of smoking, showing up with a painless mass
8 in one side of his throat, not both sides. It's not an
9 infection. It's not presenting like anybody would present
10 with a sore throat. It's not sore. That alone, if that
11 mass were anywhere else in his mouth, we'd all be panicking.
12 And there's no reason to not take it seriously.

13 Q Did Dr. Wilson actually have cancer on his differential
14 diagnosis --

15 A He did.

16 Q -- as one of the problems?

17 A He did. It was a good first meeting.

18 Q And, in fact, is it in the medical records?

19 A It's in the medical records. It's in the billing
20 records.

21 Q And the phrase malignant neoplasm of tonsil, what does
22 that mean in lay terms?

23 A Okay. Again, I'm a stickler on definitions, sort of.
24 A neoplasm just means new growth. It does not imply whether
25 it's malignant or benign. Pregnancy, if you will, is a

1 neoplasm. I knew that would raise some eyebrows, but it is.
2 It's not a malignancy. A malignancy is cancer. It's
3 something that either grows and destroys you locally or it
4 spreads to another part of your body and destroys you there.
5 That's the definition of a cancer.

6 Some cancers grow without spreading, meaning without
7 spreading to your lungs or your lymph nodes or other parts
8 of your body, and some cancers just take off straight from
9 the gates and try to kill you as quickly as possible.

10 Q And did Dr. Wilson put in his notes on the problem list
11 malignant neoplasm of the tonsil?

12 A He did.

13 Q This is from Exhibit No. 1, it's Page 7?

14 A Yes, at the bottom, it says problem list. And there's
15 electronic medical record -- I suspect it's an electronic
16 medical record jargon that's carried over. It just means
17 that once we've established a line -- the diagnosis on a
18 patient, it carries over so we don't have to keep spending
19 time -- the beauty of the EMR, the electronic medical
20 record, is we don't have to write so much. The weakness of
21 it is that we have trouble getting rid of some of the stuff
22 from our record.

23 Q And then this is the order form for the MRI, do you see
24 sign and symptom?

25 A Hang on. Last week, my prescription changed in my

1 right eye, so I'm wearing my glasses from last week, so my
2 vision is not where it should be. It says: Neoplasm M
3 consult.

4 Q And what was the testimony about what that meant?

5 A I believe Dr. Wilson said that their electronic medical
6 records, although this is not electronic medical records, M
7 stands for malignant.

8 Q Then you see the bill, problem list that was done
9 apparently after 5/21/2013?

10 A Yeah, that I don't have with me.

11 Q Go to the problem list, it says malignant neoplasm of
12 tonsil?

13 A Right. Well, it was taken quite seriously on this
14 first meeting with this gentleman on 3/26/13.

15 Q Was a biopsy ever done?

16 A Not by Dr. Wilson.

17 Q Right. A biopsy was done years later; is that right?

18 A Almost three years later.

19 Q Was Dr. Wilson's failure to ever order or perform a
20 biopsy below the standard of care?

21 A Well, generally, we don't order biopsies, we do
22 biopsies. I can't imagine telling somebody else to do my
23 biopsy for me, so we perform biopsies. It was not done.

24 Q Does the fact that these records show that cancer was a
25 concern require that it be ruled out or ruled in?

1 A Well, again, I've mentioned this before, the issue is
2 that it's what is the risk of the biopsy, a little bleeding,
3 a little tenderness less than 24 hours, the bleeding last
4 less than a day, if it last that long, versus missing a
5 diagnosis. And the key is I can't imagine that anyone,
6 frankly, sitting in the jury box would say yeah, go ahead
7 and miss the diagnosis, I don't want to have a little
8 bleeding.

9 Q What would that cancer have been in 2013? Assuming a
10 biopsy was done and cancer was discovered, what stage would
11 it have been?

12 A Well, first of all, it would have been a squamous cell
13 cancer. Knowing what we know now, especially given his low
14 risk factors for this particular cancer, it would have been
15 an HPV -- we know it's an HPV positive cancer. HPV stands
16 for human papillomavirus. The risks -- that's the cancer
17 that he ultimately was diagnosed with. And they can be very
18 slow in growth.

19 Now that I've brought the subject up, we don't have
20 growth curves for cancers. There are a couple of reasons
21 for that. Number one is if you put a good seed in bad soil,
22 that seed won't grow. And if you put a bad seed in good
23 soil, that seed might not grow. In the right patient who's
24 got an immune deficient and a slightly virile in cancer,
25 that cancer can take off. Our Aids patients in the 80's

1 were dying right and left from things like this. Our
2 patients have renal transplants and are totally
3 immunosuppressed die from lip cancer. Very few people die
4 from lip cancer. This group does. So these cancers are --
5 we don't have a growth curve for any of them.

6 And the second, which is probably more important, is no
7 one is willing to tell somebody they have a cancer, let's
8 see how it does, except with two notable exceptions. And
9 one of them currently is prostate cancer, early prostate
10 cancer and the other one is certain thyroid cancers under
11 the correct circumstances.

12 Q Doctor, if this was discovered back in 2013, what he
13 most probably have had?

14 A Well, we know it was Stage 1.

15 Q And it was ultimately discovered to be Stage 4 when he
16 was diagnosed?

17 A Stage 4 by every criteria.

18 Q Okay. What happened over the intervening two and a
19 half years? Because we know that the last visit with Dr.
20 Wilson was on April 23rd of 2013, and then the first mention
21 of anything in the tonsils at the VA was in October of 2015.
22 Tell us what you understand occurred during that
23 two-and-a-half-year period?

24 A Well, for starters, after you get stents placed, you
25 have a six-month period where you're not willing to do much

1 of anything. You're on a maximum dose of every one of your
2 medications and your doctors have told you to lighten up.
3 And there's just so much you can do. But then if you're
4 told not to worry about certain things, you've got a whole
5 bunch of other things to worry about.

6 So this was brought to the attention in the VA in
7 October of 2015. I hope I'm getting my dates correct. If
8 I'm not, somebody will certainly correct me. He was told he
9 had a sore throat, although he wasn't complaining of a sore
10 throat.

11 Again, it's unilateral in adult men -- I'm sorry,
12 unilateral means one-sided. Most of the time when you get a
13 sore throat, you get it on both sides. It's very unusual to
14 just get it on one side. So he was treated with an
15 antibiotic. And again, he had an expert look at it and,
16 unfortunately, misidentify what they're looking at and was
17 told you're fine. Here, take an antibiotic. Go take care
18 of your orthopedic problems.

19 Q Then he went to see a nurse practitioner in January?

20 A Yes, he did.

21 Q And what happened at that point forward just in general
22 summary terms?

23 A I believe this is the time -- I might be mistaking my
24 dates. In January of 2016, he was told that there was
25 something there, but that was because he was complaining

1 that he was choking when he laid down. He couldn't breathe.

2 A little aside, we're starting -- there's an entity
3 known as obstructed sleep apnea, which is when you have big
4 tonsils, big adenoids, something big in your throat or just
5 remarkably obese that's preventing you from breathing
6 correctly at night so you don't get enough sleep and it will
7 obstruct your airway. We're starting to see a lot of
8 patients with tonsil and tongue base cancer presenting where
9 their first sign is sleep apnea.

10 Q What did Mr. Miller say was going on during this time
11 frame? Did he say that the spot went away based on his
12 deposition testimony that you read?

13 A No. No. He said it was still there. And what's
14 ironic about it is he could touch it with his finger. A lot
15 of the cancers that we have to treat, you can't touch with
16 your finger. You can't see them.

17 Q Based --

18 A This gentleman saw his own cancer.

19 Q Is it reasonable, right and appropriate for an ENT to
20 tell a patient like Mr. Miller that he didn't have to worry
21 about cancer based upon that MRI we saw?

22 A I can't see how. I know when I have a patient who --
23 even if I have a biopsy that's benign, I'm never a hundred
24 percent satisfied that my patient is out of the woods. And
25 I'd rather waste their time on another office visit than say

1 you're okay, go out, enjoy yourself.

2 Q So do you believe that the cancer -- that the spot that
3 was seen in 2013 was the same spot that was discovered to be
4 cancer in 2016?

5 A Yes, I do.

6 Q And why is that? How do you know?

7 A Because I don't believe in coincidence and because the
8 patient was complaining of a solid mass that did not show up
9 on an MRI. MRIs can be -- the word that we use is
10 iso-intense, meaning the way it appeared on the MRI is the
11 same density as the rest of the tonsil.

12 Think about your own throats, you have something --
13 that punching bag in the middle called the uvula and you
14 have your tonsils to either side of that, then you have your
15 soft palate and you have your tongue hanging back and we're
16 laying down in the tube and we're getting that MRI, so all
17 these structures collide with each other. And unless you
18 have a physical barrier, like hair or barium in between
19 them, they will all potentially show up as one structure.
20 And you cannot tell by looking at an MRI if you're looking
21 at tonsil or something on the tonsil or something on the
22 uvula or if it just looks all the same as the rest of the
23 tissue.

24 And if it's small -- I heard in this court today that
25 it's a very sensitive instrument. I'm sorry, MRI is

1 sensitive if you have the right test le coil. Most places
2 do not have a five test le coil MRI. Most of them have like
3 one to two test le coil MRIs and they're not that sensitive.
4 They're not going to pick up necessarily three millimeters
5 and they're such as heck not going to pick up a flat
6 three-millimeter lesion in someone's tonsil.

7 Q All right. Did Dr. Wilson make a note of where the
8 spot was in his chart?

9 A He described it and he drew it.

10 Q All right. Did the VA take a picture of it as it was
11 in March of 2016?

12 A Someone in the VA did. I only saw that recently.

13 Q Okay. Well, I want you to -- this drawing of the mouth
14 --

15 A Would it help if I just got up? Because talking for me
16 --

17 MR. MCGOWAN: Your Honor, may he step down?

18 THE COURT: He may.

19 THE WITNESS: Unless you have a pointer of some sort, a
20 laser pointer.

21 THE COURT: You may step down.

22 (Witness steps down.)

23 BY MR. MCGOWAN:

24 Q What are we looking at here? What's this thing on the
25 left?

1 A This left. This is a schematic from Dr. Wilson's chart
2 where he drew a lesion, which later he called the posterior
3 pharynx, but this area is the tonsil. That's what that is.
4 There's another one on the other side. These are the
5 pillars of the tonsil and this little triangular fossa right
6 here, is actually what it's called, is where he drew his
7 little dot right on top of the tonsil. I think in the
8 deposition, Dr. Wilson said that he drew this line to remind
9 him that this is the spot that he was concerned with.

10 Q Okay. And then what are we looking at on this picture
11 from the VA?

12 A It's going to be hard. This is what I call VA quality
13 photograph. This is the gentleman's tongue, Mr. Miller's
14 tongue. This is --

15 THE COURT: Wait a second. We do have a mic available.
16 Let's try that. We want to make sure the court reporter can
17 hear everything and the jury can hear everything.

18 THE WITNESS: This is the uvula.

19 BY MR. MCGOWAN:

20 Q Where is the uvula on the diagram that Dr. Wilson drew
21 so that we have a --

22 A This versus the schematic. Finally, this would be
23 where his left -- excuse me, his right tonsil should be.
24 Here's the date, 3/1/16. And this mass is all the way over
25 to the left side of his throat, this is -- it's quite big.

1 In most people, this is, at least, four centimeters from
2 tonsil to tonsil. So that mass is -- I know on the CT scan
3 we got, it measured 3.7, but that is in the up/down
4 direction. That's the cancer --

5 Q So does the photo of the cancer on March 1st, 2016
6 correspond to the handwritten drawing of Dr. Wilson from
7 2013?

8 A The origin of it does.

9 Q Okay. Would cancer that looks like this in a patient
10 like Mr. Miller arise and grow to this size in a month or
11 two or three?

12 A I guess it could, but -- you know, it could.

13 Q Okay. Now, from March 2013 to 2016, can it take that
14 long to get to this spot as well?

15 A Yes, that can definitely happen. We've seen -- that's
16 what I alluded to before. I don't know that there's a
17 growth curve because no one is willing to let something like
18 what happened to Mr. Miller happen to another Mr. Miller.
19 No one is willing to let something grow. Like I said, boy,
20 could you imagine if he had a biopsy back then and it was
21 benign. None of us would be sitting here.

22 Q We're going to go over these more tomorrow, not with
23 you, Doctor, but did you review in the medical records from
24 the VA histories of presenting illness relating the time
25 frame at issue here?

1 A I'm not sure what you're asking, but yes, I reviewed
2 the records of the VA.

3 Q Did you see an example in the VA records where a
4 purported oral cancer screen was negative at a time when
5 everybody knew that he had this tumor in his throat?

6 A Well, they're actually -- if I may, there were two oral
7 examinations done by the department of dentistry. One, I
8 think, almost a year before and one like three weeks after
9 he was diagnosed with that. He had that in his mouth during
10 the second examination. And the examination, which is a
11 boilerplate answer, it is a default answer on the EMR said
12 it was normal, that that did not exist. And it's the same
13 exact answer they gave a year to a year and a half before.
14 It's the exact same words. That's how I know that it's a
15 fault, if you will, of having an electronic medical record.

16 We have what are called default answers. The default
17 answers are normal, normal, normal, normal. Every time you
18 see something that disagrees with that, we change that
19 normal on your electronic medical record to say oh, no,
20 there's a four-centimeter tonsil cancer there. That was not
21 done in the VA record after he was diagnosed with Stage 4
22 cancer. That's why it's hard to depend on their EMR.

23 I don't want to bring this up. I'm probably going to
24 burst your bubble about one of your physicians, but the
25 oncologist who saw you wrote that your throat was normal

1 because the default answer was normal. Those aren't the
2 exact words, but it's in the oral pharynx examination. He
3 wrote that he was seeing you for tonsil cancer.

4 Q And what appeared in the record was his throat was
5 normal?

6 A Yes.

7 Q And that's due to EMR, electronic medical record?

8 A The EMR in April of 2016.

9 Q I'm going to wrap this up. And I'm going to ask you to
10 assume for the purpose of my following question the
11 following definitions of the word reckless, okay? I want
12 you to assume that it's not intentional or malicious, nor is
13 it necessarily callous towards the risk of harming others as
14 opposed to not. It may consist of either two different
15 types of conduct. In one, the actor knows or has reason to
16 know of facts which create a high degree of risk of harm to
17 another and deliberately proceeds to act or fail to act in
18 conscious disregard of or indifference to that risk. The
19 second is when the other -- in the other, the actor has such
20 knowledge or reason to know of the facts, but does not
21 realize or appreciate the high degree of risk involved other
22 reasonable men in his position would do so.

23 Assuming that is the definitions of reckless, do you
24 believe that Dr. Wilson in his conduct in 2013 met one or
25 the other of those definitions?

1 A Yes, I do.

2 MR. MCGOWAN: Your Honor, that would be all I have of
3 this witness at this time.

4 THE COURT: Mr. Davis.

5 CROSS-EXAMINATION

6 BY MR. DAVIS:

7 Q Hello, Dr. Myssiorek.

8 A Good to see you again.

9 Q Last time we talked, we had a little video conference
10 and it was a little bit fuzzy, right?

11 A It was fuzzy, so was my face. I had a beard then. I
12 had a beard then.

13 Q Right. Let me ask you just a few questions about your
14 direct examination. You talked about this being an HPV
15 virus?

16 A Yes.

17 Q Is that what we're talking about when we talk about P16
18 virus?

19 A Okay. HP, or human papillomavirus, or HP virus is --
20 there's several different kinds of HP viruses. Many of them
21 are benign. Some of them are particularly nasty. The ones
22 that happen in children's throats, not that they're
23 cancerous, but they're called recurrent respiratory
24 papillomas and these poor children have to go for surgery
25 over and over and over again just so they can breathe.

1 Oddly enough, very few of them turn out to get larynx
2 cancer, thank God.

3 The other kinds are the same ones we're finding in the
4 female genital tract. And I actually have a paper out on
5 this. In the late 1980s, we actually tracked women who had
6 abnormal pap smears who ended up having tonsil cancer before
7 we knew there was an HPV epidemic. Well, there was none
8 yet.

9 So the types that we are particularly concerned about
10 was Type 16 and 18 and they confer a malignant diagnosis.
11 They don't necessarily -- having the virus, just so you
12 don't panic, doesn't mean that you're going to get cancer.
13 But if you find the cancer and you have that virus, it's
14 most certainly the cause. We don't quite know why and we
15 don't know how it incorporates itself with your genome, but
16 we now have some vaccines for it. I'm saying we, I wish I
17 could take credit for it because this is a life saver. Both
18 of my daughters are vaccinated. My grandchildren are being
19 vaccinated because I don't want them having to suffer from
20 this disease.

21 Q It's not transmitted by kissing, though, is it?

22 A Not clear, but very probably not.

23 Q Right. It's a sexually transmitted disease?

24 A Well, the data that was collected on this initially was
25 from Johns Hopkins and they were asking how many -- they

1 were asking of the people that were infected and had cancer
2 how many oral sexual partners they had in a lifetime. And
3 the cut off number, I think, at that time was four.

4 At a medical convention, a surgeons' convention, I
5 asked that question at the mic. And I said please don't
6 raise your hands, but how many of you had fewer than four
7 oral sexual partners. And there was a tither in the
8 audience and no one, thank God, put up their hands.

9 Q Doctor, I'm really not interested in anybody raising
10 their hand. You made reference in your direct examination
11 on who you kissed and it's not transmitted as far as we know
12 --

13 A As far as we know. There have been no reported cases
14 that way because people who have oral sex also kiss, but not
15 everybody who kisses has oral sex.

16 Q Okay. Now, you're not a primary care physician, right?

17 A No, sir.

18 Q You alluded to this on your direct examination. You
19 said that when a person comes to you with let's just call it
20 tonsil cancer or some cancer of the neck and head, it passes
21 through many filters. What you mean by that is that someone
22 else, a medically trained person has detected something that
23 they want you to look at and most of your patients come by
24 referral, is that fair to say?

25 A Yes.

1 Q Right. So that means that someone who is not as
2 qualified as you in looking at the head and neck and mouth
3 and all has seen something that they don't like or that they
4 find interesting or whatever and they send it to you to see
5 what you think is wrong; is that correct?

6 A That's correct.

7 Q And so it's perfectly plausible that a person who is a
8 nurse practitioner, an emergency room physician, any person
9 -- it might be a dentist, a dental hygienist even, who might
10 be looking in the throat could refer you a patient because
11 they see something there they don't like?

12 A That's true.

13 Q And that's how you get most of your patients?

14 A It's hard to say. I, like your expert, work in an
15 ivory tower. We're the top of the food chain, if you will.

16 Q Right.

17 A So we don't get to see patients at the level that Dr.
18 Wilson did.

19 Q Right.

20 A Where they could be coming in with just a sore throat
21 or kid with bilateral tonsillitis.

22 Q Well, in your knowledge of the practicing of say boots
23 on the ground of an otolaryngologist, such as Dr. Wilson,
24 you would expect that most of his patients are just walk in
25 off the street patients, is that fair to say?

1 A I wouldn't know.

2 Q You wouldn't know?

3 A No, I wouldn't know what his clientele are. I do know
4 that he and I have the same standard and took the same
5 Boards.

6 Q He passed his, too, didn't he?

7 A I'm sure he did, he's double Boarded.

8 Q Yes, sir. I'm just going to go over randomly some of
9 the things you said before I get into what I really want to
10 ask you. I believe you talked about the October 2015
11 presentation that Mr. Miller made to the VA where he was
12 diagnosed with having -- he was given Augmentin.

13 A Acute tonsillitis.

14 Q Right. And I believe you said someone misidentified
15 something. Now, what did misidentify?

16 A It was acute tonsillitis.

17 Q Beg your pardon?

18 A That it was acute tonsillitis. It was one side. The
19 patient, once again, was not complaining of a sore throat.
20 I know what I would say privately, but it would be based all
21 on supposition, but the emergency room and the urgent care
22 centers are not the places where we consider diagnoses of
23 high accuracy.

24 Q And so you think that the visit on October of 2015 that
25 there was a misidentification by that. The fact that a

1 person did -- that whoever looked at him and treated him did
2 not see the lesion that you described, is that fair to say?

3 A Well, I would ask the question how did they examine
4 him? Did they have a headlight on? Did they have two
5 tongue blades in his mouth? Did they put a glove on and
6 feel his throat? I can't answer that because none of that
7 is documented.

8 Q In fact, all we can do is go by the records; is that
9 correct?

10 A We can go by a faulty record, yes.

11 Q And you view the records as being faulty because you
12 assume the cancer was present in 2013 when Mr. Miller
13 visited -- presented himself to Dr. Wilson; is that correct?

14 A I assume it's faulty because it's a different set of
15 complaints. It's not the standard complaint of somebody
16 with a sore throat. A person with a sore throat says I
17 can't swallow, it hurts. At no point -- in fact, in the VA
18 record itself, the maximum amount of pain that he
19 experienced on a zero to 10 scale was a three and that was
20 after it had been biopsied and got infected.

21 Q Not to belabor, if Mr. Miller had a lesion on his
22 tonsil when he visit Dr. Wilson in 2013 that was the size of
23 the end of a cigar, and I don't know how big of a cigar,
24 okay, that's his description -- you used the term he
25 described it like a pig's nose --

1 A I didn't use the term. I'm a northern boy. I wouldn't
2 know what a pig's nose looked or felt like --

3 Q Mr. Miller described it that way; is that correct?

4 A Yes, he did. It grabbed my eye right away.

5 Q And if it's there in 2013, in April of 2013, by your
6 learning, training and experience, it's going to be there
7 continually, right? It's not going to go away?

8 A I agree with you a hundred percent.

9 Q Right. And so would it be your testimony that everyone
10 who says, every physician or medical practitioner or whoever
11 that looks in his throat from then on that says I don't see
12 it there that they've either missed it or they're not
13 telling the truth, is that what you're saying?

14 A I think the most important part of your phrase was who
15 looks in his throat.

16 Q All right.

17 A You know, I don't know that you or anybody in this
18 courtroom would want to come to me with a hernia. I can
19 tell you, you don't want to come to me with a hernia. And
20 on my note, because this is the way the EMR works, it will
21 say no hernia, because that's the default answer.

22 Q But in this case, we've got a lesion which is there and
23 it's there until it's detected in 2016; is that correct?

24 A Correct.

25 Q By Mr. Miller's testimony and that's what you believe?

1 A Yes, I do.

2 Q So someone looking in that throat wouldn't have to know
3 what it is, they would just see it because you said on
4 direct examination that he could touch it, he could feel it,
5 he could see it himself?

6 A Correct.

7 Q So if he can see it himself, then whoever's examining
8 him, whatever they're training is, they're going to see it,
9 right?

10 A I can't tell you, sir. I wish I could.

11 Q All right. You would expect them to see it?

12 A I've worked in the VA, my friend. I did my residency
13 in the VA. I spent several years in Manhattan VA as an
14 attending. And you have these vets coming through and you
15 have to see as many as you can in a day and you cannot do
16 the kind of wonderful thorough examination we can do in our
17 ivory tower. So the answer is they may not get the full
18 exam.

19 Q When Mr. Miller presented to Dr. Wilson, Dr. Wilson's
20 records, which you have referred to, on the first visit, he
21 said there was a firm erythematous spot; is that right?

22 A Yes, I believe those are the words he used.

23 Q And then I believe on the second, he described that as
24 getting a little bit better, right? It was still
25 erythematous; is that true?

1 A That's the description. There's no EMR on this.

2 Q And on the third visit, his description is that there's
3 no erythematous spot at all; is that right?

4 A There are a lot of things that are in that third
5 description that --

6 Q I understand.

7 A That just can't be accounted for.

8 Q I want to ask you to look -- and I know how you
9 disregard VA doctors, but I'd for you to look at this.

10 MR. DAVIS: This is one of the VA records, Your Honor,
11 that's already in, but I'd like it marked as Defense 1, if
12 that's okay.

13 THE COURT: Let's have it marked -- is it marked now?

14 MR. DAVIS: It's already in evidence.

15 THE COURT: But you want it -- you indicated you want
16 to go ahead and have it marked?

17 MR. DAVIS: Yes, sir.

18 If I can stand next to the witness? I can probably
19 help him get through this.

20 THE COURT: That's fine.

21 BY MR. DAVIS:

22 Q Do you recall reviewing this when you reviewed the VA
23 records?

24 A Yes, I did.

25 Q It's a progress note, right?

1 A It's a progress note from April 16th, 2013.

2 Q Now, chronologically, April 16th, 2013, would be after
3 the second visit with Dr. Wilson and before the third visit,
4 according to the medical records; is that right?

5 A I believe this is when he had his heart attack.

6 Q Right. And he presents to the emergency room; is that
7 correct, with chest pains?

8 A Correct.

9 Q It says that in his records?

10 A Yes, it does.

11 Q Now, who is the doctor who's the author of this
12 document?

13 A It's a Dr. Siddiqi. I'm not good with some names,
14 which one's the first name, which one's the last name. I'm
15 pretty sure Siddiqi is his last name.

16 Q I think it is Siddiqi. And if you turn over to the
17 last page, which is 328 in the record, about halfway down
18 the page, it says that Dr. Siddiqi is an ER physician?

19 A Yes, it does.

20 Q And you smiled?

21 A Yes, I smiled.

22 Q ER physicians are sort of like fighter pilots in the
23 profession, aren't they? They see lots of stuff that comes
24 in. They see people show up with different problems and
25 then it's their job to refer them out.

1 A They are triage nurses. They are triage nurses. Most
2 of us see ER physicians not as glamorous as they are on TV
3 where they're doing cardiac bypasses in the emergency room.
4 We see them as somebody who sees a problem and turfs it out
5 somewhere. But in this particular case, this man is
6 complaining of chest pain and I sincerely doubt that he took
7 one more second to look at this man's throat while he's
8 crashing and burning in front of him.

9 Q Well, let's just look at the records and see what the
10 records say. Turn to the second page.

11 A I will.

12 Q And there about halfway down, a little more than
13 halfway down, it says, HEENT, what does that mean?

14 A It's head, eyes, ears, nose, throat.

15 Q And then it says PERRL, what does that mean?

16 A That his pupils were equally round and reactive. He
17 had macular degeneration.

18 Q Right. And it says EOMI bilateral?

19 A So EOMI, extra ocular motion is intact bilaterally,
20 both eyes.

21 Q Now, is it your testimony he probably didn't -- he just
22 wrote this down, he probably didn't examine the man?

23 A I would bet on it.

24 Q You would bet on it?

25 A Yes, sir.

1 Q To a reasonable degree of medical certainty, this is a
2 lie?

3 A I'm having trouble saying it's a lie, I'm just saying
4 it's a use of an electronic medical record to get this man
5 to his stent placement ASAP.

6 Q All right. Then go on and read what it says next,
7 oropharynx clear. Did I read that right?

8 A I gave Mr. McGowan a lesson on this yesterday. It's
9 oropharynx. It's that X that's throwing everybody. The
10 oropharynx clear, no erythema or exudate.

11 Q Now, the oropharynx, did I say it right that time?

12 A No.

13 Q I'm sorry I'm mispronouncing it. That's the tonsil
14 area, is it not?

15 A Yes, it is.

16 Q That's the tonsil area?

17 A I'm not arguing with that.

18 Q And he says it's clear?

19 A He says it's clear.

20 Q On the date that's before the third visit to Dr.
21 Wilson?

22 A Yes.

23 Q Now, what else did he say?

24 A I think I read that already. No erythema or exudate,
25 moist mucus membranes.

1 Q Exudate would be like pus?

2 A Or any stuff that doesn't belong there.

3 Q No erythema, right?

4 A Exactly.

5 Q Now, if that's true -- let's just assume for a second
6 for the purpose of my question. If that's true and this is
7 a legitimate medical exam, the so-called erythematous spot
8 is gone; is that fair to say?

9 A No.

10 Q No, it's not?

11 A No.

12 Q And why not?

13 A Because only the erythema is gone. He was given
14 antibiotics. The mass is still going to be there and unless
15 a qualified person putting on a glove with a headlight on is
16 going to examine this patient, this is worthless.

17 Q This is the kind of doctor who would send you something
18 because they saw something they didn't like and they would
19 send it to you and say check this out, doctor, right? This
20 is the filtering you were talking about that you go through?

21 A It's one of them. And, unfortunately, 95 percent of
22 what comes through is -- didn't need to be seen.

23 Q After the first visit of Mr. Miller to Dr. Wilson, did
24 the standard of care require him to get a biopsy on that
25 first visit?

1 A On the first visit, not necessarily. I will tell you
2 what I might do in my practice if I had 30 patients coming
3 out the door, I would simply say you know what, I need more
4 time. I'm not rushing you through this. Just in case you
5 have some trouble because of the biopsy, I'm going to want
6 you in my office for, at least, half an hour. So I would
7 schedule it, but I would make sure I scheduled it at a time
8 that was convenient for the patient and myself.

9 As I've already told you, you have to get consents.
10 Nowadays, we have to have computer identification of the
11 patient. We have to have a universal precaution statement
12 made. All these things take time, so it's not just boom,
13 boom, you're in and out. The procedure takes maybe five
14 minutes.

15 Q Is my answer no, it is not a violation of the standard
16 of care to not do a biopsy?

17 A Yes, my answer is no, on that first visit, it was not a
18 standard of care violation.

19 Q An ordering an MRI was not a violation of the standard
20 of care?

21 A No, I don't think so.

22 Q It's helpful, right, to see if there was a mass there?

23 A Well, it would be helpful in many cases, you know, if
24 it were done on the correct patient.

25 Q And was it a violation of the standard of care for Dr.

1 Wilson to not biopsy Mr. Miller on the second visit?

2 A Yes.

3 Q It was?

4 A Yes, it was.

5 Q There was an immediate need for a biopsy on that second
6 visit, a week later?

7 A An immediate need, no. There was always a need. And
8 saying whether the first appointment or the second
9 appointment, obviously, poor Mr. Miller didn't know he was
10 going to have an MI in the interim, but he should have been
11 biopsied. The timing of it is only critical is that it
12 should have been done. It was never done.

13 Q Squamous cell carcinoma most often involves a mass,
14 right?

15 A No.

16 Q No?

17 A Most often, not necessarily. They can be spreading.
18 They -- in fact, in fact, the ones that are born from
19 cigarette and alcohol abuse usually start by spreading along
20 the surface as opposed to ones that occur as a buried mass.

21 Q We're talking about an HPV here, we're not talking --

22 A HPV, that starts as a --

23 Q We're not talking about cigarettes and alcohol, are we?

24 A Sure not.

25 Q We're talking about a cancer that's caused by HPV?

1 A Yes, sir.

2 Q And most of those have a mass?

3 A Correct.

4 Q Right. That mass --

5 A That's why the patient could feel it.

6 Q Sure. And could always feel it while nobody else
7 could, is that fair to say?

8 A No, it's not. Because nobody else did.

9 Q Did you see -- in the three years between the last time
10 that Dr. Wilson saw Mr. Miller and the diagnosis by the VA
11 Hospital, did you see any record where any physician
12 confirmed the spot that was on his tonsil?

13 A I can't answer that yes or no, but I can answer it,
14 though.

15 Q Beg your pardon?

16 A I can't answer it yes or not, but I can answer it,
17 though.

18 Q Can you remember seeing one? Can you remember seeing a
19 record where a physician confirmed that there was a spot on
20 the tonsil?

21 A It's not the way -- that question should be answered
22 then, there's no place in his medical record where somebody
23 stated that they could see and feel this tonsil because no
24 one did. If somebody in that emergency room had actually
25 taken the time to feel this man's throat, trust me, they

1 would have recorded it because a lot of people don't do
2 that. Why? In one case, the man's having a heart attack.
3 I think putting a finger down the throat of a man having a
4 heart attack might not be a great idea.

5 Q You remember giving your deposition?

6 A I sure do. I stood you up and I apologized for it.

7 Q That's okay. You remember me asking you the question,
8 given the finding of no pathology and a negative MRI, what
9 would Dr. Wilson have biopsied? And you remember your
10 answer being perhaps nothing?

11 A On a negative -- was that a hypothetical? I don't
12 really recall, sir.

13 Q You want me to show it to you?

14 A Sure. Mr. Davis, could you repeat the question?

15 Q Well, I asked you, given a finding of no pathology
16 after the third visit and a negative MRI, what would Dr.
17 Wilson have biopsied? And your answer was --

18 A What would -- okay, that's was where it hung up. What
19 would he have biopsied. The answer would be nothing. But
20 the findings -- there were findings.

21 Q And do you also recall telling me --

22 THE COURT: I'm sorry, Mr. Davis, do you want the
23 deposition back or you want me to go ahead and open it?

24 MR. DAVIS: Just hang onto it a second, Your Honor.

25 BY MR. DAVIS:

1 Q And you also recall telling me that at that third visit
2 that it would not have been a smart thing because Mr. Miller
3 was on Plavix, it would not have been a smart thing to do a
4 biopsy on that third visit?

5 A It would not have been a smart thing, but it would have
6 been necessary.

7 Q And you recall laughing when I asked you if you would
8 take out his tonsils and you told me that wouldn't be smart
9 either?

10 A No, that would not be the right thing to do.

11 Q Right.

12 A Plavix is a platelet inhibitor. You know, you will
13 clot after Plavix. Your arteries won't, but everything else
14 will. But the patient wasn't examined on that third visit.

15 Q You've actually written an article, have you not, about
16 the dangers of bleeding in older people in tonsillectomies;
17 is that correct?

18 A I don't recall.

19 Q You don't recall?

20 A I'm serious, I don't recall.

21 Q Okay.

22 A Is this the one that was authored by Dr. Alvey and
23 myself?

24 Q I believe so, yes, sir.

25 A Okay.

1 Q It is dangerous for older people to have a
2 tonsillectomy, right? Even when you take out one tonsil,
3 you don't take out both, do you?

4 A I've yet to have an indication, short of cancer, to
5 remove the tonsil on a 60-year-old. In my career, I think
6 the highest I've gone has been 50 and I regretted it. The
7 tonsil, it's a dreadfully painful procedure.

8 Q Yes, sir.

9 A And the common indication for tonsillectomy is for a
10 chronic infection. And once you're 60, it's no longer a
11 chronic infection. You're starting to think about things a
12 lot worse, but not on both sides.

13 Q Right.

14 A And frequently, that tonsillectomy does not get rid of
15 the pain for those patients. So the problem is that they're
16 probably poorly indicated and I won't do it. But the
17 article that you're attempting to quote said that as your
18 age goes up, your incidents of bleeding goes up.

19 Q It does. It becomes more dangerous; is that correct?

20 A I think it's not more dangerous, it's just more
21 horrible for the patient.

22 Q The opinions you've expressed today are opinions based
23 on the fact that you believe that the tonsil which was
24 diagnosed in 2016 was present when Dr. Wilson examined Mr.
25 Miller in 2013?

1 A Yes, exactly.

2 Q And tell me if I'm wrong. We know certain things about
3 the records. Let's just talk about the records. I know you
4 disbelieve some of the records, okay?

5 A Yes, sir.

6 Q In fact, you have to disbelieve all of that third visit
7 with Dr. Wilson, don't you? You have to pretty much
8 disbelieve all of that to come to your conclusion?

9 A Yes, I do.

10 Q If that's true, you're opinions aren't; is that
11 correct?

12 A I'm sorry, my opinions aren't what?

13 Q You're opinions aren't true. If we believe everything
14 in that third visit, then your opinion won't hold water; is
15 that correct?

16 A No.

17 Q No. You believe that the cancer disappeared on the
18 third visit and came back?

19 A I don't believe it disappeared.

20 Q You just believe because of antibiotics, it became less
21 inflamed?

22 A I never said that either.

23 Q What do you believe happened then --

24 A I believe he wasn't examined --

25 THE COURT: Hold on a minute. We've got two people

1 talking at once. Let him finish his question, then you can
2 answer.

3 THE WITNESS: I apologize.

4 BY MR. DAVIS:

5 Q When he can't visualize or feel an erythematous spot,
6 how do you explain that?

7 A You know, it's the same way I would explain that he
8 wrote that the hypopharynx was clear, as he did in the
9 second office visit. And the only way to examine the
10 hypopharynx is to do a flexible laryngoscopy, which was only
11 done on the first visit. It wasn't done on the second or
12 the third. He wasn't billed on the second or the third. So
13 he's charting something that never occurred.

14 Q Talking about his tonsils, not his hypopharynx.

15 A No. That is hypopharynx. It's written there. I can
16 pull it up for you.

17 Q Sure, I understand that.

18 A You may understand it, but he wrote that he did
19 something that he clearly didn't do. So if he didn't do
20 that, why would I believe that he felt this man's tonsil?
21 The only word I have on that is Dr. Wilson versus Mr.
22 Miller.

23 Q Let's talk about what we know then. We know that we've
24 got a negative MRI, right?

25 A We have an MRI that did not show a lesion.

1 Q Right.

2 A We do know one thing, it did not show any pathological
3 lymph nodes in 2013.

4 Q Right. We know this, too. We know that I've, at
5 least, shown you one document of another medical provider,
6 who by that document, by that medical record says that
7 there's no erythematous spot. We know that, too, don't we?
8 That's in the record.

9 A There's a record that says that.

10 Q Whether you believe it or not, right?

11 A Whether I believe it or not. As sure as this paper is
12 in front of me.

13 Q And we also know that in March of '16 that the VA did a
14 CT which showed a mass, right?

15 A Yes.

16 Q And that's less sensitive than an MRI under contrast,
17 isn't it?

18 A No.

19 Q It's not?

20 A No, it's not.

21 Q A CT is better at picking up the mass --

22 A Depends on which MRI you're using. If you're using an
23 old-fashioned MRI, a brand new CT scanner is much better.
24 In fact, many of us are depending on CT and CTA for
25 examining our patients' pharynxes.

1 Q Because you feel that the cancer that was diagnosed in
2 2016 is in the same location that Dr. Wilson -- that Dr.
3 Wilson noted in 2013, because of that, you can state to a
4 reasonable degree of medical certainty that the cancer
5 existed on that date; is that right?

6 A Yes, I will.

7 MR. DAVIS: Thank you. No other questions.

8 THE COURT: Any redirect?

9 MR. MCGOWAN: Very briefly.

10 REDIRECT EXAMINATION

11 BY MR. MCGOWAN:

12 Q You touched on things about the second and third visit
13 about the hypopharynx, correct?

14 A Yes.

15 Q All right. On the first visit, this says there was --
16 you would agree, would you not, that the hypopharynx was, in
17 fact, examined by way of flexible laryngoscopy?

18 A Correct. He also stated that Mr. Miller couldn't
19 tolerate a mirror exam. A mirror exam is when you take a
20 mirror that's bent like this and warm it up and we get it to
21 the back of the patient's throat while holding onto their
22 tongue and we ask them to vocalize. We can see a
23 reflection. This is the way it was done in 1845 for the
24 first time by a Dr. Garcia. But this gentleman wouldn't
25 tolerate it. In fact, most doctors don't do it nowadays

1 because it's just easier to scope the patient. I still do
2 it because I did as a speech therapist in college, so I've
3 been doing it for 40 years.

4 Q Was there a bill generated by Dr. Wilson's office from
5 that first visit, March 26th, for a flexible laryngoscopy?

6 A Yes, there was.

7 Q On the second visit and the third visit, do we have
8 notations of hypopharynx changed and hypopharynx is grossly
9 clear?

10 A Well, yeah, that's what I was mentioning.

11 Q How is it that you can determine that? What's the only
12 way you can determine that as an ENT? Is it with a mirror
13 or with a flexible laryngoscopy?

14 A A mirror or a flexible laryngoscopy. And since the
15 patient didn't tolerate the mirror the first time, he wasn't
16 -- it's not recorded in this record, nor is it recorded in a
17 bill that he had it done. I suspect you can ask the patient
18 if he had it done.

19 Q We will.

20 A I'm sorry, Mr. Miller if he had it done, he's no longer
21 a patient.

22 Q So to examine hypopharynx, in this case, you'd have to
23 do a flexible laryngoscopy. And there's no indication in
24 the notes that happened; is that right?

25 A None.

1 Q And then there's no indication on the bill from those
2 two visits?

3 A None.

4 Q So does that lead you to doubt or question the veracity
5 of the statements made in the second and third visits by Dr.
6 Wilson?

7 A It did.

8 MR. MCGOWAN: Thank you. Nothing further.

9 THE COURT: Any recross?

10 MR. DAVIS: None, Your Honor.

11 THE COURT: Thank you, Doctor. You may step down.

12 (Witness steps down.)

13 MR. MCGOWAN: May the witness be excused, Your Honor?

14 THE COURT: Any objection?

15 MR. DAVIS: None, Your Honor.

16 THE COURT: Doctor, you're excused.

17 THE WITNESS: Thank you.

18 THE COURT: Ladies and gentlemen, that concludes the
19 testimony we're going to hear today. I'm going to allow you
20 to go home. Do not discuss the case. Do not be looking up
21 any medical terms or looking at pictures of anything you may
22 have heard or think you heard today. Don't discuss the case
23 with anybody you come in contact with.

24 I'm going to ask that you be back in your jury room --
25 or back downstairs ready to come up to your jury room at

1 9:30 tomorrow morning.

2 Everyone remain seated while the jurors are excused.

3 (Whereupon, the jury was excused for the day.)

4 THE COURT: Anything further from the Plaintiff?

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

6 THE COURT: From the Defense?

7 MR. DAVIS: Yes, Your Honor.

8 THE COURT: Yes.

9 MR. DAVIS: Move to strike the testimony of Dr.
10 Myssiorek, except his qualifications. At the end of his
11 cross-examination --

12 THE COURT: I'm going to ask that you come forward a
13 little bit.

14 MR. DAVIS: At the end of his cross-examination, Dr.
15 Myssiorek stated on the record that he based his opinions on
16 the fact that he believed that the cancer was present in Mr.
17 Miller's tonsils on the day that he was seen by Dr. Wilson.
18 When I questioned him further, he said he got there by the
19 fact that the cancer had been diagnosed in 2016 and because
20 the cancer that was diagnosed in '16 was in the same place
21 in his opinion as the drawing of the spot that Dr. Wilson
22 had made, he deduced that cancer was present in 2013.
23 That's res ipsa loquitur by the book, Your Honor, and I move
24 to strike his testimony because that's not a theory that's
25 recognized in South Carolina.

1 THE COURT: Thank you. Mr. McGowan, be glad to hear
2 from you.

3 MR. MCGOWAN: That's not what res ipsa is, Judge, and
4 that's not what he said. If Mr. Davis is correct, that
5 means that no expert could ever make a deduction from known
6 facts. This exhibit, which is in evidence, is enough for
7 the jury to conclude that it was, in fact, the same. Res
8 ipsa is we're presuming negligence by the fact that an act
9 occurred. That's not what the doctor testified to at all.
10 He doesn't say Dr. Wilson was negligent because of so and
11 so. He said the cancer was there based upon my deduction
12 and my review of the medical records. It is simply not res
13 ipsa loquitur at all. It just doesn't apply.

14 THE COURT: I'll deny the motion.
15 Anything further?

16 MR. DAVIS: No, Your Honor.

17 THE COURT: We'll be at ease until 9:30 in the morning.

18 (Whereupon, Court was adjourned at 6:00 p.m. until
19 Tuesday, January 29th, 2019.)

20 Tuesday, January 29th, 2019

21 THE COURT: Is the Plaintiff ready to proceed?

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

23 THE COURT: Defense?

24 MR. DAVIS: Yes, sir. One thing, Your Honor.

25 THE COURT: Yes, sir.

1 MR. DAVIS: Yesterday, we had a document that I thought
2 I offered as Defense Exhibit 1. It was actually marked by
3 the court reporter. She informed me this morning that we
4 never formally moved it in or accepted it as a piece of
5 evidence. So I'd like to do that.

6 THE COURT: What document was that?

7 MR. DAVIS: It was one of the medical reports.

8 THE COURT: Mr. Davis is formally moving Defense
9 Exhibit 1 into evidence. Is there any objection?

10 MR. MCGOWAN: No, sir.

11 THE COURT: All right. Defense Exhibit 1 is in
12 evidence.

13 MR. DAVIS: Thank you.

14 (Whereupon, Defendant's Exhibit No. 1 was admitted into
15 evidence.)

16 THE COURT: All right. Let's bring the jury in.

17 (Whereupon, the jury enters the courtroom.)

18 THE COURT: Good morning, ladies and gentlemen. I
19 appreciate your promptness this morning. The next time we
20 take a break when you go back to your jury room, I'm going
21 to ask that you elect a foreperson from among yourselves.
22 So whenever we take the next break, I'm going to ask that
23 you elect a foreperson. Let that person then write their
24 name on a piece of paper and hand it -- and your number and
25 hand it to the bailiff. He'll get it up to me. And then

1 when you come back into the courtroom after that first
2 break, whoever the foreperson is will take this first seat
3 on the front row.

4 Mr. McGowan, call your next witness.

5 MS. GOODSTEIN: Thank you, Your Honor. The Plaintiff
6 would call David Miller.

7 THE CLERK: Place your left hand on the Bible and raise
8 your right.

9 DAVID MILLER,

10 after being duly sworn, testified as follows:

11 DIRECT EXAMINATION

12 BY MS. GOODSTEIN:

13 Q Good morning again, David. I know you brought a bottle
14 of water up there, but if you need more, let me know and I'm
15 happy to get you some more, okay?

16 A Okay.

17 Q Now, if you would, please, just introduce yourself to
18 the jury.

19 A My name is David Miller.

20 Q David, how old are you?

21 A I am 68 years old.

22 Q Where were you born?

23 A I was born in Charlotte, North Carolina.

24 Q Now, where do you live now?

25 A I live in Sharon, South Carolina.

1 Q How long have you lived in Sharon?

2 A Well, the property that I have there, I bought back in,
3 I believe, 1979, but the home I live in now, the log home, I
4 built it, basically, around 2008.

5 Q Now, did you build that log home yourself?

6 A Well, I did all of the contracting myself. You know, I
7 have a lot of friends that work in the building industry, so
8 I had people come out that did a lot of the work and
9 everything, but I pretty much was my own contractor.

10 Q David, are you married?

11 A No, I'm single.

12 Q How long have you been divorced?

13 A I got divorced in probably around 1974, latter part.

14 Q Now, do you have any kids?

15 A I have one child.

16 Q How old is your daughter?

17 A My daughter is 44 years old.

18 Q David, have you ever served in the military?

19 A Yes, I have.

20 Q And what branch were you in?

21 A I was in the Marine Corp.

22 Q When were you in the Marine Corp?

23 A I was in from June of '70 to May of '76.

24 Q Now, would this have been during Vietnam?

25 A Yes, that's the Vietnam era.

1 Q What was your job in the Marines?

2 A Well, initially, I started out as a radar technician,
3 then, eventually, I got into a position of what was called
4 flight and test evaluation. Since there are some of the
5 problems that you have on aircraft in the air that you
6 cannot copy on the ground, it was kind of like flying around
7 trying to analyze what was wrong with the fire control
8 system, which is shooting down other airplanes. It's
9 air-to-air missile system is what I did.

10 Q Now, when you were in this job in the military, was
11 there something kind of unusual that happened?

12 A Well, there's quite a few things kind of unusual,
13 that's just the nature of being in the service. But,
14 eventually, I did end up having two back operations.

15 On one of the times when we came in, we had what was
16 referred to as a hard landing, where you just an exceptional
17 amount of G-force when you're landing. And I noticed a lot
18 of pain was radiating down in my left leg. So the flight
19 surgeon give me an exam after that and noticed that my left
20 leg had begun getting smaller than my right leg, which was
21 something that I hadn't noticed. So he asked me if I had
22 ever had polio and I said, No, I've never had polio. And he
23 said, For some reason, your left leg is getting smaller than
24 your right leg. And I said, Oh, that ain't good and he
25 said, Nope.

1 But anyway, they sent me to the Naval Regional Medical
2 Center in San Diego. They did a myelogram. Sure enough, I
3 had a herniated disk on the left side. So they went ahead
4 and took care of that. And as fate would have it, when they
5 did the operation, the neurosurgeon who did that said he had
6 to take like a stainless steel hammer and chisel and kind of
7 do my spinal part, you know, where the thing had kind of
8 compressed and when he did, he herniated the disk on the
9 other side.

10 So after 30 days of convalescent leave, I come back and
11 sure enough, the same problem was happening in the right
12 leg. So I had another back operation. And then after that,
13 they said well, you're pretty much going to be going out of
14 the service after this. And that pretty much ended
15 everything.

16 Q Okay. So when you say pretty much ended everything,
17 what do you mean by that?

18 A I mean being discharged on disability.

19 Q Okay. Now, is that an honorable discharge?

20 A Oh, yeah, I have an honorable discharge.

21 Q Is that why you wear leg braces?

22 A Well, actually, when I got out of the service, I was
23 only considered 20 percent, but as a period of time, the
24 back injury got worse and worse and worse and the condition
25 got worse and I kept losing more and more of my reflexes.

1 So now, I do have to wear leg braces. I've got this foot
2 drop in both feet where you have to wear AFOs to keep your
3 feet kind of propped up so you don't stumble. And the
4 cartilage in my left knee is completely gone, so I have to
5 also wear a knee brace.

6 Q Now, does all of this entitle you to healthcare through
7 the VA?

8 A It surely does. I've got what's called
9 service-connected disability. So whenever they do that,
10 they do -- as long as you've got service-connected
11 disability over 50 percent, they will cover everything for
12 you.

13 Q Now, when you got out of the military, what did you do
14 next?

15 A Well, after I got out of the military, I went back -- I
16 had gone to college before and it looked like this Vietnam
17 War thing was going to go on forever. And at the time I
18 went in the service, they had the draft, that's why I went
19 in. It wasn't like you could escape that or become a
20 fugitive. So anyway, I went to college in Arizona, which
21 was my last duty station. And I finished up a degree in
22 business at Arizona Western College when I got out.

23 Q Okay. Now, after a distinguished military career and
24 college degree, what did you do next?

25 A Well, I came back up to the Charlotte, North Carolina

1 area that I was from. That's where my ex-wife and daughter,
2 you know, they were living in that area. And I took a job
3 with Duke Power as a -- well, I went through the reactor
4 operator training, which lasted about a year, and took a job
5 with Duke Power.

6 Q All right. Tell me a little bit more about the Duke
7 Power reactor program.

8 A Well, anyway, they have a year training program that
9 was at the McGuire Nuclear station where you went through
10 the reactor operator training. Part of the time, you spent
11 at NC State University at their practice reactor and after
12 that, you had about a year of the school and you graduate.
13 And I got sent to Oconee.

14 The problem with that was I was originally hired by the
15 Catawba Nuclear plant, which is the one that's close to
16 here. So I had already bought the land and when they
17 transferred me to Oconee -- Duke Power owns their own real
18 estate company and everything, but if you own a home,
19 they'll buy your home back for you. But if you have land,
20 you're pretty much stuck.

21 So I had gone through and gotten all my visitation with
22 my daughter and everything straightened out and everything
23 to live in this area and it just pretty much messed me up.
24 And as fate would have it, Three Mile Island happened while
25 I was in the training program. So since I wasn't having a

1 chance to do the things I wanted to, some jobs came up
2 really good doing a travel job and all these nuclear power
3 plants that they had shut down, that they had all this money
4 invested in and they really needed to get running, you could
5 get a 12-hour, 14-hour a day job, six and seven days a week,
6 so I took the road job. And by doing that, hell, I could
7 make enough money where I could take long time off
8 vacations. I got to spend more time with my daughter that
9 way and got further ahead in life. So that's the direction
10 I took.

11 I did that for as many years as I could. But during
12 that time, my back kept getting worse and worse and worse.
13 First, I lost the use of my left leg. I still was able to
14 do my job, but then once I lost all my reflexes in my right
15 leg, in order to do the health physics work that I was
16 doing, what you do in that job, you go in and you assess
17 radiological areas, tell people how long they could stay and
18 you have to monitor them. But in a nuclear power plant or
19 any of these other power plant situations, you've got to be
20 able to crawl around with all the piping and everything like
21 that, set up collection bags in case you got contaminated
22 water. And it's not something -- you know, if you've got
23 bad reflexes and bad health, you just can't do your job no
24 more.

25 Q Now, David, if you would, tell the jury what you did

1 for employment after you were 100 percent disabled through
2 the VA?

3 A Well, what I've done, I had some rental property and I
4 had my little farm and stuff like that. So there for a
5 while, things got pretty bad to where there just wasn't too
6 much I could do. There was a lot of stumbling and falling
7 until you got use to the situation that I've got here now.
8 So they went ahead and said you can be on disability, so
9 that's what I took. I mean, you don't make as much money as
10 you did working, but that's the option I took.

11 Q Now, you say you ran a rental company?

12 A Oh, no, I didn't run a rental company, I just owned
13 rental houses. I bought rental houses while I was working.

14 Q Okay. But you continued to do that?

15 A Well, I just have one rental house left. Yes, I still
16 have one rental house left.

17 Q But before, you had multiple rental houses; is that
18 right?

19 A Oh, yeah, I've owned more than one home, yeah.

20 Q And where were those located?

21 A More or less in the Charlotte area, Charlotte, North
22 Carolina area.

23 Q Did you have any that were a little bit further away?

24 A Well, I, actually, owned -- yes, I owned rental
25 property in Daytona Beach and that's where I ended up moving

1 as a residency before I moved back up here to South
2 Carolina.

3 Q Now, who would do the work on those rental houses?

4 A Well, my friends and everything. I've got a friend of
5 mine, Joey, we've been friends forever. And that was the
6 good thing about having people who were in the building
7 industry, if I ran into problems with anything while I was
8 out of town, I could contact them, you know, whether there's
9 a heating and cooling, plumbing, electrician, whatever the
10 case may be, and get things taken care of no matter where I
11 was.

12 Q Now, please tell the jury a little bit about who Joey
13 is.

14 A Well, Joey is a good friend of mine. He and I went
15 through junior high school together. We ended up having bad
16 marriages at the same -- just about the same time. And we
17 ended up -- even though I had moved out to Dallas, Texas,
18 whenever the Marine Corp took us both in. You know, I sat
19 around and joined the Marine Corp and while I was in the
20 Marine Corp, I got drafted in the Army. He decided he was
21 going to take a chance on the draft and he got drafted in
22 the Marine Corp. Anyway, we ended back in the Marine Corp
23 together back in the same place.

24 Then after I got out the service and everything, we
25 just been buddying around. We were buddies when we were

1 teenagers and buddies in adult life. So that's pretty much
2 the way our life has been.

3 Q Over, let's say, the past 10 years, typically, how
4 often do you see Joey?

5 A All the time.

6 Q And have you and Joey been friends through the good
7 times and the bad?

8 A Oh, yeah, there's been plenty of good and bad.

9 Q Now, you helped Joey out before with cancer; is that
10 right?

11 A Well, yes, he ran into a situation with the VA that he
12 had some polyps inside of his esophagus that they noticed
13 one time. They said well, we can go in arthroscopically and
14 take care of this, but then they kept delaying and delaying
15 and delaying and four years later is when they finally got
16 to the point where they wanted to treat him. They almost
17 killed him. They had to sit there and collapse his left
18 lung, disconnect his esophagus at the top and bottom and
19 then try to sew that back up. Instead of doing the thing on
20 the quick and dirty like they could have arthroscopically,
21 it ran into a mess before they got a chance to get ahold of
22 it.

23 Q So are there certain things you're comfortable going to
24 the VA for and certain things you go outside of the VA for?

25 A Absolutely.

1 Q Tell me when you would seek treatment inside the VA.

2 A If you go for cardiology in this state, I would rate
3 the VA as the top hospital in the whole state. Anything
4 else, just about forget it. I mean, some of the stuff they
5 do is almost like third world. It's not so much that
6 they've got bad people, it's just the way they run their
7 management is bad.

8 Q Explain that for me a little bit more.

9 A Everything they do, it just takes so much time. It's
10 just like, for instance, we've run across the situation
11 where they talked about the emergency room nurse
12 practitioner that in 2015 I went to see. This is not an
13 exaggeration, that poor woman probably has to see around 120
14 people during an eight-hour period. They don't get a chance
15 to sit around and do like thorough this and thorough that.
16 It's a matter of trying to see everybody over a matter of
17 minutes than it is actually doing some really good
18 examinations and things where they can actually go through
19 and find out everything that's going on with people. And
20 it's just a matter of the way that they're staffing.

21 Q All right. David, I want to take you back to 2013.

22 A Okie dokie.

23 Q Now, tell me why you decided to go to a provider
24 outside of the VA back in 2013 when you first noticed
25 something going on in your throat.

1 A Okay. At this time in 2013, I'm 62 years old. I have
2 Medicare at this time and I've also got social security, so
3 I've got more of a cushion to have things where if I see
4 something outside of the VA and stuff like that, the extra
5 expense that I go through is well afforded.

6 Okay. I noticed, I guess, around March of 2013 that
7 when I would eat something, it would feel like a little
8 something was caught in my throat. And it just kind of felt
9 like a little bit of -- you know, I could feel something
10 that just wasn't right.

11 So anyway, I tried to see in the mirror what was going
12 on and I could kind of like catch a glimpse of something,
13 but I couldn't really see it very well. So what I did is I
14 took my finger and I run through and I could actually touch
15 something that if you -- to give you a good description of
16 what this looked like, I've kind of explained it before like
17 the back of a cigar, you know, where it's kind of rounded.

18 But what you do, if you look at your finger and how
19 it's rounded, this is the way that little tumor looked in
20 the back. If you look at a pencil eraser, it's just about
21 the same color as what a pencil eraser is and just about
22 that same size. So if you look at a pencil eraser and you
23 kind of rounded it up and everything and you put it right at
24 the top of the back of your mouth, right at the top of the
25 tonsil. Not in the back part, you know, where you got your

1 gag reflex and all that other stuff where you can run your
2 finger down and (made noise), like that, it wasn't in that
3 part. It wasn't in the swallowing part, it was up in the
4 top.

5 So in order for me to really find out where it was, I
6 took my finger and run it across the top roof of my mouth
7 and I could touch it. And it had kind of a firm feeling
8 whereas most of the skin and everything that's around there
9 is, you know, really soft tissue, it had that really firm
10 spongy feeling. But it was never big and it was never
11 painful, even to the point to where I had Stage 4 cancer,
12 that cancer was never painful. You look at any time that
13 they have examined me and stuff like that. So if you have
14 that and it isn't painful, it doesn't mean that it's not
15 cancer.

16 And I have a lot of cancer in my family. My mother
17 died of cancer and her two older sisters died of cancer. So
18 I've got a lot of cancer in my family, so as soon as I
19 noticed this little bump, I wanted to find somebody that I
20 could see that could tell me if there was something wrong
21 with it.

22 Q How long had it been that you noticed this thing in the
23 back of your throat before you called Dr. Wilson's office?

24 A As soon as I found it, I started looking for somebody
25 to go to. It was a matter of weeks. I was in a doctor's

1 office within a matter of weeks after that.

2 Q And did you make that appointment yourself?

3 A Yes, I did.

4 Q How long did you have to wait for an appointment after
5 you called?

6 A Oh, he got me in pretty quick. It wasn't really one of
7 those wait for a long time.

8 Q Now, did you ever miss an appointment with Dr. Wilson?

9 A No, I did not.

10 Q Did you ever have to reschedule an appointment with Dr.
11 Wilson?

12 A No.

13 Q Now, let's focus on that first appointment you had with
14 Dr. Wilson, starting at the very beginning. Did you fill
15 out a questionnaire when you got there?

16 A Let me get some water. You know, with saliva, your
17 throat gets dry.

18 Q Take as much time as you need.

19 A That's one of the things that happened with the
20 radiation, your saliva glands got fried and they don't come
21 back.

22 Okay. What was the question again, please?

23 Q We were just talking about the questionnaire getting
24 filled out. Who do you remember being listed as your
25 emergency contact?

1 A Oh, my friend, Joey Williams.

2 Q At that first appointment, what did you tell Dr.
3 Wilson?

4 A Well, I explained to him that, you know, I noticed a
5 small bump in the top of my right tonsil and I also
6 explained the fact that there's also a lot of cancer in my
7 family and I was concerned about looking at it.

8 Q Now, did the spot hurt?

9 A Absolutely not. Even to the point of where after years
10 later and it was Stage 4 cancer, there was never any pain
11 involved with that little spot.

12 Q What kind of exams and tests did Dr. Wilson do in the
13 appointment that first time?

14 A Oh, well, he did a physical exam of it. You know,
15 he'll tell you he could reach his finger back in there and
16 touch it. But then we started to do some other things where
17 he was trying to like go down and boy, I tell you one thing,
18 when he hit the gag reflex and stuff like that, that was
19 rough, I wasn't handling that. But then again, this little
20 thing that was on my tonsil was way up at the top. But he
21 tried to do some other stuff lower down and, you know, I
22 remember that was pretty rough. I kept gagging.

23 Q So you remember him doing something where he tried to
24 look at the back of the throat?

25 A Yeah, he stuck a mirror in it.

1 Q Do you remember a test where he put a tube in your nose
2 and down to your throat?

3 A Yep, yep, yep.

4 Q What did you say that felt like?

5 A I felt like -- rough. It's just one of those -- yeah,
6 that was a rough thing to try to handle.

7 Q Now, at that appointment, did you tell Dr. Wilson you
8 had a concern for cancer?

9 A Oh, absolutely. That's the biggest thing that I was
10 worried about.

11 Q And what did he tell you?

12 A He said well, you know, we need to start going through
13 the process of what -- you know, if it is cancer and do some
14 tests. We've got things we can do. So we just started the
15 process.

16 Q All right. You say you started the process. Can you
17 be a little bit more specific?

18 A Oh, yeah. He scheduled me for -- he did give me a
19 prescription for antibiotics, that's one of the things he
20 did. He also in the office said we need to do an MRI. And
21 it was in his office that we did the setting up of the MRI.
22 And that's, basically, the two things that we done about the
23 care and everything else, the MRI and the antibiotics.

24 Q Okay. Now, I'm just talking about the first
25 appointment right now. We'll get into the rest a little bit

1 later. But at the first appointment, did he schedule an
2 MRI?

3 A I don't remember if it was at the first appointment or
4 the second appointment. That part, I can't really -- I know
5 we had an MRI scheduled, but exactly when we scheduled the
6 MRI, I couldn't be able to really say definitely on that
7 one.

8 Q All right. Now, the test that we're talking about with
9 the mirror, did Dr. Wilson do that test at any other
10 appointment?

11 A Oh, no, no, no.

12 Q Now, the test that you're talking about with the tube
13 down your nose and into your throat, did Dr. Wilson do that
14 test at any other appointment?

15 A No.

16 Q Now, do you think you would have remembered if he had
17 done this test again?

18 A Oh, yeah.

19 Q And why is that?

20 A Well, that's just something that once you have that
21 kind of experience, you don't forget it.

22 Q Now, after that MRI, did he do any other tests?

23 A No.

24 Q Did he talk about doing any other tests?

25 A No.

1 Q Did he tell you that you needed any additional tests?

2 A No.

3 Q Did he tell you that you needed a biopsy?

4 A No.

5 Q Would you have remembered if he told you you needed a
6 biopsy?

7 A Oh, absolutely.

8 Q If he had told you to get a biopsy done, would you have
9 gotten one?

10 A Absolutely, yes.

11 Q Now, at the second visit with Dr. Wilson, did he review
12 your MRI results with you?

13 A No.

14 Q What happened at that appointment?

15 A I'm not so sure that the second visit wasn't the one
16 where he set up the MRI, but, you know, like I say, there
17 wasn't nothing remarkable happen -- maybe the second -- that
18 seems to -- I seem to think that the second one is when we
19 set up the MRI, but I'm not really for sure on that. I
20 can't remember anything that went on other than that.

21 Q Now, you said that Dr. Wilson prescribed you an
22 antibiotic?

23 A Yes.

24 Q And you took that antibiotic as directed?

25 A Oh, yes, yes.

1 Q Now, do you believe that -- were you not told to
2 followup with Dr. Wilson at some point after the antibiotic?

3 A Well, I came in -- the last time that I came in with
4 him was when we reviewed the MRI on our last visit.

5 Q Okay. Tell me about that appointment.

6 A Well, we had set up a time for me to come in for the
7 MRI, to review it. And in between the time that I had the
8 MRI and we reviewed the MRI, I had a cardiac incident where
9 I had to have three stents put in. So that happened prior
10 to -- after I had the MRI and prior to reviewing the MRI
11 pictures is when I had the stents put in.

12 Q Okay. On that third visit, was that in the exam room?

13 A In the exam room, no.

14 Q Where was that appointment?

15 A That appointment, when I went for the third visit is
16 when he reviewed the pictures from the MRI that I had.

17 Q Okay. And what did he tell you when you reviewed the
18 MRI?

19 A Well, he was just sitting there with the MRI and he
20 asked me about the stents I had put in. He asked me if I
21 was on blood thinners and I said, Yes, I'm on Plavix. And
22 he said well -- you know, I think we discussed -- I may have
23 told him or he may have asked, but anyway, I told him I was
24 going to be on that for like six months, so he knew that.
25 And then he said, Well, we don't need to go in and do

1 anything with your tonsils unless he's kind of an emergency
2 in this case, you know, since I was on the blood thinners.
3 And I said, Well, you know, that sounds good to me.

4 So he's sitting there and he has the pictures laid out
5 on his desk, looking at them, looking at them. And he says,
6 Well, I don't see anything that concerns me about the C
7 word. And I said, The C word? And he said, Yes, he said
8 cancer. He specifically said cancer. And at that point in
9 time, I'm just fat, dumb and happy and just that is exactly
10 what I like to hear.

11 Q At that point, did Dr. Wilson tell you that you needed
12 to have any additional tests to rule out cancer?

13 A No.

14 Q Did Dr. Wilson tell you that you needed a biopsy?

15 A No.

16 Q Did Dr. Wilson talk about doing a biopsy?

17 A No.

18 Q Did he share with you that you needed to go somewhere
19 else to get a biopsy?

20 A No.

21 Q And did he tell you that cancer had not been ruled out?

22 A No.

23 Q When you left his office that day, what did you believe
24 was going on with your throat?

25 A I just thought I had a little, small benign tumor. It

1 was not painful. It didn't really hurt my swallowing or
2 anything. I just thought well, that's the way life is.

3 Q Were you relieved?

4 A Yes.

5 Q Did you share your relief with anyone?

6 A Yes.

7 Q And who was that?

8 A Everybody that would listen, especially my good friend.
9 That was the first one I called because him and his friend
10 said they had been praying for me. And I said, Well, that
11 hasn't worked too much for me yet, but it seemed to happen
12 this time. But then, again, the way it turned out, maybe
13 not now that I think about it.

14 Q When you say your good friend, who are you referring
15 to?

16 A Joey Williams back there.

17 Q Now, at this last appointment, had the thing in your
18 throat gone away?

19 A No.

20 Q Did it go away from your -- the last time you saw Dr.
21 Wilson until the first time you went back to the VA about
22 your throat in 2015 or early 2016?

23 A No.

24 Q Did you from time to time look back there?

25 A Well, I could see it every now and then, but when I

1 looked at it, it never got bigger, it never hurt more and it
2 never changed, the part that I could see.

3 Q And was it a feeling that something was stuck back
4 there?

5 A Well, it's just like if you try to swallow something
6 and you had like something like tingling in the back of your
7 throat. You could tell something is there that shouldn't
8 be, but like I say, it wasn't painful or anything.

9 Q And on that third visit with Dr. Wilson, did you have
10 any kind of examination done by Dr. Wilson?

11 A No.

12 Q Did he put on a glove and feel back there?

13 A No.

14 Q Did he look back there?

15 A No.

16 Q Did he do the test where he used the mirror?

17 A Oh, no, no.

18 Q How about the test where the tube goes down your nose
19 and into your throat?

20 A No, no, no.

21 Q And based on what you were told by Dr. Wilson, did you
22 think you had cancer?

23 A No.

24 Q Now, when is the next time you sought care for your
25 throat after that third appointment with Dr. Wilson?

1 A Well, in 2015, I was having a little bit of a problem
2 with swallowing. This is in, I guess, October of 2015.
3 Things were just getting a lot tighter in my throat and, I
4 don't know, just kind of an uncomfortable feeling. So I
5 went to the VA to see if they could give me something for
6 some relief from that.

7 Q Back in October of 2015, were you having any other
8 symptoms along with the issue of your throat?

9 A Well, to the best of my recollection, it did feel like
10 I had soreness and kind of pressure in there, but other than
11 that, I don't think I was having too many problems with
12 anything else other than, you know, what you normally have
13 when you've had three back operations and stuff.

14 Q And during this time period, did you still get your
15 primary care through the VA?

16 A Well, yeah, I was getting primary care through the VA
17 at this time.

18 Q Did you go once a year and have a checkup or go to get
19 your prescriptions refilled?

20 A Well, what happened after I had the stents put in, on
21 an annual basis, I get to see a cardiologist. And then
22 every year, I have in this town here what's called a nurse
23 provider. That's with Rock Hill. These are not government
24 employees. These are government contracts. And what they
25 do is they make sure -- and once a year, which is in

1 January, they do like -- take blood samples, take urine
2 samples, see if you've got diabetes or anything like that
3 and then they renew all the prescriptions that you got.
4 They see if any of your prescriptions needs to be changed.
5 And there's Deborah Lanis, the one that I've been seeing for
6 a number of years here in Rock Hill. I do that every
7 January on an annual basis, yes.

8 Q And at these yearly examinations, did the nurse
9 practitioner ever put on a glove and feel in the back of
10 your throat?

11 A No, that's not their function. They don't do any
12 treatment. If you call -- even though we can't have a cell
13 phone, trust me on this one. If you call the nurse provider
14 where she's at, the number is 366-4848, the first thing you
15 get is a recording that says if this is an emergency, hang
16 up and dial 911. They don't even do so much as removing a
17 splinter out of your finger. They're not there to perform
18 medical functions. They're there to make sure that if you
19 have something that you need, they contact the right person.

20 To give you a good example, this last January when I
21 was there, I needed my knee braces. They kind of were
22 tearing up. And she went ahead and contacted the people
23 with orthopedics and the prosthetics people at Dorn VA and
24 I've already had these replaced through Hanger Orthopedic
25 Care in Rock Hill. That's all she does. She doesn't do

1 exams. They do not do physical exams. They have never done
2 a physical exam. She's the nurse provider. She don't look
3 at anything other than the blood work that has been done and
4 the tests that they do there.

5 Q Now, you still get cardiology care through the VA,
6 right?

7 A Yes, I do.

8 Q And in these cardiology appointments, did any of the
9 doctors or anybody, did they ever put on a glove and feel in
10 the back of your throat?

11 A No.

12 Q Now, when you went and got your leg braces through the
13 VA, did anyone ever put on a glove and feel in the back of
14 your throat?

15 A No.

16 Q Now, take me back to January of 2016. You saw your
17 nurse practitioner and you get a referral to an ENT; is that
18 right?

19 A That is correct. I told her that well, I think I need
20 to see somebody about getting my tonsils out. That's what I
21 told her.

22 Q Tell me about that first appointment with the VA ENT.

23 A Oh, that was a good one. They didn't know I had a
24 tumor, I never told them. So what they were doing, they
25 started doing the exam on me and they looked over and said,

1 Do you know you have a tumor? And I looked at them and I
2 said, Yeah.

3 Q And why did you never tell the VA?

4 A Well, I thought -- after I saw Dr. Wilson, I thought
5 this was just a small, benign tumor in the top of my tonsil.
6 It wasn't hurting. It never did hurt. And at this point in
7 time, it's been with me so long, I didn't consider anything
8 different than the freckles I had and the birthmark I've got
9 on my wrist. It looked a little different than the rest of
10 me. It wasn't exactly something I was born with, but it's
11 just something that happened.

12 Q So were you ever told to look at it and make sure it
13 wasn't cancer? Did you have any indication this may be
14 cancer?

15 A No.

16 Q So tell me a little bit more about that first
17 appointment with the VA ENT?

18 A Well, after they got through ranting and raving and
19 cussing me, I sat there and I said, Well, I went to an ENT
20 around three years ago and we had the tests done and
21 everything and he told me that it was not cancerous. And
22 then after they said -- and I just so happened to have --
23 when he give me a prescription for the antibiotics, I have a
24 habit of keeping the medicine bottles when they're empty and
25 it had the date and everything and the doctor who prescribed

1 it for me. I said, Here's the doctor -- and the reason I do
2 that is because you're all the time hearing about medicine
3 that's being recalled or stuff don't work like it's supposed
4 to. And it's not a bad idea if you're given a prescription
5 that you keep your bottle and that's just why I kept that.

6 So I showed them that and after that, they said, Oh,
7 well, it's not like you're a complete idiot and you just
8 ignored the fact that you had a little tumor. You did try
9 to do something about it. I said, Yes, and I was told after
10 his tests that he run that it was not cancerous. But right
11 now, it's getting to the point where it's uncomfortable.
12 And I had already been told that I was going to have to
13 spend like a week in the hospital.

14 So in October when I was seeing the person in the
15 emergency room, I wasn't wanting to have things during
16 football season and during the holiday season, we've got
17 Christmas and Thanksgiving coming up. And it's not really
18 all that bad of shape, but I knew I was going to have to
19 have my tonsils out, so I started going through all that
20 process that following January.

21 Q Now, when you say that you told the VA doctor about the
22 tests, what tests are you referring to?

23 A Well, the test that I had was the MRI that we had had.

24 Q And did that doctor tell you anything about the MRI?

25 A Well, what they did, initially, they said -- I said,

1 Well, I've done an MRI --

2 MR. DAVIS: Your Honor, objection, he can't quote a
3 doctor.

4 THE COURT: I sustain the objection.

5 BY MS. GOODSTEIN:

6 Q Now, did the VA ENT order any kind of tests?

7 A I told him -- the first thing he did was they ordered a
8 CT scan.

9 Q Okay. And as a result of that CT scan, what happened?

10 A Well, they called me in to review it and he looked at
11 me and he said, Well, you've got a tumor. And I said, Yeah,
12 I pretty much figured that.

13 Q And what happened after that?

14 A Well, then, he said, We have to do another test on you.
15 This next time, you're going to have to have somebody come
16 up here and drive you because we're going to have to put you
17 under a little anesthesia. So before we set up this, you're
18 going to have let us know you've got somebody that can drive
19 you up here and you can't have your driver's license because
20 we want to make sure that somebody drives you back.

21 Q And what test was that?

22 A They were going to do a biopsy on me.

23 Q And tell me what that procedure was like.

24 A Well, I not only thought they was going to do a biopsy,
25 I thought they was going to do something with my tonsils.

1 And you know, whenever you've been put under, you don't have
2 any clue about how long you've been under. But it wasn't
3 like they put me totally to sleep, so coming out, I said,
4 You know, this doesn't seem like it took very long. And one
5 of the guys that did it, he said, No, it didn't take but
6 about 10 minutes. And then I said, Well, nothing's hurting.
7 And he said, Well, we didn't take your tonsils out or
8 anything. We just took some little chips of meat off your
9 tonsil area where you've got that tumor.

10 Q And tell me what the results of that biopsy were.

11 A It came back cancerous.

12 Q And did they tell you what stage?

13 A Not at this time, they didn't.

14 Q Okay.

15 A But as soon as the biopsy came back, they called me in
16 and said, Well, we've got bad news. You've got cancer. And
17 then they said, Now, the next thing we have to do is we have
18 to set you up for what's called a PET scan. The PET scan
19 will be done in Charleston. And I said, Well, am I going to
20 have to have somebody drive me for that? They said, No.
21 They'll have to contact you, though, because there's certain
22 things -- it's just like when you go through an operation,
23 you can't eat at certain times and you can't eat like sweet
24 foods and stuff like that. But anyway, they'll get in touch
25 with you about everything about the PET scan. So then they

1 set me up for the appointment with the PET scan and I went
2 down to Charleston and got the PET scan.

3 Q Now, what was it like hearing that you had cancer?

4 A That's rough. That is some of the hardest thing --
5 especially after you sit there and watch your mother die. I
6 had that I was really close to. When she died, she had home
7 care and it took her over a year. She went from around 175
8 pounds -- she was kind of a big-boned woman, about
9 five-eight. And when they took her out of the house, she
10 weighed a little less than 70 pounds.

11 The tumor that she had, it was a brain tumor. When
12 they took the skull out, it was inoperable, but they
13 couldn't put the skull back, so they had to just sew her
14 skin up. So as she was home, the tumor grew out from
15 underneath her scalp and it was about half the size of a
16 football before it finally took her life.

17 During the time it was taking her life, she was going
18 blind. She lost her voice. The bed sores come out. And
19 this was during the time that I was in the sixth grade. I
20 was staying with them because when my mother got a divorce,
21 I was the youngest of the family, so my aunt and uncle
22 didn't have any kids and my grandmother was also there, so
23 they thought it was better if I stayed there. So during my
24 sixth grade, I got to sit there and watch that. That's why
25 cancer -- and I had an older aunt that died of cancer before

1 I was even born. That's why this cancer thing was really
2 something that was at the top of my list in case I ever
3 faced it.

4 Q Now, when did you learn what the treatment options
5 were?

6 A Well, whenever I got the PET scan back, they had me go
7 talk to a radiologist by the name of Thakkar. And he
8 started reviewing the -- he said, Well, you have a large
9 tumor now. Now, here, I've got a large tumor. This thing
10 that's in the back of my throat never got bigger, never got
11 smaller, never hurt.

12 What had happened, this tumor was growing from my
13 tonsil, but it was growing on the inside of my neck. It
14 goes through this part and the Stage 4 cancer is where it
15 pops into my lymph nodes. The lymph nodes -- there's three
16 lymph nodes in your neck. Two out of the three lymph nodes
17 ended up with cancer. But the tumor ended up growing down
18 through here.

19 If you look at the scar on my neck from when they was
20 burning out with radiation -- if you feel your collarbone
21 right here, and then you can take that soft part where you
22 can push down, that's where they had to shoot the radiation
23 to kill the tumor that had grown down inside of me. So this
24 tumor, the back part never got larger. It's the one on the
25 inside that got bigger. That's another thing, and here

1 again, it was never painful. But I had a large tumor on the
2 inside of me by this time.

3 Q Now, before you started your treatment, did you have to
4 go see a dentist?

5 A Well, that's another thing. One of the last things
6 when I went to see Dr. Thakkar, he says, We need to get on
7 this real quick. He said, You've got Stage 4 cancer, we
8 need to hit this aggressively. I said, Well, according to
9 the VA, I've got one more hoop to jump through. I've got to
10 see a dentist.

11 Q Now, why do you have to see a dentist?

12 A Well, they didn't tell me this at first. It took 30
13 days for the VA -- after I had been diagnosed with Stage 4
14 cancer, it took 30 days for the VA to get me an appointment.
15 It had to be a VA dentist. So here I've got Stage 4 cancer,
16 I wait 30 days and I finally get an appointment with the
17 dentist.

18 I go into the dental office and the first thing they do
19 is they do one of these bite-wing-type x-rays, you know,
20 where they do your whole jaw. Then they say, Okay, now, you
21 need to talk to a dentist. I go in and the dentist was a
22 little itty-bitty bald guy. And he's sitting back like this
23 and the first thing he says to me, Do you use dental floss?
24 I looked at him and I said, Yeah, I use dental floss. And
25 said, Hey, you know, I've got Stage 4 cancer. This has been

1 going on while I've waited 30 days for my appointment with
2 you. And we're going to have an oral hygiene conversation?

3 Q David, what I'm specifically -- so the jury can
4 understand why the appointment was so important with the
5 dentist, explain to the jury why that was -- before
6 radiation, why the appointment was so important.

7 A Here, I didn't find this out until I went back for the
8 radiation, but I had to have one tooth removed, which is
9 this little tooth to the side here. And the reason it was
10 so important to see a dentist first is if you have any teeth
11 removed after the amount of radiation that I was getting to
12 my jaw, if I have any tooth removed by accident or dental or
13 anything else, it starts a deterioration where your whole
14 jawbone goes away. I can't have a dental implant or a tooth
15 removed for the rest of my life.

16 Q David, explain what you mean by your whole jaw could go
17 away.

18 A Well, the name of the thing -- I forget the name, it's
19 kind of a long name, but what happens is it starts a
20 deterioration and your jawbone just dissolves. That's what
21 happens if you have to have a tooth removed now. This was
22 never explained to me at the beginning of the process. I
23 didn't know this until I walked back into Dr. Thakkar, the
24 radiation doctor's office. And I'm not going to postpone
25 this after Stage 4 cancer any longer, so I'm stuck with

1 that.

2 Q Now, David, was there anything else that had to be done
3 before you could get the radiation treatments?

4 A Well, other than putting your ports and stuff like
5 that, you know, you had to have all that put in.

6 Q Okay. Now, have you seen the video that we are about
7 to show?

8 A I don't know if I've seen it or not. Is it the one
9 where they're showing the process that you go through --
10 what I went through for the radiation treatment?

11 Q That's exactly the video I'm talking about.

12 A Yes.

13 Q Okay. Can you compare the video we're about to see
14 with the radiation you received?

15 A Yeah, I could.

16 Q Are they substantially similar?

17 A Yes.

18 Q Other than the fact that you are not the person in the
19 video, are there any other substantial differences between
20 the video and your procedures?

21 A No.

22 Q Now, I'm going to stop the video from time to time just
23 so you can explain to us what's going on.

24 (Whereupon, the video was played for the jury.)

25 Q David, does that look like the room where you received

1 your radiation treatments?

2 A Yes, it does.

3 Q And that looks like the machine?

4 A Yes.

5 Q Did they place something in your mouth?

6 A Yes.

7 Q Now, what is this plastic mold-looking thing?

8 A What they did with that, this is something -- you've
9 seen those things -- it's kind of like a fishnet thing that
10 they heat up. And when you're laying back and they let it
11 cool down, it completely grabs your body and forms to the
12 whole form of it.

13 Q Now, did you have to have more than one of these done?

14 A Yes, I did.

15 Q Why is that?

16 A Because -- well, the tonsil they did a biopsy on got
17 infected and I ended up losing like about 16 pounds before
18 they got a chance to really start the radiation treatment on
19 me. So they made one initially so that they could start and
20 then they had to redo it because of the weight that I had
21 lost.

22 Q David, I distracted you from the video, that was my
23 fault. But they secure this man, do they not?

24 A Oh, yes, they do. There's a bunch of bolts that goes
25 around -- because whenever you're in here and they're

1 shooting this radiation in you, you cannot move. So they
2 sit there and they take bolts and they bolt down all around
3 your shoulders and around your back and everything, so
4 you're just laying there really super still.

5 Q Can you move?

6 A No.

7 Q That's why they bolt you down?

8 A That's exactly why they bolt you down.

9 Q How many of these treatments did you receive?

10 A Thirty-five.

11 Q What's happening here?

12 A Well, this is where they're getting down to start
13 getting focused in to where they're shooting, to point to
14 where they're needing to hit you at. Because this thing
15 here is made to where it can move all the way around because
16 you're going to have radiation -- they usually with -- with
17 me, they started at the top and then as more of the
18 radiation treatments got, the more and more they worked
19 around in getting to the lower part.

20 Q Now, what are you feeling during the radiation?

21 A Well, the first thing they did was they burned the
22 tonsils out of my throat. During that part, you feel --
23 you're not only feeling the burning that's going in there,
24 you can kind of like smell it and taste it. Because at this
25 point in time, your taste buds haven't been fried and

1 everything -- you know, you just can feel everything that's
2 going into you.

3 Q So in this video when you're receiving the radiation,
4 is there a smell involved?

5 A Yeah, there's a smell. Whether there's iodide there
6 from the radiation or whatever, there is a scent that goes
7 along with it.

8 Q So about how long would you say you have your leg
9 bolted to the table like this?

10 A Well, the actual radiation procedure and everything is
11 just a matter of minutes. It doesn't take long at all.

12 Q I don't want to keep the jury watching the video if
13 it's substantially similar the whole way through?

14 A Oh, it's pretty much similar the whole way through.
15 Like I say, with me, they started out at the upper top at
16 first. My tonsils were never removed with a tonsillectomy.
17 They were burned out with a radiation. They burned them
18 completely out by radiation. Then they went down the neck
19 and took care of the part of the lymph nodes and everything
20 and the tumor that was going down inside of me. They went
21 down and they burned it as it's going down inside of my
22 body.

23 Q So the process of radiation, is it a painful process?

24 A Well, there's a lot of pain involved, especially after
25 the process and the burning that's done into your skin until

1 it heals up.

2 Q David, I need you to describe for the jury in detail
3 the process that you went through in these 35 radiation
4 treatments.

5 A Well, whenever you start having damage to your skin on
6 the outside, your body has a tendency to scab over. When
7 you've got these kind of burns on the inside, your body
8 doesn't scab over. It secretes this kind of a mucus that is
9 kind of thick like you think about if you got -- I don't
10 know if you've ever put up wallpaper, the paste that you use
11 for wallpaper, it's this really, really, really super thick
12 stuff that comes oozing out of the burns and everything,
13 sores that's on the inside of your body.

14 Whenever you try to do anything like swallow or
15 anything like that, that part of your throat when it goes
16 down on your lungs, when you're drinking water or eating
17 food and stuff like that, that closes up, that keeps the
18 food and everything from going inside of your lungs, keeps
19 getting jammed open. That's why usually when people have
20 this procedure done, they suggest that you have a feed tube
21 put in. I chose not to do that. It might not have been the
22 smartest thing I ever did, but anyway, I lost 40 pounds
23 during the process of this. That's one of the reasons why
24 if you ever look at a picture of me now, I don't look
25 anything like I used to, physically or anything else.

1 But you're constantly -- you can forget about laying
2 down any time for a while. You have to sleep sitting up
3 because as soon as you lay back down, all this mucus and
4 stuff like that from the inside burns is going to choke you.
5 I mean, this stuff is thick and you're constantly coughing
6 and throwing it up. That was one of the hardest things
7 about going through the radiation. Because I knew when they
8 bolted me down -- this procedure -- they didn't shoot you
9 with radiation for long, but I know if I started choking,
10 there's no way in hell that they could bring -- because when
11 they did mine, the table raised me up really high. They had
12 a higher table where they raise you up. And there's no way
13 that they can get there very quick if you start choking. I
14 mean, you would be pretty much gone. So you have that back
15 in your mind. But luckily, I'm not claustrophobic and I
16 used to be on a flight crew, so there's certain things I can
17 adapt to pretty good.

18 But the burn on the outside, this was a horrible thing.
19 But they gave me some stuff called zinc oxide and it pretty
20 much took care of a lot of the scarring. But the scar
21 itself on the outside, those four-by-eight guaze pads that
22 you get, I'd cut like about two inches off of them to where
23 it would fit, but the whole sore on the side of my neck was
24 like four inches by six inches and it just worked its way
25 down and down and down to where -- as they worked it down,

1 it just got lower and lower and you can -- it's just like a
2 big pus open sore where the meat is just gone off of your
3 neck. It's not a pretty sight.

4 Q Was that painful?

5 A Yes.

6 Q What did it feel like?

7 A Well, if you had a very large branding iron and you
8 stuck it to your neck, that's pretty much what it felt like.

9 Q Now, you said you didn't have a feeding tube. So what
10 could you eat during radiation?

11 A Well, Boost drinks. If it hadn't been for Boost, I'd
12 been a goner. But the sad thing is, when you get on
13 chemotherapy, you wouldn't believe how nasty things can
14 taste. The only thing that tasted kind of like normal was
15 chocolate.

16 And one time I went to Sonic, you know, I'd go to Sonic
17 on the way -- it was Rock Hill Radiation where I was having
18 the radiation treatment, so I'd go to the Sonic there in
19 York. If you lose too much, they have to stop your
20 radiation treatments, so I had been trying to keep my weight
21 up as much as I could. So I got me a big, old large
22 chocolate shake. And you know at Sonic how they put a
23 cherry on top of your chocolate drink, I sit there and bit
24 into the cherry and it wouldn't have been any more repulsive
25 if somebody had scooped up the kitty litter box and stuck it

1 in my mouth. You just wouldn't believe how chemo can make
2 things taste. It can make things taste horrible.

3 But my diet during that time was chocolate Boost and
4 then I would take like cream of chicken, cream of celery,
5 cream of mushroom, cream of potato and cream of onion soup,
6 blend that up in the blender and try to drink that down.
7 But that was my complete diet. That's all I could get down.

8 Q Now, David, tell me about your schedule during this
9 time. Because you were having chemo and radiation at the
10 same time; is that right?

11 A That is correct.

12 Q Tell me how your schedule worked.

13 A Just try to survive. I mean, you can't sleep at night.
14 This is a horrible process to go through. Words can't
15 describe what it's like to not sleep at night and go through
16 this. And you have to do it everyday, I mean, they can't
17 skip. I mean, if you do that, you just set your process
18 back.

19 Q Now, at some point, did you no longer have to worry
20 about chemo making things taste bad?

21 A Well, whenever they stopped the chemo and all this has
22 gone by the wayside, my taste buds never came back. And, of
23 course, now, the doctor told me that beforehand. He said
24 your saliva glands, the ones on the right side, you'll never
25 get them back. He said the ones on the left may or may not

1 come back. So they did come back a little bit on the left
2 side. I do get a little bit from there. And my taste buds,
3 they've never come back. Nothing taste like -- nothing
4 pretty much taste like it used to, except for shrimp taste
5 what shrimp used to and if I've got like baked chicken, that
6 kind of taste like it used to. Nothing else taste like what
7 it used to.

8 Q All right. Now, when you were going through this
9 process, was there anyone who was there with you?

10 A Oh, yeah, my friend, Joey, he was there and my puppy.

11 Q And what was your puppy's name?

12 A Buddy.

13 Q And did Buddy help you through?

14 A Oh, yeah.

15 Q Now, before you had the chemo, did you have to have a
16 procedure done?

17 A Before I had the chemo?

18 Q Yes.

19 A Well, they had to put a port in, yes.

20 Q And what was that like?

21 A Well, that wasn't really all that bad. That was Dr.
22 Beau who did that and they put me under when they put the
23 port in, so I wasn't really awake when they did that.

24 Q Now, did you have any of the typical side effects that
25 we all hear about with chemo, the vomiting?

1 A Yeah, I had to take a -- I got me a prescription for
2 nausea pills, that kind of helped out.

3 Q What is it like to go through radiation and then to
4 vomit?

5 A Well, like I say, whenever you start doing this stuff
6 with that really thick pasty stuff, you're talking about
7 gumming up. And see, when you throw up, it wouldn't so much
8 come up from your intestinal system as much as it would come
9 up from just your throat.

10 Q Now, did you lose your hair?

11 A Oh, I -- and worse than that, I can do without my hair.
12 You know, the hair that normally a man will have on him.
13 You know, if you look at a picture of me with a beard and
14 everything. They hair don't grow on my neck anymore. The
15 radiation totally burned that hair away, too. I mean, it
16 burned away all of it.

17 And the chemo -- according to the guy that did the
18 radiation, the radiation killed the hair on this part of me
19 and stuff like that, that's why my beard doesn't hardly grow
20 out anymore, and it used to be darker. Whenever I got
21 through -- when I first started chemo and the radiation
22 treatment, what I did is I went ahead and shaved -- while I
23 was sitting there trying to eat and I felt something and I
24 thought man, this feels like fleas. Did my dog bring fleas
25 in? It wasn't fleas, it was my hair falling out. So I said

1 oh, I can't go through trying to eat and stuff like this, so
2 I went ahead and shaved everything off. I shaved my head,
3 shaved my beard, shaved everything. I got all my hair off.
4 I mean, I didn't lose my eyebrows, but I did shave
5 everything off.

6 But then after all the radiation treatment and
7 everything, when my beard come out, it come out white to
8 begin with and then it started out gray. I mean, the whole
9 chemistry of the whole body changed from this. I mean, it's
10 weird.

11 Q Can you explain to a jury a little bit more of what
12 it's like to not have saliva glands?

13 A To not have what?

14 Q What it's like to not be able to produce saliva.

15 A Trying eating anything, like a steak. You forget about
16 hamburgers, Subway subs and all that other stuff, anything
17 with bread. If I go to Bojangles, I can do the biscuit and
18 gravy okay, but you can't do things like sausage biscuits,
19 the old chicken biscuits, forget any of that stuff.
20 Basically, right now, my diet is more like soup, salads and
21 pasta. That's pretty much what my whole diet circulates
22 around, that's pretty much it.

23 Q And what about your ability to taste the foods you are
24 able to eat?

25 A Well, you can't. I've only tried steak one time since

1 I've gone through this treatment. And when you don't have
2 saliva, try chewing a lean piece of steak or something like
3 that. You just can't do it. When you try to swallow it,
4 you will choke, or when you try to keep drinking and
5 drinking and drinking, you just kind of wash the taste of
6 everything out. And even if I didn't do that, it just
7 doesn't taste like it used to anyway, so it's not worth it.
8 So I don't even do steak anymore or pork chops or anything
9 like that.

10 Q David, there's a category at the end of this called
11 loss of enjoyment of life. What I want you to share with
12 the jury is the difference in your life now as opposed to
13 your life after radiation and chemo.

14 A You mean from being fat, dumb and happy to just being
15 dumb? That's not much of a choice. But yeah, your quality
16 of life just goes to crap. You can't go out and eat things.
17 You constantly have to -- if you go on a travel and stuff
18 like that, the normal things you would eat like chips, maybe
19 get hungry and eat cheese crackers, peanut butter, stuff
20 like that, forget it. There's no more peanut butter and
21 jelly, no more none of that. It's just -- you're just
22 clamped down. You try to do something and it's just -- if
23 you've got such a narrow band width of what you can do and
24 what you can live with, it's just not fun anymore.

25 Q Has this affected your friendships?

1 A Well, not so much my friendships, it just your
2 happiness sucks. You know, you can't be a part of the group
3 as much as you used to, you know, that sort of thing.

4 Q Does it affect how you date now?

5 A How I what.

6 Q How you date.

7 A Oh, yeah, it's a lot different. You know, if you go
8 get caught by some woman, you know, if you go out to
9 Hooters, you can't get that frying pan up side the head. If
10 you lose one tooth, well, there goes the rest of your jaw,
11 so you can't do that either. You kind of pretty much have
12 to keep everything in line.

13 Q As a result of the radiation and chemo, what kind of
14 worries do you have now?

15 A I'm not out of the woods on this cancer thing yet.

16 Q Has that affected -- let me step back. Do you still
17 have Buddy today?

18 A Oh, no, he passed away. He had cancer.

19 Q And when did Buddy pass?

20 A It was March 13th of last year.

21 Q And have you considered getting another dog?

22 A No.

23 Q Why is that?

24 A Well, I don't know how much I'm going to be around
25 after this. If you get a puppy or something like that, you

1 just don't know. You don't want to have something that you
2 have to put off on somebody else at some point in time.

3 Q Do you worry about your jaw?

4 A Do I worry about my what?

5 Q Do you worry about losing a tooth and your jaw?

6 A Oh, absolutely. The way I have to do now with my
7 dental work, they have an extra fluoride toothpaste that I
8 have to use, so I brush my teeth with regular toothpaste
9 first, then I go in with the extra fluoride toothpaste. But
10 when you do that fluoride toothpaste, you can't drink or eat
11 anything for a while. And I have to do the extra fluoride
12 toothpaste twice a day.

13 And what has happened, the radiation and everything,
14 where they hit you in the side of the jaw has eaten some of
15 the soft meat away from my jaw bone, so your teeth that come
16 up above your gumline, they enamel on them. Well, that's
17 what protects your teeth from getting cavities, but your
18 roots don't have that enamel. So you have to constantly
19 make sure that the root exposure that you have inside of
20 your gum is cleaned off and it has this extra fluoride
21 toothpaste. That helps protect it from getting cavities.

22 Q Is there any question in your mind -- while you've been
23 through all of this, the radiation, the chemo, loss of
24 taste, saliva glands, all of that, is there any doubt in
25 your mind why you've gone through all of this?

1 A No.

2 Q And why?

3 A I didn't have very good medical practice to begin with.
4 When I first saw Wilson, this was not handled properly.

5 MS. GOODSTEIN: That's all the questions I have for
6 now. Please answer any questions that the Court or Defense
7 has for you.

8 THE WITNESS: Okay.

9 THE COURT: Ladies and gentlemen, let's take a break.
10 We've been sitting here for about an hour and 10 minutes.
11 Let's take about a 10 or 15-minute break. I instruct you
12 when you go back to the jury room, if you would elect a
13 foreperson among yourselves. Again, I remind you, do not
14 discuss anything that you've heard. Don't discuss this
15 case. Don't talk about it among yourselves. You can talk
16 about anything else, but not this case.

17 Mr. Miller, if you would just keep you seat.

18 We're going to let the jury be excused, everyone remain
19 seated.

20 (Whereupon, the jury exits the courtroom at 10:41 a.m.)

21 (Whereupon, a short break was taken.)

22 THE COURT: Plaintiff ready?

23 MR. MCGOWAN: Yes, Your Honor.

24 THE COURT: Defense?

25 MR. DAVIS: Yes, Your Honor.

1 THE COURT: And I do have a note that Juror Number 268,
2 Matthew Willoughby is the foreperson.

3 Mr. Miller, if you will come on back and have a seat.

4 THE WITNESS: Yes, sir.

5 THE COURT: All right. Let's bring the jury in.

6 (Whereupon, the jury enters the courtroom at 11:01
7 a.m.)

8 THE COURT: Thank you, ladies and gentlemen.

9 And I believe Mr. Willoughby, Number 268, you are the
10 foreperson.

11 THE FOREPERSON: Yes, sir.

12 THE COURT: Again, I remind the jury the foreperson has
13 no greater say in deliberations or anything that goes on in
14 the jury room; however, they do have the role of
15 communicating with the Court and making sure that
16 instructions are properly followed.

17 So with that, Mr. Davis, it is your witness.

18 MR. DAVIS: May it please the Court.

19 CROSS-EXAMINATION

20 BY MR. DAVIS:

21 Q Good morning, Mr. Miller. How are you doing?

22 A Pretty good, Buster. How are you?

23 Q I'm great, thank you. I want to ask you if you can go
24 back over with me when you first went to Dr. Wilson's
25 office. You had described the lesion, as you call it, the

1 spot that was in the back of your throat about the size of
2 your little finger, is that the way -- I couldn't see from
3 over here.

4 A Well, it's not much bigger than the end -- it's not
5 like your little finger sticking out. It's kind of like
6 just the little -- if you got like that much of the bump of
7 it sticking out, yes.

8 Q And you could see that yourself?

9 A Well, it was really tough to see it, but I finally got
10 a few angles where I could kind of catch it and look back in
11 my throat and I could catch a glimpse of it, yes.

12 Q And I want to get straight with the fact that that
13 never changed from that time until you had a diagnosis in
14 2016; is that correct?

15 A Not that I could tell, that is correct.

16 Q It was always there?

17 A It was always there, yes, sir.

18 Q And between the last time that you saw Dr. Wilson and
19 2016 when you were diagnosed, you never went to any
20 physician to show them that spot or to ask them what it was?

21 A Oh, no.

22 Q Never?

23 A No.

24 Q And when you had your annual exams by the person that
25 you -- whoever examined you annually in January, you never

1 told that person that you had this spot on the back of your
2 throat?

3 A I may have mentioned it to the provider that I had had
4 a doctor look at a tumor, but that's the nurse practitioner,
5 yeah. You know, it's not like -- I was thinking you were
6 talking going to an ENT or something like that, no. But the
7 nurse practitioner, I may have brought it to her attention
8 before, yes.

9 Q Have you had an opportunity to review your VA records
10 yourself?

11 A I don't know if I've been looking at them or not.

12 Q Do you know whether or not there's any record of the
13 nurse practitioner or anybody else making a note that you
14 reported having this spot in the back of your throat?

15 A I may have gone to a nurse practitioner and just sit
16 there and happen to mention it, yes.

17 Q You may have?

18 A I may have.

19 Q All right. Do you know if there's any record of that?

20 A Well, there may be. You know, yeah, there may be, you
21 know, if you sit there and say well, you know, I got that
22 little tumor -- like I say, I just pretty much accepted it.
23 I may have mentioned it, I may have not. It just doesn't
24 really register. I know I never went to -- the first ENT I
25 went to was Wilson and then Dr. Wells with the VA was the

1 other ENT that I went to and that's the only ones we
2 specifically talked about.

3 Q Right. And Dr. Wells was the ENT with the VA; is that
4 correct?

5 A That is correct.

6 Q And was he in Charleston?

7 A Oh, no, he's in Columbia.

8 Q He's in Columbia?

9 A Yes, sir.

10 Q And that's at the Dorn VA, right?

11 A That is at the Dorn VA.

12 Q And that's right off of I-77, right?

13 A Yeah.

14 Q You can see it from the highway, right?

15 A Yep, yep, yep.

16 Q Do you know if it's Exit 9 or not?

17 A Yeah, it's Exit 9B, if I'm not mistaken.

18 Q Seventy miles from this courtroom?

19 A It's approximately that.

20 Q And that was Dr. Wells?

21 A Dr. Wells, that is correct.

22 Q Is he the doctor that diagnosed you?

23 A Well -- you mean with the cancer?

24 Q Yes, sir.

25 A He's the one that ordered up the biopsy and everything.

1 Q I see. Now, before I go to asking you about specific
2 visits, let me ask you this because I'm a little bit
3 confused. How many visits did you have with Dr. Wilson to
4 the best of your knowledge?

5 A To me, it was three visits.

6 Q Three visits?

7 A Uh-huh.

8 Q And so on the first visit is when you reported to him
9 the spot that was in the back of your throat?

10 A Yeah.

11 Q And do you now have a memory as to whether or not he
12 ordered the MRI after that first visit -- or on that first
13 visit?

14 A It may have been the first or the second visit, but it
15 was somewhere through there. I don't have -- I couldn't
16 really say -- you know, I can't say for sure which one.

17 Q Okay. And then you now admit that you did have a third
18 visit? Because you recall, when I took your deposition, you
19 couldn't remember if you had a third visit?

20 A Well, yeah, just thinking about it. But the last visit
21 I had would have been the third visit, which was after I had
22 the stents put in.

23 Q Right.

24 A That would have been the final visit.

25 Q So you remember three visits?

1 A Well, I do pretty much, yes.

2 Q Let me ask you, in the course of your treatment for
3 this, do you remember a Dr. Siddiqi? Do you remember that
4 name?

5 A That doesn't ring a bell.

6 Q Do you remember a Dr. Steele?

7 A No.

8 Q Dr. Fernandez?

9 A No.

10 Q Do you remember a Dr. Bayer? Like the aspirin, Bayer?

11 A No.

12 Q Do you remember a Dr. Naidu?

13 A Yeah, he's the chemo doctor.

14 Q He's not with the VA, is he?

15 A No, he's with Carolina Blood and Cancer, if I'm not
16 mistaken.

17 Q And they're located in Rock Hill?

18 A Yes, they are.

19 Q And then Dr. Thakkar?

20 A Dr. Thakkar, he was the radiation doctor that treated
21 me, yes.

22 Q And he was at the blood place, too, right?

23 A No, no, no, he's at Rock Hill Radiation.

24 Q Rock Hill Radiation?

25 A Correct.

1 Q And his office his located in Rock Hill?

2 A Yes, that's correct.

3 Q And do you remember the nurse practitioner named
4 Landis?

5 A Yes, yes, she's my -- she's what's referred to as my
6 provider.

7 Q Right. Okay. And you would see her every January?

8 A Every January, I would see her.

9 Q So if you saw Dr. Wilson in 2013, you would have seen
10 her in 2014, January?

11 A If you're talking about -- okay, when I saw Dr. Wilson,
12 which was the end of March and April of 2013, the next time
13 I would have seen the nurse practitioner would have been in
14 January of '14, uh-huh.

15 Q And then you would have seen her again in '15?

16 A That is correct.

17 Q And as we sit here today, you can't specifically recall
18 ever telling Ms. Landis, Nurse Practitioner Landis about
19 this spot on your throat?

20 A Oh, I probably told her that, yes.

21 Q You probably did?

22 A Yes.

23 Q Do you have a memory of doing it?

24 A Well, I'm saying that I may have mentioned to her that
25 somebody had checked me for cancer and stuff like that. I

1 may have talked to her about it, yes. It's not something
2 that's out of the question.

3 Q Okay. The last time you saw Dr. Wilson, do you recall
4 whether or not he told you about whether or not you should
5 return to his office?

6 A Oh, after the last visit, we had no other scheduled
7 appointments to return to this office, no, we did not.

8 Q I believe you said he actually went over the MRI with
9 you; is that right?

10 A The last visit that I had with him, he didn't go over
11 the MRI with me, he had them in front of him as he was
12 looking at them. I was sitting across from him at his desk
13 and he had what I thought to be the MRI that was sitting in
14 front of him. So I was sitting across from the desk. I
15 never sat there and looked at the images that he was looking
16 at, but I was sitting across from him when he did.

17 Q So you were in some part of his office, it had a desk
18 in it?

19 A Yeah, it had a desk in it.

20 Q And the MRI was laying down on the desk?

21 A Yeah, in front of him.

22 Q And he was looking at it telling you about it?

23 A He was looking at it and after he looked at it, he
24 said, I don't see anything that concerns me about the C
25 word. And I said, C word? And he said, Yeah, cancer. So

1 that was on our last visit.

2 Q And Dr. Wilson called it the C word?

3 A Yeah, and then he referred to that -- when I asked him
4 the C word, he said cancer.

5 Q And from that time on, the spot stayed in your throat
6 the same way?

7 A That's exactly right. I could tell no change in it
8 from the time they got it removed with radiation.

9 Q Do you remember a nurse practitioner named Eubanks?

10 A No.

11 Q When you were treated at Dorn VA, I believe you told us
12 that they first took a CT scan; is that right?

13 A That was the first thing -- when I went to Dorn in
14 2016, you're saying?

15 Q Right.

16 A Yes, they did a CT scan.

17 Q And then they took a biopsy?

18 A That is correct.

19 Q Now, tell me about the biopsy. Because I think at the
20 deposition we talked about your tonsils got infected from
21 that; is that right?

22 A It certainly did.

23 Q And you had some problems with that infection, right?

24 A Oh, I certainly did.

25 Q Tell me about that.

1 A Well, I ended up -- well, what happened -- there was a
2 combination -- here's the combination that ran into the
3 problem. Whenever I went to the dentist, which is one of
4 the things I had to do and got my tooth pulled, he gave me
5 some antibiotics, the dentist there in Rock Hill that I went
6 to that was prior to the radiation treatment.

7 Q Let me stop you if you don't mind me interrupting you.
8 You went to a dentist in Rock Hill?

9 A Yes, I did.

10 Q And what was his name?

11 A That, I don't recall. He was a dentist that come off
12 the list of the ones that the VA had given me. And to be
13 honest with you, I do not remember his name.

14 Q He was a private practice dentist?

15 A Oh, yes, yes, yes, he was in private practice. He was
16 not attached to the VA.

17 Q And he had an office in Rock Hill?

18 A He has an office in Rock Hill. It's close to where
19 Winthrop College is, yes, sir.

20 Q I apologize for interrupting you. I was asking you
21 about the nurse practitioner, Eubanks, do you recall her?

22 A Well, I don't -- if it was somebody I just saw maybe
23 one time, I don't never catch their names. It's just like
24 that dentist that pulled my tooth, I can't tell you what his
25 name is.

1 Q Okay. But you got an infection from the biopsy?

2 A Oh, yep, yep, I sure did.

3 Q And the infection caused what to happen?

4 A Well, it caused me to have a -- you know, the -- what
5 happened -- okay, the dentist give me the antibiotics, so
6 I'm on these antibiotics. So anyway, they think that -- the
7 first thought was when they did the biopsy and all of a
8 sudden, they're trying to do a CT scan for me so I can --
9 you know, another CT scan. Now, this CT scan is going to be
10 done with Rock Hill Radiation so that they can pinpoint the
11 exact areas where this tumor is at this time. Okay. Due to
12 the fact that my tonsil got infected by this biopsy, I was
13 not able to lay back all the way without choking.

14 Q I see.

15 A So Dr. Thakkar, he come up with -- he thought -- the
16 thought process was my God, you know, what's wrong here?
17 You know, sometimes when you go in and you take a biopsy,
18 you stir the cancer up and it starts growing at a fast rate
19 and spreading. That's what he felt had happened. This is
20 what he's telling me.

21 So what happens from this point here, he contacts Dr.
22 Naidu and he says, Look, we've got a situation here to where
23 I have to get this guy on strong chemo. They think the
24 reason that I needed to get on this strong chemo was because
25 they think this cancer is spreading. So then Dr. Naidu and

1 everything, he moves my appointment up by one week and he
2 sits there and says okay, well, get him to come in here.
3 They put one of those pumps where they stick an IV in you
4 and it pumps this chemo in you over a period of a week.
5 That's what he did for me.

6 Q That's Dr. Thakkar or Dr. Naidu?

7 A That's Dr. Naidu at Carolina Blood and Cancer. I think
8 that's the name of it. Hopefully, I'm giving you the right
9 name. I'm trying to give you all the facts.

10 Q Go ahead.

11 A Now, I've got this chemo stuff in me. So then they get
12 ahold of Dr. Borhanian, Dr. Bo --

13 Q Dr. Bo?

14 A Yeah, he's the one that's going to put the port in for
15 me.

16 Q And where is Dr. Bo located?

17 A He was located here in Rock Hill. And he does his work
18 at whatever the name of that hospital is in Rock Hill.

19 Q I see.

20 A So anyway, that's where his practice would be at. So
21 he goes ahead and moves up his schedule to where they're
22 going to have me have a port put in so that they can start
23 all this process. Now, they got all these people that's
24 really doing everything they can because they think I've got
25 cancer spreading. And the problem is see, I can't lay back

1 and do any of this other stuff unless -- without choking.

2 So when they do this thing to put the port in, they
3 have to put me under. When they put you under, they take
4 one of them plastic hoses and stick down your throat. When
5 they stuck that hose down my throat, what I didn't realize
6 at the time, if you can imagine what a big fat zit would be
7 like if you popped it in your throat, that's what happened.
8 That plastic hose popped that tonsil that had gotten
9 infected.

10 And the very next day, I'm sitting there trying to eat
11 some breakfast and I'm sitting there and I take a bite of
12 something and it just comes out like a flood. This is
13 something like drinking a soda real fast. When that tonsil
14 in my neck starts draining, it just goes all the way down.
15 I mean, it just flattens out. But then I can breathe.
16 Everything is fine. I can lay back and my God, everything
17 is fine.

18 The problem is these antibiotics I'm taking that the
19 dentist give me and this chemo treatment that Dr. Naidu put
20 in, your body has to have a certain amount of good biotics
21 in your intestine system in order for you not to have
22 diarrhea. Between the chemo that I was getting and those
23 antibiotics, I lost 16 pounds in this one week. I was
24 dehydrated. I couldn't -- if I drank something or eat
25 something, it come straight out of me.

1 Q Back to whatever it was that popped, that was part of
2 the infection from the --

3 A Oh, that was the tonsil that popped, that's what was
4 choking me. It wasn't like the cancer was growing rampant
5 in me, the tonsil was swelling up with septic poison.
6 That's what they said later on.

7 Q It was infected?

8 A Infected.

9 Q Right, okay. Thank you. So we agreed on three visits,
10 right?

11 A Three visits, yes.

12 Q And you remember at the deposition, you couldn't
13 remember --

14 A Well --

15 Q That's okay.

16 A Well, I just try to remember the different times of
17 everything.

18 Q I got you. Now, when I -- you may recall this. At
19 your deposition, I asked you about the effects that cancer
20 was having on you these days. And my question to you was,
21 Are there any activities of your life that you were doing
22 before you were diagnosed with tonsil cancer that you can't
23 do now because of that? Do you remember me asking you that
24 question?

25 A Yeah.

1 Q And your answer was, You mean other than the change in
2 diet and not being able to eat peanut butter?

3 A Well, that's part of the thing, yeah.

4 Q And then I asked you -- and then you went on -- and
5 then I said, Other than that, what? And you say, I mean,
6 it's taken away from my ability to go from point A to point
7 B -- it hasn't taken away from my ability to go from point A
8 to point B as far as, you know, walking and stuff like that?

9 A Yeah, it hasn't affected me physically like the walking
10 part, no. I can still get around just as good as I could
11 before.

12 Q Then you say it was pretty bad going through the
13 treatment?

14 A Oh, yes.

15 Q But other than that, I guess I'm going from point A to
16 point B okay. Is that fair?

17 A Well, I tell you what, I'm disabled from the Vietnam
18 era. I'm used to things happening. And that's the good
19 thing about being disabled for a while, you just kind of
20 accept things and go with it.

21 Q Well, everyone appreciates your service. I mean that
22 in all sincerity. But I want to ask you why at your
23 deposition didn't you tell me the things that you've told
24 this jury today about losing your taste buds and the other
25 things that happened to you after this?

1 A Oh, well, my saliva glands have never come back and my
2 taste buds. I just don't really -- you know, here again,
3 after you've gone through something for a while and by the
4 time I give the deposition that I have for you, it's just
5 see, I accept things. It's just like that little tumor that
6 was in there, I just accepted it as being part of me before
7 I found out that it was cancerous. You just kind of accept
8 things and you just don't dwell on them.

9 Q Right.

10 A You know, you just kind of accept things.

11 Q And that was -- your testimony is that was present from
12 the time you first saw Dr. Wilson until you were diagnosed
13 with cancer. And during that time, it didn't cause you any
14 problems?

15 A It was never -- you know, if you look at every time
16 that I've gone to any doctor and they asked me about the
17 pain and everything, there was no pain with that.

18 Q And no problems with swallowing and no problems with
19 any of that?

20 A Well, I had some little -- I started having some tonsil
21 swelling. And actually, about a couple years prior to
22 getting the tonsil and everything shrunk in my neck, I was
23 having those problems like sleep apnea, that started
24 becoming more frequent, you know, where you're laying down
25 and you roll over and all of a sudden you find yourself kind

1 of choking at night. That was happening prior to having the
2 tumor shrunk. But then after the tumor shrank, that didn't
3 happen anymore.

4 Q Did you ever report that sleep apnea to any physician?

5 A Nope.

6 Q You were a boxer; is that right?

7 A Well, I used to fight.

8 Q And how many times did your nose get broken?

9 A It's never been broke, it's been bloody quite a few
10 times.

11 Q Right. Do you know whether or not that had anything to
12 do with your sleep apnea?

13 A Well, it didn't -- the sleep apnea didn't happen until
14 about two years before I had the tumor shrunk down, so I
15 wouldn't think it would because my fighting days was over
16 with a long time ago.

17 Q And for whatever reason, you never sought treatment for
18 sleep apnea --

19 A Oh, no, I never did because I wasn't really crazy about
20 getting one of those CPAP machines. I had my friend over
21 there go through that, so I never chose to go that route.

22 Q I understand.

23 MR. DAVIS: Thank you very much, Mr. Miller.

24 THE WITNESS: You're welcome, Buster.

25 THE COURT: Thank you, Mr. Davis.

1 Any redirect, Ms. Goodstein?

2 MS. GOODSTEIN: No, Your Honor.

3 THE COURT: Thank you.

4 Mr. Miller, you can step down.

5 THE WITNESS: Can I talk to people now?

6 THE COURT: Yes, you can.

7 THE WITNESS: Okay.

8 (Witness steps down.)

9 THE COURT: Mr. McGowan, call your next witness.

10 MR. MCGOWAN: Yes, sir, Your Honor. The Plaintiff
11 calls Ronald Blum.

12 THE CLERK: Sir, I'll have you stop here to be sworn.
13 Place your left hand on the Bible and raise your right.

14 RONALD BLUM, M.D.,

15 after being duly sworn, testified as follows:

16 THE CLERK: Thank you, sir. Come around and have a
17 seat.

18 DIRECT EXAMINATION

19 BY MR. MCGOWAN:

20 Q Dr. Blum, can you start with just telling the jury a
21 little bit about yourself, including your medical education
22 and training?

23 A Yes. Good morning. I grew up in upstate New York, in
24 Buffalo. I did my graduate work at the University of
25 Rochester in Rochester, New York. Then I went back home and

1 did my medical school education at State University of New
2 York in Buffalo. From there, I did my medical internship in
3 Baltimore at the Baltimore City Hospital, Johns Hopkins
4 University Medical Center. From there, I went to
5 Washington, D.C., Bethesda, Maryland, the National Cancer
6 Institute, the Washing VA Hospital, where I served the
7 United States Public Health Service and was able to have
8 that credited towards my subspeciality training. From
9 there, I went to Boston, where I was at the Boston City
10 Hospital, it's part of Harvard Medical School. I completed
11 my speciality training in medical oncology and internal
12 medicine at the so-called Dana Farber Cancer Institute at
13 Harvard Medical School. And that made me Board eligible and
14 Board certified in both internal medicine and the
15 subspeciality of medical oncology.

16 Q Oncology, what does that mean?

17 A Oncology, ology is study of, onc is growth. So it's
18 Greek for growth, so it's a -- oncology is the study of
19 growth. It's the name that's used for cancer. And as a
20 medical oncologist, my speciality is diagnosis, prognosis
21 and treatment of people with cancer with chemotherapy with
22 medical treatment.

23 Q Okay. Can you tell us about your academic career and
24 clinical responsibilities?

25 A So my academic really goes back to medical school. I

1 did research in medical school and graduated with thesis
2 honors. When I was in Baltimore, I did teaching and had an
3 academic appointment at Johns Hopkins. From there, I went
4 to Bethesda in the United States Public Health Service to
5 not have an academic appointment at that time, but then went
6 to Boston and was a fellow instructor and assistant
7 professor at Harvard Medical School. And from there, I went
8 to New York at New York University Cancer Center, became a
9 full professor of medicine. And my academic activities
10 really went on going forward from that point.

11 Q Have you spent your career, essentially, in the cancer
12 field?

13 A Yeah, it actually goes back to high school. I was
14 fortunate enough to get an actual science foundation
15 fellowship as a high school student at Roswell Park, which
16 is a cancer center in Buffalo. And for a variety of
17 reasons, that's been my focus and still is my focus
18 lifelong.

19 Q And more than 40 plus years?

20 A Oh, many more by now, since high school.

21 Q Do you have any experience working in VAs?

22 A Yes, so the VA has been part of -- actually, as I think
23 about it, I did some courtships at the Buffalo VA as part of
24 medical school. When I was in Washington, I worked at the
25 Washington VA as part of my training. When I went to

1 Boston, I actually was the head of medical oncology at the
2 West Roxbury VA, which is part of the VA system. When I
3 went to New York, eventually -- we haven't talked about it,
4 but I had increasing responsibility and became clinical
5 director of the National Cancer Institute Center at New York
6 University and part of that included the Manhattan VA where
7 I saw patients, taught, did research, had administrative
8 responsibilities. And this was at the New York VA Hospital.

9 Q You have education and experience involved in the field
10 of head and neck cancer?

11 A I do. One of the programs we built -- and again, we're
12 looking at a long career. Early on, when I worked at the
13 National Cancer Institute, one of my responsibilities was
14 overseeing the development of a drug, chemotherapy drug,
15 which was one of the first active drugs thought to be
16 effective in head and neck cancer, a drug called Bleomycin,
17 and wrote some pivotal papers, landmark papers with
18 Bleomycin.

19 Fast forward, by 1999, I became director of a program
20 called Continuum Cancer Centers of New York, which is an
21 academic and community-based program, but it turns out that
22 it has one of the leading head and neck programs in the
23 country with -- for a variety of reasons, has really leaders
24 in the field from pathology, radiology, the disciplines of
25 head and neck treatment, radiation oncology, medical

1 oncology, surgical oncology as well as a very strong
2 so-called support of services.

3 And in that position, I saw patients with head and neck
4 cancer, if you will, sort of a disproportioned number
5 because as part of my clinical, both in my private practice,
6 but also in the teaching practice, head and neck cancers
7 were overrepresented because this was a center of excellence
8 and did a lot of teaching about it. It was involved in
9 research. Part of my responsibility as the director was to
10 oversee research in head and neck cancer. And our group
11 published one of the major textbooks in head and neck cancer
12 and did research that supported, if you will, some of the
13 original observations on diagnosis, treatment and prognosis
14 of head and neck cancer.

15 And also, administratively, I was responsible -- in my
16 role as cancer center director, we have what's called tumor
17 boards. They're required to have certain characteristics
18 and it was my responsibility to oversee them. I attended
19 multi-disciplinary head and neck tumor boards on a regular
20 basis. So really, my head and neck experience is
21 significant, particularly in the position I last held.

22 Q Have you been called upon in the past to give input to
23 judges and juries and lawyers on issues related to cancer,
24 diagnosis, treatment, prognosis, things of that nature?

25 A Well, for the last 10 to 20 years, the answer is yes.

1 As part of my clinical administrative research and
2 administrative responsibilities, I often was called on
3 really to look at -- to review quality of care, issues of
4 discipline, et cetera and that sort of began to inform the
5 fact that I could be of value to lawyers, both defense and
6 plaintiff lawyers, in looking at the merit of issues as it
7 related to medical malpractice for cancer.

8 MR. MCGOWAN: Your Honor, at this time, we would move
9 Dr. Blum as an expert in the field of medical oncology or
10 cancer medicine.

11 MR. DAVIS: No objection.

12 THE COURT: I find that Dr. Blum is qualified to
13 testify as an expert in medical oncology.

14 Ladies and gentlemen, normally, a person cannot give
15 opinion testimony. Normally, when a person testifies, they
16 must testify as to what they either saw, heard or sensed by
17 smell or something of that nature; however, there is an
18 exception when someone is qualified because of education and
19 experience. They're permitted to give their opinion in
20 certain areas if the Court qualifies them that way. This
21 witness will be qualified in the area of medical oncology to
22 give opinion testimony in that area. That does not mean
23 that you must accept the opinion, but it is evidence for you
24 to use in any way you see fit and give the weight and
25 credibility you believe is appropriate.

1 Mr. McGowan.

2 MR. MCGOWAN: Thank you, Your Honor.

3 BY MR. MCGOWAN:

4 Q Let's start with just the basic definition of cancer.
5 Boiled down, what is cancer?

6 A I smile because, certainly, in my encounters with
7 patients, you have to start with the basic biology. And I'm
8 sure people know cancer in many ways, either from personal
9 experience or from relatives or just from being aware of it
10 or, in fact, hearing Mr. Miller's testimony.

11 But, basically, cancer is a disease where a cell loses
12 certain properties and takes on, transforms from being a
13 normal cell to a cancer cell. And those properties are
14 uncontrolled growth, so, normally, the body is very clever
15 in stopping growth. An example of a heart -- how your heart
16 doesn't grow beyond a given point in a normal condition.

17 But cancer cells transform and they divide and have a
18 mass. They lose their ability to self-destruct. One of the
19 properties that cells have is when they're sick and old and
20 they pfft, so they just sort of go away and get taken away
21 by inflammatory cells and they lose their adhesion.

22 Normally, cells stick where they belong, but cancer has the
23 property, they lose that characteristics and they spread.
24 They can get into the blood stream, they can get into the
25 lymph channels and they spread to other parts of the body.

1 For head and neck cancer, for example, to the lymph nodes or
2 can spread to other organs, vital organs.

3 And also, what cancer cells do is they are very
4 adaptive in the metabolism changes. So that, as you all
5 know, people who have advanced cancer and are dying, they
6 become malnourished, they become catabolic. They look as
7 though they've been in a concentration camp. That's all
8 part of the cancer biology, cells grow, they spread, they
9 attack vital organs and they, essentially, starve -- they
10 consume the energy and the patient starves and dies.

11 Q Tell us about cancer of the tongue. Tell us generally
12 about that.

13 A So each cancer has certain characteristics that are
14 well studied and understood. There's the whole category of
15 head and neck cancer. These are so-called squamous cancers.
16 They're cancers that arise in the lining of the head and
17 neck area. The location of the head and neck is very
18 important. Whether or not it's more anterior, that is lip,
19 anterior tongue, like tip of your tongue. So that's the
20 oral pharynx.

21 Then you go back, if you will, into the hypopharynx,
22 which is going deeper down your throat, if you will, that's
23 called the -- I'm sorry, this is oral. The next going in is
24 the oropharynx and then the hypopharynx is like your voice
25 box. So these three areas each have their own

1 characteristics. Cancer of the tonsil is of the oral
2 pharynx. It's between the oral and hypopharynx. It's in
3 between the three sections.

4 Q Now, some of us heard about cancer being staged in this
5 trial, Stage 4, Stage 1, Stage whatever. Tell us about
6 cancer staging, what that generally is about, and then how
7 it's done for tonsil cancer. I understand there's actually
8 medical literature about this; is that right?

9 A So when we see patients, they say how am I going to do,
10 what's my prognosis? And what's evolved over the years
11 based on following thousands of patients and identifying
12 those things that are important in prognosis, it turns out
13 that the American Joint Cancer Commission, called AJCC, has
14 over the years developed strong evidence based, that is
15 following through these cancer centers of which we were part
16 of, a longstanding history of establishing how far the
17 cancer has spread.

18 The stage, if you will -- and stage is broken down very
19 specifically by the size of the tumor, so-called T stage, by
20 the degree to which lymph nodes are involved could be -- as
21 in head and neck cancer, the number and location of the
22 lymph nodes, that's called the N status, and then the third
23 component is M, metastases, that is spread. So cancers, in
24 general, head and neck specifically are staged by their T
25 stage, how big they are, whether or not the nodes are

1 involved, that is the N stage, and then M, whether or not
2 they've spread.

3 And each cancer site has its own specific ways of
4 staging and that stage predicts its prognostic. Stage 1 has
5 a given prognosis, Stage 2, Stage 3, Stage 4, again,
6 specific for each cancer site.

7 Q You've seen AJCC Cancer Staging Manual?

8 A Yes.

9 Q Is this relied upon by experts in the field?

10 A Yes, it's required. In order to be certified as a
11 cancer center by the American College of Surgeons, you have
12 to document each patient that is diagnosed with cancer in
13 your system with a particular -- with a specific stage based
14 on AJCC criteria of T, N and M.

15 Q Okay.

16 A And one of my responsibilities was to oversee and make
17 sure that got done in order to continue my certification.

18 Q All right. And this is the front page of the AJCC
19 Cancer Staging Manual, seventh edition?

20 A It's the cover of the book that sits on my desk and
21 almost all oncologists' desk because it's very complicated.

22 Q Okay. We have some of the charts and information out
23 of this book down here. Would it help you to kind of go
24 over this with the jury so we kind of understand what
25 staging is all about?

1 A Or I can do it just with my hands. I talk with my
2 hands. Either way, whichever you feel would be best to
3 inform the jury.

4 MR. MCGOWAN: Your Honor, may the witness step down to
5 help explain these?

6 THE COURT: Yes, you may.

7 (Witness steps down.)

8 BY MR. MCGOWAN:

9 Q All right. So let's go through tumor staging for head
10 and neck cancer.

11 A So the first thing that I would do clinically -- I can
12 use my fingers. So this is the -- so what I want to show
13 here, this is the nose, this is the back, this is the oral
14 pharynx, which I talked about, and then going back in here,
15 this is the oropharynx and the hypopharynx is way down here,
16 but the tonsil is here in the oropharynx. So that informs
17 the stage for patients like Mr. Miller.

18 Q So the hypopharynx is kind of deep down back there?

19 A Yes, it's oral is what you can actually see,
20 hypopharynx is back further. And I think Mr. Miller
21 described it quite well. It's not apparent just looking in
22 your mouth. You don't see it.

23 So I talked about T stage -- let me make some
24 adjustments here. I can do it better by hand. So T1 is a
25 small lesion that is less than two centimeters. A T2 is two

1 to four centimeters. T3 is more than four centimeters. T4
2 means it's locally invasive. So that's the T stage.

3 So N is the nodes. So N is no nodes. One is usually
4 one node. N2 is lots of nodes on the same side. N3 is
5 across the other side.

6 And then metastases are -- metastases is not relevant
7 in this case. There's no evidence to date that Mr. Miller's
8 disease has spread.

9 So then based on that, what we can do with cancers in
10 general, head and neck specifically and hypopharynx cancer,
11 even more specifically, is be able to stage the patient
12 based on the T, N, M stages. And that's what I did. That's
13 what I do when talking to a patient and family and that's
14 what I did.

15 Q All right, Doctor, tell us fundamentally what this case
16 is about and the subject matter.

17 A Basically, this case is about Mr. Miller sought Dr.
18 Wilson's opinion in March of 2013 because of something he
19 felt and described for you this morning. It's my opinion,
20 at that time, there was an early stage cancer, a Stage 1
21 cancer, that is a tumor less than two centimeters, as Mr.
22 Miller described to you.

23 And as we can see on MRI, less than two centimeters
24 done at that point. There was a failure to do further
25 diagnostic tests, a failure to treat at that point had the

1 diagnosis been established, as I believe he had a cancer of
2 the tonsil at that point. It was delay in diagnosis. And
3 as a direct consequence of that delay, Mr. Miller, instead
4 of being curable with surgery alone with a high probability,
5 that cancer advanced untreated, became T2, involved lymph
6 nodes. According to classification for hypopharyngeal
7 cancer, he would have gone from a T1 to a T2, N2, Stage 1 to
8 Stage 4, surgery was no longer an option, cure was
9 exceedingly unlikely and needed concurrent chemotherapy and
10 radiation rather than surgery with the consequences that Mr.
11 Miller has described to you in terms of the additional
12 treatment that he needed, chemotherapy and radiation, and a
13 significant increase going from survivable cancer to a
14 cancer that more likely than not is not survivable.

15 Q So if this had been caught March, April or a reasonable
16 time thereafter, what stage would it have been and what
17 treatment would it have required?

18 A He would have been Stage 1, that is less than two
19 centimeters. There would not have been any evidence of
20 nodule involvement. He would have been a Stage 1. Standard
21 of care would have been a tonsillectomy, removal of the
22 tumor, because this tumor has a tendency to spread. He
23 would have also probably had some sampling of the neck nodes
24 on the right side, those would have been node negative. And
25 he would have been staged N1, N0, Stage 1, would have had

1 tonsillectomy and would have had, based on the AJCC
2 statistics, about a 70 percent chance of being cured.

3 Q And the surgery would be a tonsillectomy?

4 A Yes.

5 Q And there would be no chemo and no radiation called for
6 in Stage 1?

7 A That's correct.

8 Q So Stage 4 -- went from Stage 1 to Stage 4, what
9 incremental change in treatment was required -- change in
10 treatment and prognosis was required by virtue of the cancer
11 going from Stage 1 to Stage 4?

12 A So we know based on enormous amounts of experience and
13 literature and clinical experience is that a person who has
14 N2 disease, Stage 4 disease for a tonsillar hypopharyngeal
15 cancer, surgery is not an option because of the need to not
16 only treat the local area, the lymph nodes, but also to
17 prevent spread. That the standard of care is radiation to
18 really focus on the actual sites of known tumor.

19 The purpose of the chemotherapy given at the same time
20 is two-fold. One is to make sure that a spread, even though
21 it's not apparent, is taken care of by putting chemotherapy
22 in the whole body, but also, the chemotherapy makes the
23 radiation better. It's a radiation, quote, unquote,
24 sensitizer. So the standard of care is chemoradiation.
25 Given all it's side effects, we know that can improve

1 outcome, that is treat the symptoms of the advanced disease
2 as well as reduce the chances, not to zero, but reduce the
3 chances of the cancer coming back.

4 Q So what I hear you saying, Stage 1, tonsillectomy,
5 Stage 4, chemoradiation?

6 A Yes.

7 Q Before at Stage 1, chance of cure was greater than 50
8 percent?

9 A Yes.

10 Q Stage 4, less than 50 percent?

11 A Yes.

12 Q Now, I want to talk to you about chemo. You've had
13 patients on chemo for -- I mean, you've been dealing with
14 this your entire career, is that fair?

15 A Fair.

16 Q Tell us what chemo, especially the kind of chemo used
17 in this case, does to the body.

18 A So I have a general, I'd say enormous experience with
19 head and neck cancer getting these two drugs that Mr. Miller
20 got, Carboplatin and Taxotere. The story that Mr. Miller
21 tells is certainly one that rings true in the many patients
22 that I've seen. There is this notion of patients
23 underreporting the side effects, patient-reported outcomes.
24 Everybody wants to be a good patient. Oh, doc, it was a
25 piece of cake, until you talk to the care partner, it wasn't

1 quite that easy. So there is this notion of underreport.

2 But in general, the process that Mr. Miller went
3 through, from my perspective, would have been -- just the
4 logistics, it's given every three weeks. Mr. Miller had a
5 number of different treatments. Because of the risk if the
6 chemotherapy goes outside the vein, it causes a burn, so a
7 port is placed that is accessed to the veins under the
8 chest. And that's done usually under conscious sedation,
9 local anesthesia. A patient spends hours getting the
10 chemotherapy in an infusion suite or area, gets intravenous
11 fluids, gets medication to try and reduce the risk of nausea
12 and vomiting and allergic reactions to the chemotherapy. In
13 the immediate post-chemotherapy phase, there is a fatigue.
14 Patient's really feel whipped. That can last -- with this
15 particular treatment can last days, sometimes weeks.
16 There's a lowering of the blood count, which occurs about 10
17 days out. It puts people at increased risk for infection.
18 By three weeks, they're pretty much recovered from the
19 chemotherapy, so then we treat them again.

20 The basis of chemotherapy is that chemotherapy kills
21 cells. Cancer cells are more sensitive, if you will, to the
22 chemotherapy, but so are normal cells. So what you want to
23 do is just stay ahead of the curve, so it's been well worked
24 out by clinical trials the timing of the chemotherapy to
25 make sure you give enough dose to kill the cancer, not the

1 patient, but there are side effects of the cancer.

2 Those are the acute side effects of the chemotherapy.
3 But then there are other issues in terms of hair loss from
4 the chemotherapy, some numbness and tingling in the hands
5 and feet from the Carboplatin, in particular. Those are the
6 main side effects of the chemotherapy in the acute setting.
7 Those are the basics I would tell a patient. I would say,
8 now, I'm ready for your questions.

9 Q So the medical records that are in evidence reflect
10 that he had weekly treatments starting on May 17th, 21st,
11 31st, and then June 7th?

12 A Yes. So I want to correct -- what I was describing was
13 Carboplatin and Taxotere given without radiation, it's just
14 concurrent. And the idea here, that is weekly in order to
15 maintain the blood level of both drugs while he's getting
16 chemotherapy to take advantage of the potentiation of the
17 radiation by the chemo. So for Mr. Miller, appropriately,
18 it was given on a weekly basis.

19 Q So if you're just getting chemo, it might be spread out
20 every three weeks?

21 A Sure.

22 Q But because it's radiation, you've got to keep getting
23 hit with it during that time to take full advantage of the
24 additive effect between the chemo and the radiation at the
25 same time?

1 A That's correct.

2 Q And is that -- in your experience treating patients
3 like this, it can be pretty hard on the patient?

4 A Many, many, many patients.

5 Q And is that pretty hard on them?

6 A Pardon me?

7 Q Can that be really hard on the patient?

8 A I can't hear you.

9 Q Can it be hard on the patient?

10 A Yeah, this is the real deal. The goal is to get
11 maximum benefit, but the chemotherapy is not easy. But the
12 potential benefit is far greater than the side effect and
13 that justifies it. Although chemotherapy and cancer
14 treatment has come a long way, still for head and neck
15 cancer, this is the best we can do and it's not easy.

16 Q What is the chemo actually doing? Is it just,
17 essentially, poisoning the cancer cells?

18 A Yeah. To reinforce the point, chemotherapy kills
19 cells. Cancer cells are more susceptible to the chemical
20 therapy than normal cells, and so it's a delicate balance.
21 You kill more cancer cells and, hopefully, don't kill the
22 patient.

23 Q Okay. Radiation, you've had patients undergo
24 radiation?

25 A Many.

1 Q Now, were you in the courtroom to see the video of the
2 radiation?

3 A I did.

4 Q Is that what it's like?

5 A Yeah. So one of the features of our cancer center was
6 everything was in the same building. So I would be managing
7 patients who were getting concurrent chemotherapy for head
8 and neck cancer. I would go down to the radiation suite.
9 They were coming in everyday. If there were some issue, I
10 would visit them with my white coat flashing, oh, he's in
11 the treatment room. That's okay, I'll go in, just don't
12 turn on the machine. So I'd go in while they're positioning
13 the patient. So I have many experiences of actually being
14 in the radiation room while a patient's being set up or
15 taken down.

16 Q We heard about -- from David about the process of
17 making the radiation masks. Start with a blank like this?

18 A Yep.

19 Q Heat it up and then mold it around the shoulders and
20 face of the patient?

21 A Yep, yep, yep.

22 Q What's the purpose of that?

23 A Just like chemotherapy, radiation, again, kills cancer
24 cells. Cancer cells are more sensitive to radiation than
25 normal cells, but it's a very delicate balance,

1 particularly, now with modern techniques, using
2 computer-aided imagery, you can give a very high dose with
3 confidence that you're getting the tumor and not the normal
4 cells. But that assumes the patient doesn't move through
5 the treatment, which could last a minute, plus or minus.
6 The patient can't move because if they move, then A, you
7 miss the cancer; and B, you put intense radiation dose in a
8 normal structure. So the purpose of the mask is just to
9 make sure the patients don't move.

10 And it ain't easy for patients, either. I can't tell
11 you how many times I've told people to hang in there and
12 this is why you need to do this. It's not easy. I have
13 difficulty understanding having to go through this myself,
14 but I've seen many people -- and Mr. Miller told the story.
15 Incredibly, people do have the motivation and the
16 self-control to be confined under this mask.

17 Q And you're actually bolted to the table so you can't
18 move?

19 A Yep, can't move.

20 Q And that mask is not like a net, it's a plastic net,
21 but it's hard plastic?

22 A You're riveted to the table so you can't move.

23 Q Okay. Tell me about the effects of radiation. What do
24 you tell your patients to expect? You say, all right, you
25 have head and neck cancer and you have to have radiation.

1 A Unfortunately, even with modern techniques, the
2 salivary glands, as it turns out, are very sensitive to
3 radiation. And your salivary glands are very much in
4 proximity to cancers of head and neck, including tonsillar
5 cancer. And, basically, they get damaged, they become
6 nonfunctional.

7 And loss of saliva -- I think Mr. Miller's story is one
8 I've heard many, many times, particularly in patients after
9 their radiation. They're oral cripples. From not having
10 any saliva, it affects speech, quality of life, certainly,
11 chewing, swallowing, taste. And that's superimposed on any
12 damage that's done to normal oral function as a consequence
13 of the damage to not only salivary glands, but also the
14 muscles, tongue. The term we use is oral cripple.

15 We've done a lot of search to try and minimize the
16 effect the salivary glands, try and minimize the field
17 effect of the radiation. That's a whole area of research
18 that I've been involved in as part of an interdisciplinary
19 program. But it's still a huge side effect, both acute and,
20 particularly, chronic for patients who've had radiation
21 therapy to the oropharynx and hypopharynx.

22 Q On an acute basis, are skin burns hard to deal with?

23 A Yeah, you -- the answer is, of course, yes, and Mr.
24 Miller described it. But those can be quite severe in the
25 head and neck and actually lead to wet burns, that is

1 they're oozing, second, third degree burns. And this can
2 take weeks, months to heal and the long term effects are
3 scarring.

4 Q In Dr. Thakkar's notes, which are in evidence, the
5 desquamation was used. Can you explain --

6 A Yeah, that's the -- if you've got a burn in the kitchen
7 or whatever, you can either get a blister, but if it's -- if
8 you don't get a blister and burns through the blister, than
9 you have open oozing. And that's -- there's no skin on top
10 and it burns the skin off.

11 Q And that has a tendency to cause scarring over long
12 term?

13 A Yes.

14 Q How about dry mouth from the lack of salivary glands?

15 A Yes, that's the oral cripple that I just described.

16 Q Altered taste?

17 A No taste. I hear no taste. Mr. Miller described in a
18 way that I've heard it described many times.

19 Q Sores in the mouth and the throat?

20 A Yeah, so the mucosa, the lining of the throat -- of the
21 mouth is very sensitive to the effects of radiation and
22 chemo, so people get quote, unquote, canker sores, which are
23 really -- can be severe, totally limit any oral function
24 down to they can't brush their teeth because it's painful,
25 certainly, can't eat, weight loss associated with the acute

1 oral effects.

2 Q So your throat becomes kind of a whole canker sore?

3 A It can start as a canker sore, but the whole mouth --
4 as I tell patients, it, basically, sucks, and there's just
5 no other way to describe it. And, hopefully, the acute side
6 effects resolve over time. We can support people by using
7 various nutritional aspects. And as Mr. Miller described, a
8 lot of things we can do to improve oral -- do scrapings and
9 all sorts of things to -- oral mouthwashes, both standard
10 and experimental approaches to ensure that this crap that's
11 in the mouth gets cleaned out, doesn't get superinfected,
12 lots of things you can do, but the long and the short of it
13 is is it sucks.

14 Q Now, you heard the testimony of Mr. Miller about the
15 loss of taste, permanent dry mouth, scarring, gums, showing
16 the roots of the teeth receding, worried about an injury to
17 the jawbone, hair loss and --

18 A Sir, if I can interrupt you. The term that Mr. Miller
19 couldn't remember was osteonecrosis. And so what happens
20 is, particularly for the oropharynx and the lower jaw, is
21 that the bone really can't replenish because the cells, the
22 so-called osteoblast constantly repair bone, because you've
23 got a lot going on in your mouth, they're damaged by the
24 radiation. So the bone becomes weak, teeth fall out.

25 So part of the attempt is to remove teeth early on that

1 you think are going to need removing so the osteoblast are
2 still there and can do some remodeling before the long term
3 effects of osteoblast loss occurs. So what Mr. Miller
4 described is a well-established standard of care how to deal
5 with the effects on the jaw.

6 Q And on the issues that he reported, taste, hair loss,
7 receding gums, scarring, all of that, in your view, are they
8 directly related to the radiation chemotherapy treatment?

9 A Yes.

10 Q Now, in this case, he had both radiation and chemo.
11 And one of the chemo drugs is a drug called Carboplatin and
12 there was radiation given with it?

13 A Correct.

14 Q Is there an increased risk of future leukemia from a
15 combination of radiation and Carboplatin when used
16 simultaneously?

17 A The evidence -- the biology is pretty well established,
18 and that is both radiation and drugs like Carboplatin damage
19 DNA and predispose to development of a transformed cancer
20 cell. Certainly, for other cancers where there's long-term
21 followup, there is an increased incidents of second cancers
22 as a result of the chemo and the radiation. The concurrent
23 chemoradiation that Mr. Miller got has only been used maybe
24 in the last five to 10 years on a regular basis. That's one
25 of the advantages of giving it at the same time, so we don't

1 have the long-term followup. But that is a risk and
2 something that I would tell people and it is on our informed
3 consent.

4 Q So radiation treatments, he had a total of 35
5 treatments; is that correct?

6 A Yes.

7 Q And we have them starting May 13th and they were pretty
8 much every day of the week?

9 A Monday through Friday.

10 Q Until -- July 4th was missed. Is this the way
11 radiation is given, in sequence in that way?

12 A Yes.

13 Q And why is it given day after day after day after day?

14 A So the biologies are actually very well worked out.
15 And that is radiation causes sublethal DNA damage and it
16 turns out that damage can be repaired pretty much in a 12 to
17 16 hours, so that we try to again take advantage of the
18 differential between normal and cancer cells. Normal cells
19 can repair DNA damage quicker than cancer cells, so the net
20 effect is normal cells repair, cancer cells can't, they die.

21 Q And then if we put both together, is this his treatment
22 regimen for those three months, chemo and radiation put
23 together?

24 A That's the standard of care.

25 Q Now, with the radiation, does it actually cause burns

1 immediately or are those things that sort of accrue over
2 time?

3 A The effect on the skin is cumulative, so you see the
4 most extreme burns towards the end and then in the weeks
5 following radiation.

6 Q I want to turn now to whether you have an opinion that
7 the spot complained of in 2013 was the same thing that was
8 the cancer in 2016. Do you have a view on that?

9 A I have the opinion that it's the same -- the cancer was
10 present in 2013 continuously through the diagnosis in 2016.

11 Q Can you tell us why you believe that?

12 A Lots of reasons. I guess the most compelling is Mr.
13 Miller's testimony in deposition and today that this never
14 went away and that he could feel it way back -- certainly,
15 had a sense that it was there. Again, going back to the
16 underreporting of patient reported symptoms. I would
17 characterize this as sort of an incidental. Mr. Miller was
18 told it's not cancer, don't worry about it. So it just
19 becomes part of the aches and pains, no aches and pains, per
20 se, but just like some of the things that's there.

21 But there's no question in my mind that it persisted.
22 Not easy to see. Because it's way back, you really do need
23 to have expertise with either a head and neck mirror so you
24 can flash a light down there with a mirror or with
25 laryngoscopy, that is to actually take a little fiberoptic

1 scope and be able to see the tonsil, which is where the
2 cancer was.

3 There's no question in my mind that it advanced. A, by
4 imaging studies, B, by this symptoms with respect to Mr.
5 Miller -- this is not sleep apnea. What -- the airway, as
6 this tumor got bigger, clearly began to compromise the oral
7 airway, the oropharyngeal airway and you could get the sense
8 of sleep apnea, but that's a different disease. But,
9 certainly, difficulty breathing in a particular position,
10 particularly as the, if you will, opening contracts just by
11 position or by, in this case, tumor.

12 Q Okay, Doctor, we've seen this before. This is what Dr.
13 Wilson drew the first visit when he did the laryngoscope.

14 A Right.

15 Q And then this is from the VA, March 1st, 2016. Would
16 this be through a scope as well?

17 A Yes.

18 Q Does the proximity -- do these two locations
19 correspond?

20 A Yes, same spot.

21 MR. MCGOWAN: Now, I want to publish to the jury, Your
22 Honor, it's part of the medical record from the VA.

23 THE COURT: All right.

24 BY MR. MCGOWAN:

25 Q These are in evidence as the Dorn VA records. And

1 you've reviewed this as part of your work in the case, have
2 you not? And it's an ENT consult note dated February 11th,
3 2016. And the reason for the request, Patient has had
4 issues with tonsils for years. Swelling, sore to swallow,
5 needs evaluation for possible removal. HPI, Veteran with
6 mild sore throat and lump in throat sensation one to two
7 years, no dyspnea, no stridor, no dysphagia, no hemoptysis.
8 Then we have one from February 19th, 65-year-old male with
9 past medical history of back surgery times three, coronary
10 stents times three. Presents with three-year history of
11 enlarged right tonsil. Minimally responsive to antibiotics.
12 Now affecting speech and swallowing.

13 We have another one now from March 29th and it says,
14 Miller, David Allen is a 65-year-old male with hypertension,
15 coronary artery disease, referred from ENT clinic with
16 tonsillar cancer. Patient states that three years ago, he
17 started experiencing intermittent right-sided sore throat.
18 He says he was seen by a local ENT in Rock Hill who ordered
19 an MRI of the neck, which patients states he was told did
20 not reveal a malignancy. Patient states he has been placed
21 on multiple antibiotics over the past three years with
22 minimal relief of the sore throat. Patient states because
23 of chronic tonsillar problems, he wanted to have his tonsils
24 removed, seen by Dr. Wells.

25 Then we have the last one from Dr. Thakkar. He was the

1 radiation oncologist; is that right, Doctor?

2 A That's correct.

3 Q And he wrote, Patient is a delightful 65-year-old
4 nonsmoker, Marine veteran presenting with a large tonsillar
5 cancer. He notes the tonsillar irritation about three years
6 ago, at which time, he saw an ENT in Rock Hill, workup was
7 negative at that time. The symptoms persisted, but he was
8 clear that they did not progress significantly until
9 recently when he sought additional input from Dr. Wells
10 after bringing up this issue with his PCP. Lesion did not
11 respond well to antibiotics and he saw ENT for further
12 evaluation.

13 Now, tell me sort of the rule -- seems like all these
14 doctors are taking a history of presenting illness, and HPI,
15 especially the VA doctors. What is the role of an HPI in
16 the care of a patient, the evaluation of a patient?

17 A A history of present illness, HPI, is what you can get
18 from a history in context. Part of it comes from the
19 patient, part of it comes from old medical records and the
20 medical records that you have available. Part of it comes
21 from pattern recognition, how important, if you will -- as a
22 physician, how important is this story relative to your
23 ability to develop a so-called differential diagnosis, what
24 could be going on and what's the importance of the story as
25 opposed to the physical findings, the laboratory, the

1 imaging studies, biopsy, et cetera. So it's an attempt to
2 put a story on a clinical circumstance. And the weight of
3 each of these elements varies by the clinical situation.

4 Q Last question, would the location of this particular
5 growth be easily amenable -- or easy to see without the use
6 of a scope or instruments or, specifically, looking for it?

7 A You can see the oral cavity. And one of the problems
8 is that the tonsil, particularly that part of the tonsil
9 where Mr. Miller's cancer is, you can't see and that's why
10 ENT specialists have the mirrors -- actually, as part of my
11 experience, I got pretty good at it with the indirect
12 laryngoscopy, but not very good at it. It's very tricky to
13 do and that's why an ENT specialist is required to be able
14 to get a good look at this area. That's why instrumentation
15 has been developed, including various scopes, laryngoscopes,
16 et cetera to look in there. You can't really see that area.
17 I think as Mr. Miller described, he sort of thinks he saw
18 it, but really, you can either do it by palpation, by feel,
19 which causes gagging because you're way in back, or indirect
20 laryngoscopy or direct laryngoscopy. Not easy to see.

21 Q Is it fair to say that the two times when we have it
22 documented in the medical record, a scope was used?

23 A That's my assessment of the medical records, yes, and
24 my experience.

25 MR. MCGOWAN: Doctor, thank you very much.

1 THE COURT: Mr. Davis.

2 CROSS-EXAMINATION

3 BY MR. DAVIS:

4 Q Good afternoon, Dr. Blum.

5 THE COURT: Let me do this. Lawyers approach.

6 (Whereupon, a bench conference was held in the presence
7 of the jury but outside the hearing of the jury.)

8 THE COURT: Ladies and gentlemen, the Court just needed
9 a logistical question answered.

10 You may proceed, Mr. Davis.

11 BY MR. DAVIS:

12 Q Dr. Blum, you remember me taking your deposition; is
13 that correct?

14 A By video conference, yes, I do.

15 Q And at that deposition, you told me that if you were
16 not hired to give standard of care testimony, you would not
17 be giving standard of care testimony. Is that still your
18 position today?

19 A Yes, it is.

20 Q So none of the testimony you gave in your direct
21 examination was intended to imply to this jury that there's
22 any negligence on the part of Dr. Wilson; is that correct?

23 A That was my intent.

24 Q Now, you have looked at -- oh, excuse me, I'm sorry.
25 Have you examined Mr. Miller?

1 A No.

2 Q Have you met him before today?

3 A Nor have I met -- I see him in the room, but I have not
4 met him. Not talked to him.

5 Q Have you spoken with him on the phone?

6 A No, I have not.

7 Q Have you talked with any of his treating physicians?

8 A I have not talked to any of the physicians.

9 Q And yet, you have a prognosis for him today that he's
10 got incurable cancer and will probably get leukemia; is that
11 right?

12 A I don't think that's a fair representation of my
13 testimony. My testimony is had he been diagnosed in 2013,
14 he very likely would have been cured. Because of the delay
15 in diagnosis, it's unlikely that he is cured. And that
16 there is a risk, albeit a low risk, an unknown risk, but
17 nevertheless, a risk that he could have a secondary cancer.
18 The other side effects he had from his treatment are
19 apparent to Mr. Miller and to the jury and to me.

20 Q So when you say low risk of secondary cancer, you're
21 not talking about more likely than not, you're talking about
22 less likely than not, it's a low risk?

23 A In all fairness, my testimony is less likely and the
24 data is very weak, it is a possibility.

25 Q And when you talk about he is not yet cured and he is

1 incurable, as we go on and as he progresses from year to
2 year without developing a secondary cancer, his mortality
3 goes up; is that correct?

4 A I don't understand the question.

5 Q In other words, as he progresses from year to year
6 without the cancer coming back, there's a greater chance
7 that he is cured; is that right?

8 A The statistics that we use are based on five years for
9 this type of cancer, head and neck cancer, five years from
10 diagnosis and treatment without recurrence is the statistic
11 we use five-year survival quote, unquote cured. There can
12 be late recurrences with head and neck cancer, but most of
13 the recurrences happen in the first five years from
14 diagnosis and treatment.

15 Q He's about halfway there, right?

16 A Not quite 40 percent the way I do my math.

17 Q He's on his way, though?

18 A Pardon me?

19 Q He's on his way? So far, it's good news, right?

20 A Fortunately, he has not recurred, but it's early.

21 Q And the other purpose of your testimony was to tell us
22 that you believe that the cancer that was diagnosed in 2016
23 is the same spot that Dr. Wilson noted on his records, which
24 you've just seen on this board up here; is that correct?

25 A My opinion is that the cancer was present in 2013,

1 persisted, progressed until the time he was diagnosed in
2 2016.

3 Q Okay. And I believe you told me before this cancer
4 wouldn't go away, would it? It wouldn't wax and wane? It
5 wouldn't go away where you couldn't see it or feel it and
6 then come back; is that correct?

7 A The cancer's persistently there is my opinion. The
8 cancer progressed over time, got worse. Certainly, there
9 could be, if you will, observer variability in assessing its
10 size. When you say wax and wane, bigger or smaller, it
11 could have gotten a little bit bigger or smaller to an
12 examiner, but the basic biology is that cancers like this do
13 not go away, they progress over time if not diagnosed and
14 treated.

15 Q You read Dr. Wilson's record of April 23rd of 2013, the
16 third visit by Mr. Miller; is that correct?

17 A Yes, I did.

18 Q And in that -- at least, his record indicates that
19 there is no visual or palpable pathology at that point. And
20 I asked you at your deposition, I said in order for you to
21 reach the opinions that you've reached today, you would have
22 to ignore that timing, would you not?

23 A That's what I said on my deposition.

24 Q Right.

25 A But let me be very clear, you said to me according to

1 the records, but it's now apparent to me very clearly that
2 on that third visit, there was no examination. And that's
3 evident by a number of things.

4 Most importantly, I heard Mr. Miller's testimony today
5 that that encounter was done in a consultation room, not an
6 exam room. And Mr. Miller, I found very credible. If you
7 do a hypopharyngeal exam on a patient, they don't forget as
8 Mr. Miller described in the encounter of March 26th, 2013
9 with the palpation, the indirect, and then, finally, because
10 of the gagging, the laryngoscopy exam. That was the only
11 exam that Mr. Miller recalls. It's the only examination
12 that corroborates other aspects of the medical record.

13 So it's my opinion that I can't believe that -- let me
14 put it this way, I do not believe the evidence supports the
15 fact that Dr. Wilson examined Mr. Miller on that day and the
16 chart represents the save as, just use the same medical
17 record. There's no evidence of an exam that day.

18 Q And no evidence of an exam that day is strictly based
19 on what Mr. Miller says; is that right?

20 A I think it's corroborated also by the billing
21 information. My understanding is there is no evidence of a
22 laryngoscopy exam other than on the first visit.

23 Q But he could have done that with a mirror. You don't
24 bill for a mirror, do you?

25 A I don't know the specific billing structure, but,

1 certainly, I found credible Mr. Miller's recalling three
2 visits, the second and third without a full exam.

3 Q Right. And do you recall our discussion -- did you
4 read Mr. Miller's deposition?

5 A I did.

6 Q Well, then, you will recall in his deposition, he
7 couldn't even remember the third visit. He didn't even know
8 he came the third time, do you know that?

9 A From the deposition, yes. But my opinions today are
10 based on the aggregate information, including my having the
11 opportunity to hear Mr. Miller's testimony, which I found
12 very credible.

13 Q Okay. Sure. And, also, in order to reach the opinions
14 you've reached today, you'd have to find any other
15 healthcare provider who noted in the records that there was
16 no visible or palpable pathology, or words to that effect,
17 you'd have to find that not to be true, also, right?

18 A Yeah. And the basis for that is that this is not --
19 this is not a readily apparent cancer. Certainly, in my
20 clinical experience, the cancers that everybody can see,
21 this is not one that can be readily seen. I think the
22 anatomical location, the history that Mr. Miller described,
23 and the fact that Mr. Miller really felt that this was sort
24 of an incidental and didn't necessarily report it.

25 I can tell you, I've done a lot of physical exams in my

1 years as a practitioner and I count on a few fingers the
2 number of tonsils that I saw in that context while I was
3 trying to work the mirror. This is not an exam that can be
4 done by a generalist, certainly, not as part of an
5 incidental aspect of a variety of ways that patients
6 encounter healthcare providers.

7 Q I understand. And you told me in your deposition that
8 when you were contacted and hired to review this case that
9 you were told to assume that there was a delay in diagnosis.
10 Did I say that correctly?

11 A Yes.

12 MR. DAVIS: Thank you. I don't have any other
13 questions.

14 THE COURT: Any redirect?

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

16 THE COURT: Thank you, Dr. Blum, you can step down.

17 THE WITNESS: Yes, sir.

18 (Witness steps down.)

19 MR. MCGOWAN: May the witness be excused?

20 THE COURT: Any objection?

21 MR. DAVIS: No, sir.

22 THE COURT: Dr. Blum, you're excused.

23 THE WITNESS: Thank you, sir.

24 THE COURT: I have a question about logistics for the
25 lawyers.

1 (Whereupon, a bench conference was held in the presence
2 of the jury but outside the hearing of the jury.)

3 THE COURT: Ladies and gentlemen, this is an
4 appropriate time for us to take a lunch break. It is about
5 12:30. Let's do this, if you'll just be back in your jury
6 room so that we're ready to start prompt at 2:15. Just be
7 back -- and sometimes, I think the bailiff may ask you to be
8 back a little bit before that. The goal is that we would be
9 able to start prompt at 2:15.

10 Enjoy your lunch. Don't discuss the case. Don't be
11 googling or any electronic media searches on anything you've
12 heard or seen in the courtroom. So enjoy your lunch. Be
13 back ready to go at 2:15.

14 Everyone remain seated while this jury is excused.

15 (Whereupon, the jury exits the courtroom at 12:27 p.m.)

16 THE COURT: Anything from the Plaintiff before we break
17 for lunch?

18 MR. MCGOWAN: No, sir.

19 THE COURT: From the Defense?

20 MR. DAVIS: No, Your Honor.

21 THE COURT: All right. We'll be at ease until 2:15.

22 (Whereupon, a lunch break was taken.)

23 THE COURT: The Plaintiff ready?

24 MR. MCGOWAN: Yes, Your Honor.

25 THE COURT: The Defense ready?

1 MR. DAVIS: Yes, Your Honor.

2 THE COURT: All right. Let's bring the jury in.

3 (Whereupon, the jury enters the courtroom at 2:15 p.m.)

4 THE COURT: Thank you, ladies and gentlemen. Thank you
5 for your promptness.

6 Mr. McGowan, call your next witness.

7 MS. GOODSTEIN: The Plaintiff would call Joey Williams.

8 THE CLERK: Place your left hand on the Bible and raise
9 your right.

10 JOEY WILLIAMS,

11 after being duly sworn, testified as follows:

12 THE CLERK: Thank you. Have a seat.

13 DIRECT EXAMINATION

14 BY MS. GOODSTEIN:

15 Q Good afternoon, Joey. Thank you for being here.

16 Please introduce yourself to the jury.

17 A My name is Raymond Williams, Raymond Joseph Williams.

18 They call me Joey. And I was born and raised in Belmont.

19 And I lived on West Henry Street, David lived on East Henry.

20 That's how we became friends. We was about 12 years old,
21 something like that.

22 Q Joey, do you have any water up there?

23 A No.

24 Q We'll get you some water. You need to keep the volume
25 up so the jury can hear you, okay?

1 A We were in the Marine Corp together. We went through
2 some good times and bad times.

3 Q And Joey, if I can stop you right there. Tell me a
4 little bit more about when you first got to know David.

5 A Well, we were at school and I told him, I said, Let's
6 go by the house, and we went by the house. And mom,
7 naturally, had a meal put on the table. And David ate some
8 of those pinto beans and cornbread and he found a home right
9 there. And my family, my mom and dad, they adopted him
10 right off, like he was the smart kid they never had, most
11 intelligent one. Mostly, his mom, she worked all the time.
12 His grandma was there. But I think he, more or less, fell
13 in love with the meals everyday. We became, more or less,
14 brothers. He had a home and I had another brother. We
15 pretty much stayed -- well, 50 years or better now, we've
16 been friends.

17 Q Joey, can you tell the jury a little bit about who
18 David is as a person?

19 A Well, David, he -- we're really opposites. We grew up
20 in a time where you had to get out and get your own spending
21 money yourself. Your parents didn't have it to give you, so
22 we had to make our own money. Well, I cut grass, you know,
23 picked up bottles, whatever I could. And David, he had a
24 job fixing TVs at 12 years old. You know, I'd go by and
25 he'd be at the shop there and I'd say, What is that? A

1 rectifier tube. I didn't know what that was. And he ran
2 projectors at the local drive-in we had there. Like I say,
3 he was always more intelligent.

4 I liked to make my own money, but it seemed to always
5 go to partying and having fun and stuff. And David would
6 always wind up with his in his pocket. He was like take
7 care of things now, you know. He was looking more at
8 education, you know.

9 Q So Joey, you and David served in the Marines together;
10 is that right?

11 A That's right.

12 Q And what you did after the Marines is a little bit
13 different than David; is that right?

14 A Oh, absolutely.

15 Q Tell the jury a little bit about that.

16 A Well, I worked for my family. And when you work for
17 your family, you don't get a whole lot of money. And I got
18 into plumbing and I worked as a plumbing contractor. And I
19 didn't finish my schooling like David, but after we drafted,
20 you come out and you're hard at it. So I was more like
21 working two jobs to have one for bills and one for play.

22 And as far as the Marine Corp, he was looking forward
23 to a career in the Marine Corp. Now, schooling, he did get
24 that. The Marine Corp didn't offer a whole lot of schools.

25 Q Now, Joey, do you spend a whole lot of time with David

1 still?

2 A Oh, yeah.

3 Q How often do you see him?

4 A At least, once a week.

5 Q And has it always been like that? Say, in the last 10
6 years, have you seen David that often?

7 A Oh, yeah, yeah. When he was out of town working, we
8 didn't see one another that much.

9 Q Now, if you could, describe for the jury what David was
10 like before his cancer diagnosis and treatment.

11 A Oh, he was always outgoing, just have a good time.
12 Work hard and play hard. He enjoyed life to what he could.
13 Like I say, we've both been knocked down and just had to
14 come back clawing and scratching to get back up there to
15 make a go of it.

16 Q Now, I want to turn your attention back to 2013. Do
17 you remember David having complaints of something in his
18 throat in 2013?

19 A Yes.

20 Q Can you tell the jury a little bit more about that?

21 A Well, he was with me when I had mine in 2010 --

22 Q I hate to interrupt you, but when you say you had yours
23 in 2010, what are you referring to?

24 A My operation as far as cancer.

25 Q And what kind of cancer did you have?

1 A Esophagus cancer.

2 Q And did David help you through that?

3 A Oh, yes.

4 Q Can you tell the jury a little bit about that?

5 A Well, I had him down -- I didn't put my family down
6 when I went to the hospital. They give you a percentage of
7 -- whether it's a zero or 75 percent. It was supposed to be
8 arthroscopic, but it didn't wind up that. But I told him
9 before I went there that he knew what to do if it turned out
10 to be bad enough where I was going to be a vegetable. I
11 didn't want to be that. We had already talked about that
12 before. I mean, we never talked suicide or nothing like
13 that, but if it comes down to it, he knew what to do to get
14 me out of there and take me where I could go to sleep or
15 whatever. And it got close to that and he done what I asked
16 him to do. He was the only one to be notified.

17 And after so many weeks, my family got hot at Duke
18 Hospital for not letting them know anything because of the
19 privacy act. But I was in a coma at the time. When I come
20 out, they got ahold of them.

21 Q Now, going back to 2013, tell the jury what you
22 remember about David's complaints of something in his
23 throat.

24 A He said he had something in his throat back there in
25 the back. I think he tried to show it to me one time. And

1 I said, Well, I can't really tell if it's your tonsils or
2 what it is, you know. He said, Well, I'm going to have it
3 checked out. I said, Yeah, I would, too. I said, Well, you
4 know how the VA is. He never did go to the VA if he didn't
5 have to as far as something serious.

6 Q If it was something serious --

7 A He would seek outside. Now, we have an outsource
8 because they don't have proper medical personnel.

9 Q Now, there was never a point where David -- or you
10 stuck a finger in David's mouth and felt the nodule, right?

11 A Oh, I never did, no.

12 Q Now, what did he do about the thing in his throat back
13 in 2013?

14 A What did he do?

15 Q What did he do about it?

16 A He contacted a doctor to check it out. And I told him
17 I would put him on the prayer list. So he called and said,
18 I guess the prayer worked. I said, Well, I told you it
19 would. It was a joy to hear that, you know.

20 Q When you say that the prayer worked, what do you mean
21 by that?

22 A It wasn't cancer.

23 Q And that was back in 2013?

24 A Yes.

25 Q Now, did your friendship with David continue past 2013

1 and I'm talking about into 2014 and 2015?

2 A Oh, yeah.

3 Q And y'all are still best friends to this day?

4 A Oh, yeah, absolutely.

5 Q From the time he saw Dr. Wilson back in 2013 to late
6 2015, early 2016, did David ever make a comment or remark
7 about the thing in his throat?

8 A Yes, he did. He said he was having problems. Like he
9 said, as far as sleeping, it would cause him to choke a
10 little bit. He mentioned the CPAP thing and he said, Sort
11 of like that. Because sleep apnea, meaning when you go to
12 sleep, you quit breathing and a CPAP machine wakes you up
13 and makes you breath.

14 Q And you had one of those machines; is that right?

15 A I did have.

16 Q Now, were you aware that there came a time when David
17 was diagnosed with cancer?

18 A Yes.

19 Q Can you describe for the jury David's demeanor when he
20 learned he had cancer?

21 A When he found that out, he called me and he was
22 devastated. It just floored me. I just couldn't believe
23 it. It was hard to take. You know, after him going through
24 all he had been through, both of us, and all of a sudden, he
25 says Stage 4 cancer. I said how and why, what is it. You

1 know, I thought maybe it was something else, like prostate
2 or something like that. He said it was his throat. But he
3 had went to -- I don't remember where it was that discovered
4 it, whether it was Columbia or Charleston, I can't remember
5 now, but he called me right after he found out about it. I
6 said, Well, I'll put you on the prayer list. And he said,
7 Well, it's not going too good for me. But I believe it is,
8 I still believe it is. Some people don't, but I do.

9 Q While he was going through his treatments, were you
10 there for some of that?

11 A Oh, yeah. Yes.

12 Q Can you tell the jury what you observed?

13 A Well, I went with him with the chemo and I would go out
14 while he was in there getting chemo. But the radiation, I
15 told him, I said, David, you need to stop it. It looked
16 like it was taking a torch to his neck. Like taking a
17 chicken and just torching the meat and burning it. And I've
18 seen burns before and have had burns, but I told him, I
19 said, You can't take anymore of that. It's unreal. But he
20 said no, he couldn't stop. He had to keep going. And he
21 continued until the final one.

22 Q Along with the impact the radiation had to his skin,
23 what else did you notice he was going through with the
24 radiation and chemo?

25 A He just went downhill pretty quick. Just like the same

1 thing I went through. You don't know whether it's the end.
2 That's something now we're beginning to look for quicker.
3 Like earlier in the years, I never thought you were supposed
4 to live past 35. David, he was looking at like getting up
5 there in the hundreds or something, he was preparing for it.
6 I was thinking what are you doing. He was looking at
7 retirement and I'm thinking 35, that's about as far as I'll
8 get.

9 Q David was the more cautious of you two?

10 A Oh, yes, absolutely. More cautious than the whole
11 crowd, except for one maybe. He was devastated on that one
12 because he had seen Stage 4 so many times and that's the
13 beginning of the end, so to speak.

14 Q Can you describe for the jury how life has changed for
15 David based on your observations from the four years
16 diagnosed with Stage 4 cancer and went through the
17 treatments to today?

18 A Well, he was more outgoing. We'd do a whole lot
19 together. Then after that -- I mean, we'd go out to Chili's
20 or whatever, maybe a trip to Hooters every once in a while.
21 But after this -- I mean, this is our younger days I'm
22 talking about. But after this, we just stayed on the farm,
23 you know, and walked Buddy around out there a little bit.
24 Buddy was like us, he was getting to where it would take him
25 a little longer to get up and stretch and didn't eat right

1 and nothing else didn't work right either, body functions,
2 if you know what I mean. And when that comes along, it's
3 like you're just sitting and waiting for the next day, you
4 know, whether you make it or whether you don't.

5 Q So you noticed a change in David's social life?

6 A Oh, yeah, absolutely. Believe it or not, he had some
7 good looking women he was talking to. But now, he don't
8 even talk to any of them. It's a different turn around, you
9 know.

10 Q Now, Joey, your birthday was a couple of weeks ago,
11 right?

12 A Yes.

13 Q Can you tell the jury who you celebrated your birthday
14 with?

15 A My buddy there.

16 Q And what did y'all do?

17 A We went out to lunch together and had a little bit of
18 cake. We normally go to Olive Garden because both of us can
19 eat soup and pasta. We're a little bit restricted. So I
20 chose to Golden Corral. They've still got soup. There's a
21 lot of other things there you can normally get ahold of you
22 don't eat everyday or normally eat everyday. He got a piece
23 of chicken and I thought he was going to choke to death on
24 it. So he shoved the chicken to the side and we sort of
25 stayed with soup and softer stuff. We learned you either

1 have to put it in a blender or it has to be liquid.

2 MS. GOODSTEIN: Thanks so much, Joey. Please answer
3 any questions the Court or the Defense has for you.

4 THE COURT: Mr. Davis?

5 MR. DAVIS: No questions.

6 THE COURT: Thank you. Mr. Williams, you can step
7 down.

8 (Witness steps down.)

9 THE COURT: Mr. McGowan, call your next witness.

10 MR. MCGOWAN: That will be the Plaintiff's case, Your
11 Honor.

12 THE COURT: Thank you.

13 Ladies and gentlemen, the Plaintiff has indicated that
14 is all the evidence they intend to introduce at this point.
15 We need to take up some matters of law outside of your
16 presence. I'm going to allow you to go back to your jury
17 room while we deal with those issues. When we complete
18 those, we'll have you back out here.

19 So with that, you can return to your jury room. Again,
20 do not discuss the case.

21 Everyone remain seated while the jury is excused.

22 (Whereupon, the jury exits the courtroom.)

23 THE COURT: Anything for the record from the Plaintiff
24 at this point?

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

1 THE COURT: From the Defense?

2 MR. WILLIAMS: Yes, Your Honor. First, the Defense
3 would move for a directed verdict for all of the Defendants.
4 The Defense's position is Plaintiff's failed to show that
5 Dr. Wilson or the practice breached the standard, nor has
6 Plaintiff shown that the injuries suffered by Mr. Miller
7 were proximately caused by the alleged actions of Dr.
8 Wilson.

9 Further, Plaintiff's expert, Dr. Myssiorek's standard
10 of care opinions are based on allegations of negligence that
11 are based solely on res ipsa loquitur, which is not
12 recognized in South Carolina.

13 THE COURT: Mr. McGowan, do you wish to be heard?

14 MR. MCGOWAN: Ms. Harrison.

15 THE COURT: I'm sorry, Ms. Harrison.

16 MS. HARRISON: May it please the Court. Just briefly,
17 Your Honor, as this Court is aware, the standard to overcome
18 a directed verdict is very low. You're looking to determine
19 whether there is any evidence to support a claim for medical
20 negligence or medical malpractice with all evidence looking
21 in the light most favor to the Plaintiff. Here, each
22 element of cause of action has been met. The standard of
23 care was provided through expert testimony showing that if
24 there is a differential diagnosis of cancer, a biopsy must
25 be used to rule in or rule out the issue of cancer. You

1 heard testimony as well as saw medical records which
2 demonstrated that no biopsy was performed.

3 Moreover, this morning, we heard that causation was
4 demonstrated through -- because the biopsy was not done,
5 that cancer increased from Stage 1 to Stage 4 demonstrating
6 that causation. And in the expert testimony, damages were
7 demonstrated from the testimony throughout today.

8 And for those reasons, we believe a directed verdict
9 would be improper.

10 THE COURT: Thank you.

11 I'll deny the motion for directed verdict. The Court
12 finds that there is sufficient factual basis to go well
13 beyond a scintilla of evidence. However, taking the
14 evidence in the light most favorable to the Plaintiff, I'm
15 going to deny the motion for directed verdict.

16 Anything else?

17 MR. WILLIAMS: Yes, Your Honor. The Defendants would
18 also move for a directed verdict as to Dr. Wilson
19 individually. The Plaintiff has failed to show that Dr.
20 Wilson breached the standard of care. Any opinions that Mr.
21 Miller's cancer was present in 2013 during his visits with
22 Dr. Wilson are based on assumptions. Plaintiff's case
23 against Dr. Wilson is based on an assumption of negligence.
24 In essence, the Plaintiff's case rest on the doctrine of res
25 ipsa loquitur and this Court should direct a verdict in Dr.

1 Wilson's favor.

2 THE COURT: Obviously, the same motion, the same
3 rationale, I assume the same rationale opposing that. I'm
4 going to deny the motion for directed verdict as to Dr.
5 Wilson.

6 MR. WILLIAMS: Yes, sir, Your Honor. We have one more
7 directed verdict motion. We move as a directed verdict for
8 Dr. Wilson's practice, ENT & Face, P.A. Plaintiff has
9 failed to prove any negligence on the part of the practice.
10 Plaintiff has not shown any independent act on the part of
11 the practice. Through the testimony, Plaintiff hasn't
12 entered the name of Dr. Wilson's practice, ENT & Face. And
13 Plaintiff is not allowed to recover from two defendants for
14 the same alleged act of negligence. Therefore, it's the
15 Defendant's position that Dr. Wilson's practice, ENT & Face,
16 should have a directed verdict granted in this case.

17 THE COURT: Ms. Harrison, are you going to speak to
18 that issue?

19 MR. MCGOWAN: I will, Your Honor.

20 THE COURT: Mr. McGowan.

21 MR. MCGOWAN: We allege in paragraph 2 of our
22 complaint, the Defendant, ENT & Face, as a South Carolina
23 Corporation, employed Dr. Wilson and others at all times
24 relevant hereto. Defendant Wilson was working within the
25 scope and course of his employment with ENT & Face, P.A.,

1 and he held himself out to the world as a specialist in the
2 field of ENT medicine.

3 The answer, paragraph number 2, says, These Defendants
4 admit the allegations contained in Paragraphs 1 and 2 of the
5 complaint. It's never been an issue. It's a matter of law.
6 They could have admitted it from the beginning. And to say
7 that ENT & Face is now not responsible is just wrong.

8 THE COURT: Let me hear you on that, Mr. Williams.

9 MR. WILLIAMS: Your Honor, it's the Defendant's
10 position that both Dr. Wilson and his practice cannot be
11 responsible for the same act of negligence. Dr. Wilson is
12 here. He has been named personally in this lawsuit. It's
13 the Defendant's position that the Plaintiff can't collect
14 from both Defendants when the only allegation against the
15 practice is one of the employer of Dr. Wilson.

16 And in the alternative, the Defendants would ask that
17 the Court force the Plaintiff at this stage to select its
18 remedies and choose which Defendant it would like to collect
19 from in the event there is a verdict against any Defendant
20 in this matter. The Plaintiff simply is not allowed to have
21 a double recovery. The facts are the same for both
22 Defendants. All of the acts of alleged negligence are the
23 same. Therefore, it's the Defendant's position there is
24 really only one Defendant and that is Dr. Wilson.

25 THE COURT: Mr. McGowan, I'll give you an opportunity

1 to respond.

2 MR. MCGOWAN: We don't have any recovery yet, let alone
3 a double one.

4 THE COURT: We're not at that point yet, obviously.

5 MR. MCGOWAN: Yes, sir.

6 THE COURT: Let me think about that before I rule on
7 that.

8 Any other motions on directed verdict?

9 MR. WILLIAMS: One more motion, Your Honor. The
10 Defendants would ask that the Court rule as a matter of law
11 that the Plaintiffs have not proven their right to collect
12 punitive damages. The Plaintiff has the burden to show by
13 clear and convincing evidence of the willful negligence on
14 the part of the Defendants to be entitled to recover
15 punitive damages.

16 The testimony of Plaintiff's expert, Dr. Myssiorek, as
17 to recklessness simply does not rise to the level of clear
18 and convincing evidence that would allow the Plaintiff to
19 attempt to collect punitive damages in this matter. Dr.
20 Myssiorek simply agreed with Mr. McGowan during his
21 testimony that Dr. Wilson met the definition of recklessness
22 without providing an explanation for any examples of any
23 clear and convincing evidence that Dr. Myssiorek was
24 testifying to that would be recklessness. And it's
25 Defendant's position that Plaintiff failed to meet its

1 burden to show and support the claim of punitive damages.

2 THE COURT: Ms. Harrison.

3 MS. HARRISON: Your Honor, we would contend that the
4 entire testimony of that expert was to explain there was
5 recklessness and that would be the true negligence, which is
6 the failure to order the biopsy. Mr. McGowan went through
7 extensively understanding and appreciating the doctor's
8 opinions and after establishing that base, he provided the
9 definition of recklessness to which he responded yes, that
10 would be recklessness. And that satisfies, certainly, at
11 this stage the testimony that would be required and,
12 certainly, meets the purpose of charging the jury on that
13 issue.

14 THE COURT: Don't you agree, though, it would require
15 more than just recklessness to rise to the level of getting
16 an award of punitive damages?

17 MS. HARRISON: I think in order to be awarded punitive
18 damages, recklessness is one of the ways in which you can
19 charge the jury just for that. It doesn't require willful,
20 wanton. So because of that, I think recklessness in and of
21 itself warrants punitive damages.

22 THE COURT: I'm going to mull on that a little bit,
23 too.

24 MR. WILLIAMS: No, sir.

25 THE COURT: We'll take about a 10 or 15-minute break.

1 (Whereupon, a short break was taken.)

2 THE COURT: All right. I think I needed to rule on the
3 directed verdict motion made on behalf of the Defendant that
4 the Court direct a verdict as to the liability of the
5 practice. I keep saying -- do we call it F-A-C-E or do we
6 say Face? How do you refer to it?

7 MR. DAVIS: Face ENT.

8 THE COURT: Face ENT. So I deny that motion. There is
9 evidence that he was employed by Face ENT. There's
10 billings. There's the building. There's medical records
11 that would provide, at least, a scintilla of evidence that's
12 a factual issue for the jury to determine and sufficient
13 evidence to get beyond the directed verdict. So I deny the
14 motion for a directed verdict as to the practice.

15 And I also deny the motion as far as punitive damages.
16 I will admit that it appears to the Court that the expert,
17 after hearing the legal definition stated to him by Mr.
18 McGowan, the question was, was that reckless, to which he
19 answered yes. And that again, as to whether that rises to
20 the level of award for punitive damages would again be a
21 factual issue. However, there is enough of a factual basis
22 which survives the directed verdict. So I'll deny that
23 motion as well.

24 Anything further?

25 MR. MCGOWAN: Not from the Plaintiff.

1 MR. DAVIS: No, Your Honor.

2 THE COURT: What witnesses do y'all have that we can
3 get to this afternoon? Is Dr. Wilson your next witness?

4 MR. DAVIS: Yes, sir.

5 THE COURT: Okay. Let's bring the jury in.

6 (Whereupon, the jury enters the courtroom.)

7 THE COURT: Thank you, ladies and gentlemen, for your
8 patience. We're now ready to hear evidence to be presented
9 on behalf of the Defense.

10 Mr. Davis, call your first witness.

11 MR. DAVIS: Thank you, Your Honor. The Defense calls
12 Brian Wilson.

13 THE CLERK: Place your left hand on the Bible and raise
14 your right.

15 BRIAN WILSON, M.D.,

16 after being duly sworn, testified as follows:

17 THE CLERK: Thank you. Have a seat.

18 DIRECT EXAMINATION

19 BY MR. DAVIS:

20 Q Tell the jury your full name.

21 A Brian Claude Wilson.

22 Q Where do you live, Doctor?

23 A In Rock Hill, South Carolina.

24 Q What's your address?

25 A 4581 Scarlet Oak Drive.

1 Q Are you married?

2 A I'm divorced.

3 Q Do you have any children?

4 A Five.

5 Q What are their ages?

6 A Nathaniel Charles is 33, Elizabeth Lois is 30, Matthew
7 Scott is 27, Luke Brian is 15 and Luke Alexander is 12.

8 Q Are you presently employed?

9 A No, sir.

10 Q What is your employment status at this point?

11 A I'm disabled.

12 Q What is the source of your disability?

13 A It's a medical disability, physicians call it disabling
14 anxiety.

15 Q When were you diagnosed?

16 A Oh, recently. I just knew within the last couple of
17 years.

18 Q Okay. That's fine. Are you presently under any
19 medical care?

20 A Yes.

21 Q Is there any reason why you can't give truthful and
22 accurate evidence today in this courtroom?

23 A There's no reason.

24 Q Dr. Wilson, let me ask you, did you previously own a
25 business in Rock Hill from which you practiced medicine?

1 A Yes.

2 Q What was the name of that business?

3 A ENT & Face.

4 Q What was the legal status of that business, was it a
5 partnership, P.A., what?

6 A P.A.

7 Q So you were an employee of that?

8 A Yes.

9 Q Did you have any other employees?

10 A Yes.

11 Q How many?

12 A Most of the time, three.

13 Q Any other physicians employed?

14 A For a brief period, I employed one other physician
15 years ago, but most of my career, I practiced by myself.

16 Q Did you have any other physician employees there in
17 2013?

18 A No.

19 Q Dr. Wilson, you've brought with you, I believe, a copy
20 of your CV; is that correct?

21 A That's correct.

22 Q Are you Board certified?

23 A Yes.

24 Q In what discipline are you Board certified?

25 A I'm Board certified in both otolaryngology head and

1 neck surgery as well as facial, plastic and reconstructive
2 surgery.

3 Q Is that a double Board?

4 A Yes.

5 Q The second one is together, right?

6 A I mean, they're separate Boards.

7 Q And tell me about how you obtained that Board
8 certification?

9 A I did a fellowship and I believe there was an exam.

10 Q Did you sit for questions?

11 A Yes.

12 Q For both of them?

13 A Yes.

14 Q Starting with high school, will you tell me your
15 educational background?

16 A Starting with high school, I went to North High School
17 in Omaha, Nebraska for four years. Then I went to Carney
18 State College in Carney, Nebraska. It's now the University
19 of Nebraska at Carney. I was admitted to medical school
20 early, after three years of college. So started at the
21 University of Nebraska Medical Center in Omaha for four
22 years. After that, I did a one-year internship in general
23 surgery in Wesley Medical Center in Wichita, Kansas. And
24 then I did four years of otolaryngology head and neck
25 surgery at the University of West Virginia.

1 Q Was that a residency?

2 A That was a residency.

3 Q Okay.

4 A After that, there was a fellowship in facial, plastic
5 and reconstructive surgery in Birmingham, Alabama. That was
6 with the president of the American Academy of Facial,
7 Plastic and Reconstructive Surgery.

8 Q Okay. And during the course of your career, have you
9 received any honors or designations?

10 A Yes, there was the -- there's a couple here listed,
11 Saviska S. Hall award for best original research paper. I
12 was a third-year graduate of the American Youth Foundation
13 at the National Leadership Conference in Michigan.

14 Q And you've been published three times; is that correct?

15 A Yes, sir.

16 Q Are those peer-reviewed articles?

17 A They're published, yes. They have to be reviewed by
18 someone to get published.

19 Q And then where are you licensed?

20 A I'm licensed in North Carolina with a volunteer license
21 now and in South Carolina, I maintain an active medical
22 license.

23 Q You maintain an active medical license in South
24 Carolina now?

25 A I believe it's active, yes.

1 Q But you no longer practice?

2 A I'm not practicing.

3 Q Are you a member of any societies or have any medical
4 affiliations?

5 A I'm retired status now with the American Academy of
6 Otolaryngology and Head and Neck Surgery. The same goes for
7 the American Academy of Facial, Plastic and Reconstructive
8 Surgery. And a long time ago, I probably still am a fellow
9 of the American College of Surgeons.

10 Q Now, when did you cease to actively practice medicine?

11 A At the end of 2015.

12 Q And why did you cease to practice medicine?

13 A Because of my diagnosis with my medical disability.

14 Q And was that voluntary?

15 A I voluntarily stopped practicing.

16 Q Did you close your practice at that point?

17 A Yes.

18 Q Where was your practice located?

19 A At the corner of Herlong and Constitution.

20 Q And that building is still there, right?

21 A The building is still there, 197 South Herlong Avenue.

22 Q Now, in this case, do you remember the Plaintiff, David
23 Miller?

24 A No, but I keep very accurate records and I brought the
25 original records.

1 Q You have the original records with you?

2 A Yes.

3 MR. DAVIS: Your Honor, I'd like to introduce the
4 records as Defendant's 2.

5 THE COURT: Any objection?

6 MR. MCGOWAN: No, Your Honor.

7 THE COURT: Defendant's Exhibit 2 is in evidence.

8 (Whereupon, Defendant's Exhibit No. 2 was admitted into
9 evidence.)

10 BY MR. DAVIS:

11 Q When did Mr. Miller first present himself to your
12 practice?

13 A March 26th, 2013.

14 Q And do the records reflect what his presenting
15 complaint was?

16 A Yes.

17 Q What was it?

18 A He's quoted here saying, Spot in back of throat.
19 That's the quote. And then -- he had that for three weeks.

20 Q Beg your pardon?

21 A For three weeks, it looks like he had that.

22 Q If you would turn to the typed entry you have on Page 1
23 of your record there?

24 A Okay.

25 Q See where it says 3/26/13?

1 A Yes.

2 Q Who enters this into the record?

3 A This is information dictated by myself.

4 Q And what does it say where it says David Miller?

5 A The first part says David Miller. He has an

6 erythematous firm spot.

7 Q Stop right there. Tell me in medical terms what does

8 erythematous mean?

9 A Reddish.

10 Q Keep going.

11 A Erythematous firm spot on the right posterior pharynx

12 near the superior pole of the tonsil for the past three

13 weeks.

14 Q Now, in layman's terms, kind of tell us where that is

15 on the tonsil?

16 A It's -- I actually drew a picture.

17 Q Is that the picture we've seen here today?

18 A It's the picture we've seen.

19 Q After looking at that picture, does that accurately

20 reflect what's in your notes here?

21 A It does.

22 Q Okay. Let's go back to the notes.

23 A Okay.

24 Q You say past three weeks. What else does the note say?

25 A Shall I just continue reading?

1 Q Yes, you should.

2 A Okay. He does snore. He has nasal obstruction and was
3 a previous -- was previously a boxer. He quit smoking 40
4 years ago. He denies other tobacco products. He denies
5 unexplained weight loss. The denies odynophagia.

6 Q Tell us what that is.

7 A Pain with swallowing. He denies dysphagia.

8 Q Tell me what that is.

9 A Trouble getting food down. He denies hemoptysis,
10 that's coughing of blood. Keep going?

11 Q Well, you talk about the ears there. Do they have
12 anything to do with your investigation into the firm
13 erythematous spot?

14 A Well, this begins the physical exam.

15 Q Okay. Tell me what you did.

16 A Ear canals are clear. TMs are intact, that's tympanic
17 membrane.

18 Q How would you know that?

19 A I used an otoscope to look into both ears.

20 Q All right. That's not in the record, is it?

21 A No. Anterior rhinoscopy shows nasal obstruction with
22 severe septal deviation in this previous boxer. So I've
23 used a nasal speculum from the drawer of the cabinet to look
24 in both sides of his nose there. He has erythematous,
25 buried right superior tonsil firm region compared to the

1 left.

2 Q Now, tell me what the buried right superior tonsil
3 means.

4 A Well, I put region there, so those are adjectives
5 describing region. In my drawing, I've drawn the area of
6 the oropharynx just above the tonsil region. So it just
7 tells me that on the right side, it's a little bit more
8 reddish and a little bit more firm, just near the top part
9 of the tonsil region compared to the left.

10 Q How are you determining this at this point?

11 A I used a fiberoptic headlight, which was easy to look
12 into someone's mouth with that. And I'm also using a tongue
13 blade. I'm just doing this with my headlights on, using a
14 tongue blade and I'm putting my finger back there to feel.

15 Q How do you know that? That's not in the record?

16 A Well, I mean, there's no way I can describe it with an
17 adjective as firm without feeling it.

18 Q Let's go ahead.

19 A I do not feel any abnormal neck masses.

20 Q How did you determine that?

21 A Well, I felt both sides of his neck.

22 Q All right.

23 A He gags with the mirror.

24 Q Tell me about the mirror. How does that work?

25 A That's a hypopharyngeal mirror. It's a little round

1 mirror. We have a couple sizes, large and small. And you
2 can just put it in the mouth and use it with this fiberoptic
3 headlight to look both down at the hypopharynx and you can
4 also just quickly turn it and look up into the nasopharynx,
5 the part above the soft palate that you don't see with the
6 headlight when you look in there.

7 Q And he gags when you do that?

8 A Yeah. So the next thing says flexible laryngoscopy was
9 done.

10 Q What is that?

11 A Well, that's where I used a scope that has it's own
12 light source that goes in the nose. You can use it to look
13 down at the oropharynx and the hypopharynx and up at the
14 nasopharynx. Then I start describing what I see.

15 Q Okay.

16 A Keeping going?

17 Q Yes, sir.

18 A Pyriform sinus, that's part of the anatomy of the down
19 part, epiglottis, that's the thing that closes when you
20 swallow, and vallecula, that's the area right in front of
21 the epiglottis at the base of the tongue, are clear. True
22 vocal cord mobility is intact. So when I looked down, his
23 vocal cords are moving appropriately.

24 Q Now, is that all of your examination on that day?

25 A That looks like my physical exam that day.

1 Q And then what was your impression?

2 A It looks like -- you want me to keep reading here?

3 Q Yes, sir.

4 A It says schedule MRI base of skull and base of neck.

5 Q I think you skipped a line.

6 A Did I? Oh, suspicious right firm tonsil region.

7 Q Suspicious for what?

8 A Well, I don't know. I mean, I'm thinking -- I'm going
9 by the record on this patient.

10 Q I understand.

11 A I'm suspicious because it's a little bit more red, it's
12 a little bit more firm and I'm thinking of what could cause
13 this.

14 Q Let me ask you this, we've heard the term differential
15 diagnosis. What is that?

16 A That's different things that could be causing the
17 patient's complaint.

18 Q Okay. Are you starting to form that at this point?

19 A Yes.

20 Q And what's the next line say?

21 A Schedule MRI base of skull and base of neck.

22 Q Now, what is an MRI?

23 A MRI stands for magnetic resonance imaging.

24 Q What do you get back from that?

25 A You get images of this whole area between the base of

1 the skull, up here, down to the base of the neck, here. You
2 get all the area that the gentleman is complaining about.

3 Q And does that image the front and back?

4 A I mean, there are slices. They can be formatted in
5 different planes for you to look at.

6 Q And was this MRI ordered with or without contrast?

7 A Both.

8 Q Why both?

9 A Well, you get more information.

10 Q What's the difference between an MRI with contrast and
11 an MRI without contrast?

12 A Well, they're images of the same anatomy, but you may
13 get additional information based on where the contrast isn't
14 soaked up, absorbed.

15 Q Contrast goes through whatever it is?

16 A Whatever it is you're looking at.

17 Q And is that all that happened on the first visit with
18 Mr. Miller?

19 A We arranged his followup appointment. It says he will
20 followup in one week.

21 Q And when Mr. Miller came to see you that day, did you
22 take a history from him?

23 A Are you talking about a week later, the second visit?

24 Q When did you first take a history from him?

25 A Well, I go through the same process each time I see a

1 patient with the history, the exam, the ordering tests,
2 making impression, making a plan. You go through that same
3 --

4 Q Do you something that looks like that?

5 A I'm sure we do.

6 Q Turn to it, please.

7 A (Witness complies.) I've got two. Can you show me the
8 page again?

9 Q What is that page?

10 A This is a medical history sheet.

11 Q Who filled this out?

12 A This looks like it's filled out by the patient.

13 Q All right. Let me ask you this, Doctor. We're not
14 going to go over that whole sheet, but just looking at that
15 sheet, is there anything on that sheet that is pertinent to
16 your inquiry concerning the erythematous red spot?

17 A Yes.

18 Q What's on there that's pertinent?

19 A He's on four different medicines for high blood
20 pressure and he admits to high blood pressure.

21 Q How is that pertinent?

22 A Well, this could simply be a bruise or a spot, a blood
23 vessel that had popped.

24 Q Okay. Anything else that's pertinent on that page?

25 A He smoked, but it was for eight years and that was

1 several years ago.

2 Q Several, 40?

3 A Yes.

4 Q Anything else?

5 A He called us himself to make his appointment. He found
6 us in the yellow pages.

7 Q All right. Anything else on there that's pertinent for
8 your inquiry?

9 A He admits to drinking alcohol.

10 Q Okay. That's it?

11 A That's about all.

12 Q Now, you have a typewritten page. I think it's the
13 last one in that file?

14 A Yes.

15 Q And it has a typed-up history; is that right?

16 A Yes.

17 Q What do you call this? What page is this?

18 A Well, this is generated by the electronic medical
19 record.

20 Q Okay. That's what you call an EMR?

21 A EMR.

22 Q Now, there's information on this page. How does that
23 information get into the EMR?

24 A I dictate this history and the exam. And then also,
25 some of this information is entered because it's what the

1 patient has told us.

2 Q And you, essentially, put in here the spot on the
3 throat on quotation marks?

4 A Correct. And that's significant. Because I haven't
5 called it a nodule, I haven't called it a lesion, I haven't
6 called it an ulceration, I haven't called it a mass. I've
7 been very specific with quoting what the patient told me.

8 Q Okay. And that's, essentially, what you read to us a
9 few minutes ago, right?

10 A Yes.

11 Q Now, as we go down the chart, it has a place down there
12 called family medical history. Do you see that part?

13 A Yes.

14 Q And there, it says no significant family history?

15 A I dictated that.

16 Q How do you know you dictated that?

17 A Because there's no other way it would get there.

18 Q Does anyone dictate into the EMR to form this sheet?

19 A No, only me.

20 Q Only you, okay. Under your impression, what do you
21 have there?

22 A Suspicious right firm tonsil region. And I think it's
23 significant that I keep using the word region there because
24 I don't know yet if this is a tonsil stone, an infection, a
25 bruise. I don't know what it is, so I'm very specifically

1 calling it region.

2 Q Okay. And then under recommendations, you've got
3 schedule an MRI of base of skull and base of neck, right?

4 A Yes.

5 Q And then what's the next sentence say?

6 A He will followup one week.

7 Q Now, under that, it's got problem list. What is a
8 problem list?

9 A A differential diagnosis.

10 Q And what have you listed there in the problem list?

11 A It says carryover diagnosis septal deviation,
12 obstruction nasal, hoarseness, dysphonia, malignant neoplasm
13 tonsil and diagnosis hypertension.

14 Q What does carried over diagnosis mean?

15 A This gets here because of diagnosis ties from the EMR.

16 Q And have you already diagnosed a malignant neoplasm at
17 that time?

18 A No. No. This is in there because I probably needed a
19 reason to order the MRI.

20 Q And did you order an MRI?

21 A Yes.

22 Q Show me the page number that reflects your order on the
23 MRI?

24 A (Witness complies.)

25 Q That's the page?

1 A Yes.

2 Q What does it show on that page?

3 A It has the patient's name, the appointment date. It
4 has the -- it says MRI base of skull to base of neck with
5 and without contrast. It has signs and symptoms, septal
6 deviation, neoplasm in tonsil --

7 Q Stop right there. Neoplasm in tonsil?

8 A Right.

9 Q What does that mean?

10 A Well, we're trying to tell the radiologist or whoever's
11 going to read this, you know, what we want him to look for.

12 Q Okay. Now, let me ask you this, in your practice, if
13 you send a request to a radiologist and, for whatever
14 reason, the radiologist feels like he can't complete that
15 request, can't do it, how does that work? Will he get back
16 in touch with you?

17 A He'll call me.

18 Q Does that happen from time to time?

19 A From time to time, occasionally.

20 Q But in other words, if for whatever reason, the
21 radiologist couldn't complete what you've asked for, you
22 would expect to be notified?

23 A Yes.

24 Q And you made an appointment for Mr. Miller, right?

25 A Yes.

1 Q Now, did you find out anything about -- when did you
2 first learn of the results of the MRI?

3 A I got a preliminary report 4/2/2013.

4 Q How does that work? You said preliminary report. Was
5 he not finished with the report or what? What does that
6 mean?

7 A They probably know that I want this report by this day
8 because the patient has an appointment, so they're giving me
9 something.

10 Q What does the report say? I don't want you to read
11 anything you've already read and take the jury's time, but
12 look under exam and what does the exam part say?

13 A MR soft tissue neck with and without contrast.

14 Q And that means he would have done both?

15 A Yes.

16 Q And then it says reasons for exam?

17 A It says deviated septum, slash, question mark, neoplasm
18 tonsil.

19 Q Now, in medical speak, he's got question mark neoplasm
20 tonsil. What does that mean?

21 A That's what we want whoever's going to read this study
22 or do the study, we want them to be looking for something
23 like that.

24 Q Who actually read it?

25 A It says Greg, Joseph, M.D.

1 Q And what were his conclusions after reading the MRI?

2 A No definite evidence of mass or abnormal enhancement in
3 the tonsils.

4 Q And that was a preliminary report?

5 A That's the preliminary report.

6 Q Now, later on, did you get a final -- oh, by the way,
7 let me ask you this, on that preliminary report, there seems
8 to be a BW in handwriting on 4/2/2013?

9 A Correct.

10 Q Whose handwriting is that?

11 A That's mine.

12 Q What does that mean?

13 A That means I've read this and that's the date I read
14 it.

15 Q Was that your custom in your practice to initial those?

16 A Yes, I didn't want anything filed in the chart without
17 me looking at it.

18 Q Okay. Had to be initialed to be filed?

19 A Something like this, absolutely, yes.

20 Q And then did you later get a final report from the
21 radiologist?

22 A Yes.

23 Q What's the date of the final report?

24 A The date I signed it?

25 Q Yes.

1 A April 9th, 2013.

2 Q And does the final report say anything different from
3 the preliminary report?

4 A It's essentially the same.

5 Q Read under findings -- the preliminary report didn't
6 have findings, did it?

7 A I mean, I can read what the findings say on both pages
8 if you'd like.

9 Q Read the findings on the final report.

10 A Signal intensity in the naso, oro and hypopharynx is
11 normal.

12 Q Stop right there. Tell the jury what that means.

13 A It means that they've done the study both with and
14 without contrast, but they haven't seen anything abnormal in
15 either the area above the soft palate or when you look in
16 the back of the mouth, you know, the pharynx, the part you
17 can look at when you open your mouth and look in the mirror,
18 or the hypopharynx, the part that goes down to the windpipe
19 and food pipe.

20 Q And the radiologist writes a sentence starting with I
21 see, can you read that?

22 A I see no evidence of mass or abnormal enhancement.

23 Q And was his conclusion on the final report the same as
24 it was on the preliminary report?

25 A Same thing, no definite evidence of mass or abnormal

1 enhancement in the tonsils.

2 Q Do your records reflect that Mr. Miller came back to
3 see you on the second visit?

4 A Yes, my records reflect that he came back to see me.

5 Q On what date?

6 A April 2nd, 2013.

7 Q And on that day, just read to me what happened.

8 A Under the history, it says MRI was unremarkable of the
9 pharynx. He still has more erythema on the right than the
10 left.

11 Q Now, tell me this, what does that mean?

12 A This is in the history section, so that means I'm still
13 concerned, that means I've looked and there's still a little
14 bit more redness on one side than the other.

15 Q Is there redness on the left?

16 A This says he still has more erythema on the right than
17 the left. To me, he doesn't have redness on the left.

18 Q And then you have another comment there?

19 A He gave me some additional history where he -- it says
20 he took some sort of antibiotic in January from another
21 physician.

22 Q Go on.

23 A Then I go into the physical exam --

24 Q Let me ask you, do you have any independent memory of
25 this visit at all?

1 A No, I'm going strictly by my records.

2 Q That's why I want you to read it off the record?

3 A Okay. He has severe septal deviation with nasal airway
4 obstruction with previous boxing injuries. Neck has no
5 abnormal masses. Hypopharynx is unchanged. Ear canals are
6 clear. TMs are intact.

7 Q Okay.

8 A Then it says, Keflex with a refill was transmitted to
9 Wal-Mart.

10 Q What is Keflex?

11 A Keflex is an antibiotic.

12 Q Why did you give him an antibiotic?

13 A Well, because nothing shows up on the MRI and the
14 redness is less and something is making him better, and the
15 additional history that he had had a similar condition back
16 in January and was treated with an antibiotic from another
17 physician and improved.

18 Q Okay. In the records, there's a line there -- these
19 things are kind of stuck on that page; is that right?

20 A Correct.

21 Q Is that part of your recordkeeping system?

22 A Yes, it is.

23 Q How did that work?

24 A Well, I dictated this. I paid a transcriptionist to
25 type them on an 8-by-11 sheet and then they're cut with a

1 paper cutter and they're placed in each individual patient's
2 record.

3 Q So you dictate a lot, different patients?

4 A Different patients.

5 Q And between the entries, there's a line that says
6 4/23/13; is that right?

7 A Correct.

8 Q What does that say?

9 A It says 4/23/13, six foot, zero inches, 235 pounds,
10 blood pressure 149/76.

11 Q And it's got a signature there?

12 A SW.

13 Q What would that indicate to you?

14 A That would indicate that my clinical assistant has
15 taken his blood pressure and weighed him and taken his
16 height.

17 Q And then you have notes on the 23rd. This would be the
18 third visit, right?

19 A Yes.

20 Q Okay.

21 A 4/23/13, so three weeks later. And I put in italics
22 here, which tells me that I want to pay attention to this
23 particularly. He is on Plavix now, having had three stents
24 placed last week. Then I put his throat is feeling better.
25 There was no visual or palpable pathology in the oral cavity

1 or oropharynx. Can I say something?

2 Q Yes.

3 A That's significant to me, too, because remember, my
4 picture -- I sort of just sort of put some scratches back
5 there where this spot in back of throat is. And so I'm very
6 specifically saying there to myself that in both the oral
7 cavity or oropharynx, there's no visual or palpable
8 pathology.

9 Q And how would you look at that?

10 A With my headlight and to palpate it, to feel it.

11 Q And there's no laryngoscope on here. You didn't mean
12 like you did on the first visit?

13 A No, I only did that on the first time. The flexible
14 laryngoscopy was done one time on the first visit.

15 Q Okay. And why would you bill for doing that?

16 A Well, those are expensive. They have their own light
17 sources. But I wouldn't do that -- we wouldn't do that to
18 the patients because there's a separate charge for that.

19 Q But for the mirror and the headlight and all that,
20 there's no separate charge?

21 A No, that's part of the evaluation and management code.

22 Q Keep going.

23 A Hypopharynx is grossly clear. He does have septal
24 deviation with some nasal airway obstruction. Ear canals
25 have a small amount of wax. TMs are intact. Neck has no

1 abnormal masses. He will followup prn, or as the situation
2 demands.

3 Q Did you ever see Mr. Miller again?

4 A I never heard from him again.

5 Q There are two more dates down there, what are those?

6 A This is my handwriting, 4/20/16, records faxed to
7 McGowan, LLC, and then that's their main number. And then
8 the second is 6/29/16, records faxed to McGowan, LLC, and
9 that's their fax number.

10 Q Let me ask you, back at the first visit, why did you
11 order the MRI?

12 A Well, because I've got a man here, his complaint is
13 spot in back of throat. Yes, he smoked for eight years or
14 so, but it was a long time ago. I'm trying to figure out
15 what might be causing this. I'm thinking what are the more
16 common things, but I'm trying to cover all the bases. An
17 MRI can visualize those soft tissues that are deeper than
18 what I can see.

19 Q Will it tell you if there's a mass there?

20 A An MRI?

21 Q Yes.

22 A Yes. They're very sensitive and yes, they would tell
23 me if something was there.

24 Q Did the Dorn VA ever request your records?

25 A No.

1 Q Did any other physician ever request Mr. Miller's
2 records?

3 A No, no physician ever requested these records.

4 Q And so after 4/23 of '13, your records indicate that
5 Mr. Miller was told to followup prn, did you ever see him
6 again?

7 A I never heard from him again.

8 Q You heard Mr. Miller's testimony in this courtroom,
9 right?

10 A Yes.

11 Q Is it safe to say that that's different from your
12 records?

13 A Yes.

14 Q And you have no memory outside of your records?

15 A No.

16 Q Do you stand by these records?

17 A Yes.

18 Q Looking back over this -- you've had your deposition
19 taken in this case?

20 A Yes.

21 Q You have read the deposition of other experts in this
22 case?

23 A Yes.

24 Q You've read Mr. Miller's deposition in this case,
25 right?

1 A Yes.

2 Q After looking back at all of that and looking back at
3 your records, since you have no memory of it, would you
4 change the way you treated Mr. Miller in any way?

5 A No. I would do -- given a patient who came in with
6 this complaint for just three weeks with something similar
7 treated by someone else three months previously, with a
8 negative MRI, which is a very sensitive test, and a red spot
9 that has gradually gone away, I wouldn't do anything
10 different.

11 Q Do you believe that you complied or comported with the
12 appropriate standard of medical care given your treatment of
13 Mr. Miller?

14 A Yes. I'm also comfortable -- I think it's important,
15 this last line where it says he will followup prn or as the
16 situation demands because Mr. Miller has established rapport
17 with me, trust with me. I know that he will come back after
18 a scan. I know that he will come back five days after a
19 cardiac stents. So I'm confident that if something comes
20 up, he'll call.

21 MR. DAVIS: Please answer any questions Mr. McGowan
22 has.

23 THE COURT: Mr. McGowan.

24 MR. MCGOWAN: Yes, sir.

25

CROSS-EXAMINATION

1 BY MR. MCGOWAN:

2 Q Dr. Wilson, let's be clear about this, you're suffering
3 from a mental disability that prevents you from engaging in
4 any gainful employment at this time; is that right?

5 A My physician says I have disabling anxiety.

6 Q The social security administration says that, also?

7 A Yes.

8 Q And you've been struggling with that mental health
9 condition, what you told us before, your entire life; is
10 that right?

11 A I would not describe it as that, but I would say in
12 retrospect, I've probably managed anxiety all my life. But
13 it certainly was not affecting my practice in 2013.

14 Q I want to be very clear about the next set of
15 questions, Doctor. Is it true that cancer was on the table
16 when you saw him in March and April, it was in the
17 differential?

18 A It was part of the differential.

19 Q So it was a possibility?

20 A Yes.

21 Q And if cancer is on the table, the standard of care
22 required you to rule it in or rule it out, true?

23 A No, the standard of care would be for me to follow that
24 and if it persist, then, perhaps, consider the next step of
25 biopsy. But if it goes away, then it would be much more

1 likely one of the other things that I previously mentioned
2 that are more common.

3 Q So if cancer is on the table, you don't have to rule it
4 out, is that what you're telling us?

5 A I can repeat my answer. I said if the red spot that
6 the patient complained about goes away, what am I going to
7 biopsy?

8 Q That wasn't my question. My question was are you
9 obligated by the medical standard of care to rule out cancer
10 if the presenting signs and symptoms of that patient make
11 you think that it could be cancer?

12 A I'd like to answer your question the way I think any
13 physician would. Our obligation or commitment to the
14 patients is to take a history, do a physical exam, order
15 tests judiciously, make an impression and then make a plan
16 that the patient agrees with. And in this case, I had
17 followed this what he called spot and it gradually went away
18 as quick as he said he had had it.

19 Q I'm going to try again, Doctor. Simple question. If
20 cancer is on the table, does the medical standard of care
21 require you to rule it in or rule it out?

22 A I would say that the standard of care requires me to
23 follow it until it's either gone or I would take the next
24 step.

25 Q I'm sorry, is that a yes, you do have to rule it in or

1 rule it out or no, you do not have to rule it in or rule it
2 out? I'm trying to be plain.

3 A I'm trying to be plain, too. It requires me to follow
4 until whatever the gentleman is complaining about clears up.
5 If it doesn't, then I think we'd take the next step.

6 Q So do you have to rule it out or not?

7 A Well, again, when the lesion is getting smaller, you
8 know, I want to follow it until it gets better or, if it
9 doesn't, then I'm going to consider the next step.

10 MR. MCGOWAN: Your Honor, we're going to have to get
11 into his deposition. This is the original.

12 THE COURT: All right.

13 BY MR. MCGOWAN:

14 Q Do you remember giving a deposition in my office in
15 this case?

16 A Yes.

17 Q And you remember there was a court reporter there that
18 took down every word that you said, right?

19 THE COURT: Let's go ahead and have it marked.

20 MR. MCGOWAN: Yes, sir.

21 (Whereupon, Plaintiff's Exhibit No. 9 was marked for
22 identification.)

23 BY MR. MCGOWAN:

24 Q That's the transcript from your deposition that we
25 took, your sworn statement we took a while ago. Would you

1 turn to Page 23, please, Line 23?

2 A Okay.

3 Q And I asked you the same question a while ago. And I
4 asked you, Now, once cancer is on your differential
5 diagnosis, do you as a medical doctor have an obligation to
6 rule out cancer?

7 A May I read the answer?

8 Q I'm going to read it. You can make sure I get it
9 right. First of all, I don't even like calling this cancer
10 because I've never called it cancer in my notes. I've
11 called it an erythematous firm region. But yes, I want to
12 be ruling out anything that I might be able to help the
13 gentleman with.

14 Is that an accurate reading of your statement?

15 A I mean, I can read it again if you'd like, but that
16 sounded accurate.

17 Q Okay. And could you please turn to Page 26, Line 24 or
18 your sworn statement?

19 A (Witness complies.)

20 Q And there, I asked the question, Starting on March
21 26th, 2013, did you have an obligation to Mr. Miller to rule
22 out his problem being caused by cancer? It seems like your
23 answer is yes or no, and you can explain all you'd like to,
24 Doctor. Your answer, Okay --

25 A May I interrupt?

1 Q No. I'll say and I'll explain --

2 THE COURT: Hold on a second. He gets to finish his
3 question. Once he's finished, then you can answer. No
4 interruptions.

5 BY MR. MCGOWAN:

6 Q Then your answer was, Okay, well, if you're phrasing it
7 that way, I'll say yes and I'll explain with whatever I've
8 already explained.

9 So let me put it one more time on the table here,
10 Doctor. If cancer is in your differential, do you have to
11 rule it in or rule it out?

12 A It sounds like we were having the same discussion
13 during the -- what this is called --

14 Q Deposition.

15 A And here, I say, Okay, well, if you're phrasing it that
16 way, I'll say yes and I'll explain with whatever I've
17 already explained. And I think that's where I go over again
18 trying to explain when the patient comes in with the
19 complaint that Mr. Miller did, spot in back of throat and
20 I'm thinking about all the things it could be. And like I
21 said, it's getting better. I find out the additional
22 history. I mean, I don't want to bore the jury again, but
23 I'm considering things that this can be. And there's
24 becoming nothing to biopsy, the thing has gone away.

25 Q Are you unable to answer my question to you as to

1 whether you are obligated by the standard of care to rule in
2 or rule out cancer once it's on your differential diagnosis?
3 Are you unable to answer that question, Doctor?

4 A I'll go with what I said at the deposition.

5 Q Which is yes, you are obligated to rule in or rule out
6 cancer if it's on your differential diagnosis?

7 A My answer in the deposition is, Okay, well, then if
8 you're phrasing it that way, I'll say yes and I'll explain
9 it with what I've already explained.

10 Q Is it true that you have an obligation as a doctor once
11 you have a condition that might be cancer to rule it in or
12 rule it out?

13 A If it goes away -- I think Mr. Miller and I had a good
14 plan that he would follow up as the situation demands.

15 Q Okay. Are you understanding my question, Doctor?

16 A I believe so.

17 Q So I'm going to try to pose it as a yes or no and you
18 can explain all you want to. And this will be my last try.
19 Do you have an obligation as a doctor under the standard of
20 care to rule out or rule in cancer once it's on your
21 differential diagnosis?

22 A Well, again, I sat here in the deposition and I'm
23 repeating it here again saying okay, well, if you're
24 phrasing it that way, I'll say yes. So there's your yes.
25 And I'll explain it with what I've already explained.

1 Q Okay. And the only way to rule in or rule out cancer
2 in this situation is a biopsy; isn't that true?

3 A No. What am I going to biopsy?

4 Q Is it your testimony that an MRI can rule out cancer?

5 A No.

6 Q The way cancer is diagnosed in this field is a specimen
7 of tissue is sent to the lab to be looked at by a
8 pathologist; is that true?

9 A A biopsy can be helpful, that's correct, but if your
10 biopsy comes back negative, that doesn't rule out cancer.

11 Q Every day and across the country, a biopsy is the gold
12 standard for ruling in and ruling out cancerous tissue, is
13 that true or is that not true?

14 A Well, you've got to have something to biopsy.

15 Q Just answer the question, Doctor, then you can come up
16 with whatever -- you can say whatever you want after that.
17 I just need an answer to the question. This is an important
18 process. I hope you understand that. Is biopsy the way
19 cancer is ruled in or ruled out in a situation like this?

20 A I believe there's somewhere in the deposition where it
21 says a biopsy can be helpful.

22 Q No, not helpful, it is the way it's done; isn't that
23 right, by ENTs countrywide, true?

24 A Well, like I say, even a biopsy -- if the biopsy comes
25 back negative, that doesn't rule out cancer.

1 Q All right. I'm going to try this again. Page 34.

2 A Of my deposition?

3 Q Yes.

4 A Okay.

5 Q What you said there -- my question was, The way cancer
6 is ruled out when --

7 A I'm sorry, what line?

8 Q Line 9. When a physician has a concrete concern for
9 malignancy is by way of looking at the tissue directly,
10 right? And you said, That's correct. Isn't that true?

11 A May I answer?

12 THE COURT: He asking for an answer.

13 THE WITNESS: What's the question?

14 BY MR. MCGOWAN:

15 Q When we talked about this in October of 2017, you
16 agreed then and you agree now that biopsy is the way that
17 cancer is ruled in or ruled out in a situation like that; is
18 that true?

19 A It says, That's correct. Then it says, Can I add
20 something? And there was the answer I added. As a
21 physician, if I did biopsies on everybody who came in with a
22 firm red spot, I would be doing way too many biopsies. So
23 what you're saying about biopsies is correct, that's the way
24 to make a definitive diagnosis, but as a physician, I have
25 to be judicious on who I do that on because most of these

1 areas are going to clear up like they did in Mr. Miller.

2 Q So you want to run biopsies on patients who might have
3 cancer; is that true?

4 A Pardon me?

5 Q You want to do a biopsy on a patient who might have
6 cancer, right?

7 A If the lesion persist and you suspect it might be a
8 malignancy, a biopsy can be helpful, yes.

9 Q So if you think the patient might have cancer, you
10 should do a biopsy, true?

11 A If the lesion persist.

12 Q You were under the belief that Mr. Miller might have
13 cancer, true?

14 A I would say that's not true. I knew he had a red spot.
15 And then -- may I refer to my record because that's
16 recollection? I referred to it as a erythematous firm spot.
17 So I can deduce from that when I'm calling it spot that I'm
18 not sure that it's a lesion or a nodule or a mass. All I
19 know is I've drawn some little scratchy areas in a small
20 area above the tonsil and I know that's an area I'm
21 concerned about.

22 Q Your medical record says, Carryover diagnosis of
23 malignant neoplasm tonsil. That's cancer, right?

24 A That's a diagnosis tie generated by the electronic
25 medical record and it's there because it was used for the

1 sign and symptom on the MRI schedule. We needed a diagnosis
2 for what we want the radiologist or whoever is going to read
3 the MRI to look at, so that's why that's there.

4 Q You signed this record down at the bottom? It's signed
5 electronically by you?

6 A That's correct.

7 Q So we have another one, it's on your bill. It's say
8 malignant neoplasm of tonsil, right?

9 A What's the question.

10 Q On your bill, it says malignant neoplasm of tonsil.
11 It's the problem list, true?

12 A I'd have to look at that. I don't have that in my
13 chart.

14 MR. MCGOWAN: May I approach?

15 THE COURT: Yes, you may.

16 THE WITNESS: Would you like to ask the question again
17 so I make sure I answer it correctly?

18 BY MR. MCGOWAN:

19 Q You billed this on the problem list malignant neoplasm
20 of tonsil, correct?

21 A Again, these look like the same diagnosis ties that are
22 generated by the MacPractice software.

23 Q Is that a yes, the malignant neoplasm of tonsil is
24 listed on this record from your office as part of the
25 problem list?

1 A Yes. I'll say yes to that.

2 Q And you ordered the MRI and you put septal deviation,
3 neoplasm M tonsil. The M stands for malignant; isn't that
4 true?

5 A In our diagnosis database, neoplasms can either be B
6 for benign or M for malignant and when we put a diagnosis,
7 we have to select one.

8 Q And you -- it was handwritten on this form signed by
9 you, it says neoplasm M, for malignant, tonsil, true?

10 A That's true, that's part of the differential at this
11 point, yes. It's not the diagnosis or the impression, but
12 it's part of the differential.

13 Q His condition that you saw led you to believe that he
14 could have cancer, true?

15 A Well, looking at this, it also says acute tonsillitis,
16 so I was thinking that, too.

17 Q Acute tonsillitis with a firm region that's not painful
18 on one side, is that it?

19 A Well, remember, the patient gave me additional history
20 on the second visit, that he had been to another physician
21 and taken an antibiotic two or three months previously and
22 got better. So I would say yes, what you said is true.

23 Q So did you believe it was equally likely to be acute
24 tonsillitis with a nonpainful, firm region on one side only
25 versus a malignant neoplasm?

1 A I think I was being a good physician by taking
2 additional history and getting more information, seeing how
3 it changed over time. I mean, this could have been neither
4 tonsillitis or neoplasm. It could have been a tonsil stone
5 or, like I said, a bruise from the toothbrush hitting it.
6 Perhaps, he felt it too much, I don't know, or he had the
7 high blood pressure and he had a blood vessel pop. It could
8 have been lots of things. And the judicious thing was to
9 follow this gentleman since he was improving and get more
10 information from the MRI like we did and have him come back.

11 Q The thing on your list that really had the potential to
12 hurt him bad was cancer, right?

13 A Certainly, a neoplasm -- I mean, of all those things,
14 that's the one I would like to have least. Of course, it
15 wasn't until three years later that he was actually
16 diagnosed with that.

17 Q You never discussed with Mr. Miller a biopsy, did you?

18 A No, there was nothing to biopsy. And when he told me,
19 that his throat was feeling better and I couldn't feel --
20 there was no visual or palpable pathology in the oral cavity
21 or oropharynx, I didn't know what I would tell him I was
22 going to biopsy.

23 Q Did you ever on any of those three visits discuss
24 biopsying that spot?

25 A No, but I'll say this, the way that I was trained for

1 tonsillar -- suspected tonsillar neoplasm was to do a
2 tonsillectomy because that would be both diagnostic and
3 therapeutic. So since this gentleman was getting better and
4 he was on a blood thinner and he was five days out from a
5 cardiac stent and I had a good rapport with him, I knew he
6 would come back, I felt comfortable with our agreement that
7 he would follow up as the situation demanded.

8 Q So was that a no, you never discussed biopsying this
9 lesion ever?

10 A I have to go by the record. I don't see anything about
11 biopsy in this record.

12 Q Did you ever tell him that biopsy was the only way to
13 rule in or rule out cancer reliably?

14 A I don't think we got to the point -- since his area
15 cleared up and I couldn't see or feel anything, we didn't
16 get to the point where we were talking like that.

17 Q So the answer to my question is no, you never told him
18 that biopsy was the only reliable way to rule in or rule out
19 cancer; is that true?

20 A I can only go by my records. I don't have any other
21 independent recollection.

22 Q And your records do not indicate such a discussion,
23 true?

24 A No, we've already gone over all the records.

25 Q So for purposes of our trial, the evidence that we have

1 in this case, it is, in fact, true that you never discussed
2 a biopsy and the role of a biopsy in ruling in or ruling out
3 cancer for Mr. Miller, true?

4 A I would say since his throat was feeling better and
5 there was no visual or palpable pathology in the oral cavity
6 or oropharynx, we didn't get to that stage.

7 Q It's going to be a lot easier I think for everybody to
8 follow us, Doctor, if when I ask a question, if you don't
9 understand, please let me know. But if you do understand,
10 please answer it and then feel free to explain however you
11 like, okay? Can we do that?

12 A I can keep trying.

13 Q Okay. So it is, in fact, true that you never -- well,
14 did you ever tell Mr. Miller that this might be caused by
15 cancer?

16 A I have to go by my record and I don't see it.

17 Q If you believe a patient might have cancer, does the
18 patient have a right to know that?

19 A I think the patient would be wanting to know why I was
20 getting these other -- or why he was being charged for
21 flexible laryngoscopy and for magnetic resonance image and
22 so forth. I'm sure I had -- I have to go by my record. All
23 I know is I ordered that test.

24 Q Let's take this one step at a time. I'm going to ask
25 you a very direct question. Does the standard of care

1 require an ENT to inform his patient that cancer is on the
2 differential diagnosis?

3 A I'm going to -- I'm going to say no. The standard of
4 care -- if you ask what the standard of care is, it's what a
5 reasonably trained physician would do under the same
6 circumstances with a similar patient. That's what the
7 standard of care requires.

8 Q All right. Turn to Page 51 in your deposition.

9 A Okay.

10 Q Line 10. I'm going to read it and you tell me if I
11 read it correctly.

12 Question: That's not my question, Doctor. Does the
13 standard of care require an ENT to inform his patient that
14 cancer is on the differential diagnosis?

15 And your answer was, I'll say yes.

16 Is that correct?

17 A That's correct, that's what this says.

18 Q Is that your testimony today, that it is, in fact, the
19 standard of care to inform your patient that cancer is on
20 the differential diagnosis?

21 A And I will go down to Line 25 on the same page where it
22 says, If he still has something abnormal, yes.

23 Q Not my question, Doctor. Is it your testimony today --
24 does the standard of care require an ENT to inform his
25 patient that cancer is on the differential diagnosis? Is

1 your answer today still yes?

2 A I'll go with what my deposition says.

3 Q So the standard of care does require you to tell him
4 that cancer is on the differential, right?

5 A Yes.

6 Q Based on your chart, you never informed Mr. Miller that
7 cancer was on your differential diagnosis, true?

8 A I have to go with what the chart says.

9 Q So is that correct that your chart does not reflect
10 that you informed him cancer was on the differential?

11 A I'll say yes to that.

12 Q So based on the medical evidence we have in this trial,
13 you would have deviated from the medical standard of care
14 because you did not inform him that cancer was on the
15 differential diagnosis, true?

16 A I disagree with that because at the end of -- when we
17 finished -- this was what I would call an acute problem,
18 acute meaning reversible. If I still thought that he had
19 something there or if he still thought he had something
20 there -- we both agreed that his throat was feeling better
21 and there was nothing there that either of us could see or
22 palpate.

23 So I don't think you want to be scaring every patient
24 that comes in, yes, you could have cancer. You want to do
25 what I've described, take their history, do an exam, order

1 tests judiciously, make an impression and plan, follow that.
2 And if it goes away just as quick as it came, then I think
3 the better plan is to have the patient follow up as the
4 situation demands.

5 Q Based upon the medical evidence that we have in this
6 trial, which is your chart, and based upon what you say the
7 standard of care requires, we know that you did not meet the
8 standard of care relative to Mr. Miller because you did not
9 inform him that cancer was on the differential diagnosis,
10 true?

11 A I disagree with that. I'm not going to scare -- like I
12 said, we can go to my deposition here, I don't think it's --
13 maybe we should go over it so we make sure we get this
14 correct. Do you remember the page?

15 Q To be honest with you, Doctor, I don't have any idea
16 what you're talking about.

17 A We went over it a few minutes ago. Here it is. Page
18 34, Line 18, As a physician, if I did biopsies on everybody
19 who came in with a firm red spot, I would be doing way too
20 many biopsies.

21 So what you're saying about biopsies is correct, that's
22 the way to make a definitive diagnosis, but as a physician,
23 I have to be judicious on who I do that on because most of
24 these areas are going to clear up like they did in Mr.
25 Miller.

1 Q Something about the spot made you think it could be
2 cancer, true?

3 A That was part of the differential because that's a sign
4 or symptom that we told the radiologist we wanted him
5 looking for.

6 Q Does the standard of care require the ENT to inform his
7 patient that an MRI does not rule out cancer?

8 A Could you repeat the question?

9 Q Yes. Does the standard of care require an ENT to
10 inform his patient that an MRI does not rule out cancer?

11 A I'll say yes to that.

12 Q And based on your chart, you did not inform Mr. Miller
13 of that, true?

14 A I have to go by what the chart says.

15 Q And your chart does not say you informed him,
16 therefore, you didn't, true?

17 A No, the chart says that we ordered the MRI and that
18 when he came back a week later -- in our history, it says
19 MRI was unremarkable of the pharynx. So this is the part
20 where we're talking back and forth with each other.

21 Q Does the chart reflect that you informed the patient
22 that the MRI did not rule out cancer?

23 A The word cancer is not in this chart. It's in your
24 part of the deposition a lot, but it's not in my chart.

25 Q All right, fine. Does your chart reflect that you

1 informed Mr. Miller that the MRI did not rule out malignant
2 neoplasm of the tonsil?

3 A No, the chart doesn't say that.

4 Q Okay. And therefore, you didn't do it because we're
5 going by your chart, right?

6 A I am going by the chart because I don't have an
7 independent recollection of Mr. Miller's visit.

8 Q So based on the medical evidence we have in this trial
9 in this case, in this day, you deviated, you fell below the
10 standard of care because you did not inform him that the MRI
11 did not rule out cancer, isn't that the case, Doctor?

12 A I would not agree with that statement. Again, the
13 standard of care is what a reasonably trained physician
14 would do with a similar patient under similar circumstances.
15 And this lesion went away as quick as it came, in a period
16 of weeks.

17 Q Do you deny that you told Mr. Miller that he didn't
18 have to worry about the C word?

19 A I have to go by my chart. If it's not in my chart. I
20 mean, I'm going to go by what's in the chart. I kept good
21 records.

22 Q Did you tell him you don't have to worry about the C
23 word?

24 A It's not in my chart.

25 Q So you didn't say that? You didn't tell him you don't

1 have to worry about the C word?

2 A Can you ask me the question that you want me to answer?

3 Q I'm sorry, I thought I did. Did you tell Mr. Miller
4 that he didn't have to worry about the C word, the C word
5 being cancer?

6 A No, I don't see that in my chart.

7 Q Did you meet with him in your office on that third
8 visit?

9 A I believe he had to come to the office, that's the only
10 way I would have known that he's now on Plavix, having had
11 three stents placed last week.

12 Q Did you have a place in your office building that had a
13 desk in it that was not an exam room?

14 A I did have an office space that had a desk in it, that
15 was used primarily for facial, plastic and surgery patients.
16 It was a consultation room.

17 Q Do you deny that you met with Mr. Miller in that space
18 to discuss the MRI findings on that third visit?

19 A I have no independent recollection. I don't know which
20 room we used for these -- well, let me rephrase that. I
21 don't know if we went into any other rooms besides the exam
22 rooms. I know we went into the exam rooms because I did
23 exams on him. But I don't know if we went in any other
24 room.

25 Q Doctor, it is your position, isn't it -- you've seen

1 this photo before from the VA, right?

2 A I've seen that photo.

3 Q That's the same area that you drew in 2013?

4 A I can't tell from that photo.

5 Q Okay.

6 A May I say one other thing? I've read those records
7 from the VA and they refer to the tongue base, they refer to
8 the oropharynx, the hypopharynx. I've heard Mr. Miller
9 refer down here into the neck. I don't know where that
10 started.

11 Q So are you capable -- and I'll hand it to you if you
12 want to look at it. It is true that an abnormal growth is
13 in the same area 2016 as 2013?

14 A Again, you know, he was treated for that three years
15 after I saw him and I don't know where that started.

16 Q I'm not asking you where it started, I'm asking you
17 where it is. On these two pictures, they're in the same
18 spot, right?

19 A I'd have to look at a closer view. I mean, I can share
20 with the jury, you know, what I see as a physician here.
21 Here's my drawing, the uvula and here's the uvula over here.
22 Here is something that's not supposed to be there. The
23 tongue is down here where my fingers are. This little spot
24 where -- in my chart in 2013 where I've drawn some scratches
25 back and forth would be up in this area, you know, where the

1 superior part of the tonsil meets the oropharynx. And this
2 mass is down here. Like I say, I didn't take this picture,
3 but if you ask me to look at it, that's what I see.

4 Q It's the same area?

5 A No, that's not what I said. I said this area is down
6 here. My fingers would be the tongue. What I've drawn is
7 up here, but this mass is down here.

8 Q Do you see where it's connected at exactly where you
9 drew it?

10 A I tell you what, I can't see where it's connected. I
11 mean, we can pass this around -- well, they'll have this to
12 look at, won't they?

13 Q Yes, sir. It's your opinion that it's pure coincidence
14 that he had that firm nodule that you saw in 2013 and he had
15 Stage 4 tonsil cancer in the same area, right? Pure
16 coincidence?

17 A Let me phrase that and answer like this, I wouldn't
18 wish what Mr. Miller has had on anybody, but what he saw me
19 for in 2013 and how it came and went in a period of weeks
20 and then three years later, he gets this -- and when you
21 read the VA records -- I hope the jury has the VA records
22 because it doesn't say -- I mean, well, I don't have them
23 here in front of me, so I can't quote them, but they'll be
24 able to see what the VA says in regards to where this is.

25 Q My question is simple. You think it's purely

1 coincidental that what you saw in 2013 and what was proven
2 to be Stage 4 cancer in 2016 is pure coincidence being in
3 the same area; is that right?

4 A First of all, I don't agree with your statement that
5 it's in the same area. And then could you ask me any
6 additional question you'd like.

7 Q All right. So you don't even think this cancer is in
8 the same spot?

9 A The picture you're showing me there, that's the tongue
10 base and my drawing is the superior aspect of the right
11 tonsil region in the oropharynx, oral cavity area.

12 Q So you don't think it's the same spot? You don't think
13 it's the same area?

14 A I tell you, the resolution of this is not very well and
15 I can only go by my recollection of the VA records.

16 Q Let's look at some of these. This is from ENT consult
17 of February 11th. The patient has had issues with tonsils
18 for years, swelling, sore to swallow, needs evaluation if
19 possible, removal. Veteran with mild sore throat and lump
20 in throat sensation for one to two years. No dysemia, no
21 stridor, no dysphasia, no hemoptysis, right? That's what
22 the VA record says, doesn't it?

23 A One to two years, that would put him back after I saw
24 him.

25 Q We have this hematology and oncology consult March

1 29th, and it says 65-year-old male with hypertension,
2 coronary artery disease, referred from ENT clinic with
3 tonsillar cancer. Patient states that three years ago, he
4 started experiencing intermittent right-sided sore throat.
5 Says he was seen by a local ENT in Rock Hill. That's you,
6 right?

7 A I'd like to see this record if I'm going to answer
8 questions about it.

9 Q I'm going to keep reading and you -- it's in there,
10 we'll show you. By local ENT in Rock Hill, who ordered MRI
11 of neck, which patients states he was told did not reveal
12 malignancy. Patient states he had been placed on multiple
13 antibiotics over the past three years with minimal relief
14 with his sore throat. Because of his chronic tonsil
15 problems, he wanted to have tonsils removed. That's what
16 the VA record says, isn't it?

17 A Again, from this angle, I can't see that very well. If
18 I'm going to answer questions about it, I'd like a copy of
19 it to look at.

20 THE COURT: Let's do this, I suggest, let's allow him
21 to stand, give him the microphone and you put the records
22 up. He can see them and read them there. That may be a
23 little more efficient.

24 If you'll step down.

25 Hand him the microphone, Madam Clerk.

1 Let's be sure he's in a position where he can see what
2 you're reading.

3 (Witness steps down.)

4 BY MR. MCGOWAN:

5 Q 65-year-old male, hypertension, coronary artery
6 disease, referred to the ENT clinical for tonsillar cancer.
7 Patient states that three years ago, he started experiencing
8 intermittent right-sided sore throat. He states he was seen
9 by a local ENT in Rock Hill, who ordered an MRI of neck,
10 which patient states he was told did not reveal malignancy.
11 Patient states he has been placed on multiple antibiotics in
12 the past three years with minimal relief of his sore throat.
13 Patient states because of his chronic tonsillar problems, he
14 wanted to have his tonsils removed.

15 That's what this VA records say, correct?

16 A Will you ask the question again, please?

17 Q I properly read the VA record, which states it had been
18 going on for three years. He had seen an ENT in Rock Hill,
19 that would be you, and he got an MRI and was told everything
20 was fine.

21 A May I look at my record?

22 Q Sure.

23 A We reviewed his MRI on the second visit and the
24 reference is the MRI was unremarkable of the pharynx. It
25 doesn't say anything about me telling him he doesn't have

1 cancer or he does have cancer. It doesn't say anything
2 about cancer.

3 Q And in Dr. Thakkar's record, he was the radiation
4 oncologist. You know him, right? Do you know Dr. Thakkar?

5 A I know the name, yes.

6 Q And he writes, patient is a delightful 65-year-old
7 nonsmoker. Marine veteran presenting with large tonsillar
8 cancer. He noticed some tonsil irritation about three years
9 ago, at which time, he saw an ENT in Rock Hill. Workup was
10 negative at the time. Symptoms persisted, but he's clear
11 that they did not progress significantly until recently when
12 he sought additional treatment from Dr. Wells after bringing
13 up this issue with PCP. That's what his medical record
14 says, doesn't it?

15 A To answer your question, that's correct, that's what
16 that says.

17 Q You can your seat, we're almost done.

18 A (Witness retakes the stand.)

19 Q At the time that you saw Mr. Miller, were you aware,
20 were you conscious of the fact that went undiagnosed, it
21 could do him serious harm?

22 A Can you repeat the question?

23 Q Yes, sir. When you saw Mr. Miller in March and April
24 of 2013, were you aware, did you have conscious knowledge
25 that if he had a cancer that was undiagnosed, it could do

1 serious harm or even kill him?

2 A I did not think he had anything. He said he didn't
3 have anything and I could not see or feel anything.

4 Q Not my question, Doctor. Let's be a little more
5 general. In 2013, did you know as a medical doctor in this
6 field, did you have conscious awareness, conscious knowledge
7 of the fact that undiagnosed cancer of the tonsil can
8 seriously harm and even kill a patient?

9 A Yes.

10 Q And you knew -- last question. All this business about
11 a bruise or hitting with a toothbrush or some sort of -- the
12 only thing you listed about that tonsil in your medical
13 record that you signed off on was malignant neoplasm; isn't
14 that true?

15 A That's incorrect. You showed me this, it says acute
16 tonsillitis and then we talked about earlier high blood
17 pressure. You know, something could have popped in a vessel
18 there in the mouth. Red cells become erythematous because
19 they get oxygen through the mucosa. So there are -- to
20 answer your question, there are other things.

21 Q Okay. So what you're claiming is that you put
22 hypertension in there thinking that hypertension -- treated
23 hypertension might have caused him to have a firm buried
24 nodule?

25 A When I saw him on the first visit, all of these things

1 are going through my mind, whether it's a tonsil stone or
2 trauma or neoplasm, all of these things are going through my
3 mind. And that's the reason I ordered tests that I normally
4 would not order, the MRI. That's the reason I've also done
5 flexible laryngoscopy. Normally, I would do that on
6 somebody who has hoarseness or hemoptysis, but he didn't
7 have any of those. There's some reason I'm doing these and
8 that's because I'm looking for what's causing this
9 gentleman's spot in back of throat for three weeks.

10 Q We know for a fact, and you will admit, based upon your
11 record, that he had a spot on the 26th of March, a firm
12 region, true?

13 A I put here he has a erythematous firm spot on the right
14 posterior pharynx near the superior pole of the tonsil for
15 the past three weeks.

16 Q And he had it on the 2nd?

17 A It was getting better on the 2nd, but he still had some
18 erythema on the right.

19 Q And we know --

20 A Compared to the left.

21 Q And we know the MRI was between those two visits?

22 A Yes.

23 Q So we know for a fact that the MRI showed nothing about
24 this particular mass that we know for a fact he had on the
25 26th, and you will admit, even on the 2nd, true?

1 A We know that the conclusion of the MRI says no definite
2 evidence of mass or abnormal enhancement in the tonsils, so
3 -- I mean, whatever he had must have been small.

4 Q Well, he had it, right? The MRI didn't pick it up,
5 true?

6 A It looks like from my records I've put here that he --
7 this is his second visit. I put here he still has more
8 erythema on the right than the left. But then I've also
9 added this additional history, that he had taken some sort
10 of antibiotic in January from a different physician and so
11 I'm wondering if that might help him at this point.

12 Q We know he had a mass and we know the MRI didn't pick
13 it up, true?

14 A I wouldn't call -- you call it mass, cancer, lesion.
15 The only thing I call it -- on the first visit, I call it
16 erythematous firm spot and I describe where it is. On the
17 second visit, I call it -- I just call it redness. I don't
18 even call it firm, so I guess the firmness is gone.

19 Q Well, you didn't say it was not palpable, did you?

20 A I put here on the second visit, MRI was unremarkable of
21 the pharynx. He still has more erythema on the right than
22 the left. I talk about the antibiotic he had taken from
23 somebody else in January. But when it gets to my physical
24 exam, there's nothing about firmness.

25 Q Right, because you didn't check because it doesn't say

1 it was or was not palpable, true?

2 A I can only go by my record.

3 Q And it doesn't mention it one way or the other, does
4 it?

5 A It says severe septal deviation, neck has no masses,
6 hypopharynx is unchanged, TMs are intact.

7 Q So you didn't even poke it on that second visit?

8 A No, I wouldn't say that. I say his hypopharynx is
9 unchanged, so to get to the hypopharynx, you have to go
10 through the oropharynx.

11 Q Did you make any comment on your record whether that
12 nodule, that region, that spot, whatever you want to call it
13 was palpable on that second visit?

14 A I don't see anything like that on that, no.

15 Q And we know, we, being me and you, and all ENTs know
16 that MRIs can miss cancerous lesions, right?

17 A I mean, I ordered this MRI to get additional
18 information.

19 Q Try again. ENTs -- it is well known to ENTs that MRIs
20 can miss cancerous problems, true?

21 A I mean, an MRI is a pretty sensitive study, that's why
22 I ordered it. But can it miss it, sure.

23 Q And that's why the gold standard is biopsy?

24 A A negative biopsy doesn't tell you don't have cancer.
25 I mean, I want the jury to understand that you have to put

1 all of this information together, the timing, the history,
2 what he's been on previously, you know, how things are
3 changing over time, you know, the imaging is helpful. And
4 at the end, if there's something to biopsy, then that's the
5 next good step, but if there's nothing there that you see or
6 palpate, I mean, what are you going to biopsy? And,
7 certainly, it would put the gentleman at more risk to take
8 out his tonsils five days after a cardiac event.

9 MR. MCGOWAN: Thank you.

10 THE COURT: Any redirect?

11 MR. DAVIS: No, sir, Your Honor.

12 THE COURT: Dr. Wilson, you can step down.

13 (Witness steps down.)

14 THE COURT: Ladies and gentlemen, this is a good place
15 for us to stop this evening. Two things, be back tomorrow
16 at 10:00. We will start around 10:00. We've gotten some
17 indication where there may or may not be inclement weather.
18 When you leave, I think the clerk has a little short form
19 where you can call her number, the clerk's number. If there
20 is a delay, then she will have a recording on that number.
21 If there is not a delay, then go ahead and be here at 10
22 o'clock in the morning. I hope that the fear of
23 weather-related issues is just a normal southern reaction to
24 snow in the mountains. But on the other hand, call that
25 number. She may also give you the number for the county.

1 Sometimes that works and sometimes it doesn't, so do not
2 rely on that. If you believe it's going to be a delay, call
3 the number that she's going to provide for you. Hopefully,
4 we'll be able to start around 10:00 in the morning.

5 Again, don't do any research, no internet, social media
6 searches, talk about anything except what you've heard in
7 the courtroom.

8 Everyone remain seated while this panel is excused.

9 (Whereupon, the jury exits the courtroom and is excused
10 for the day.)

11 THE COURT: Anything further from the Plaintiff?

12 MR. MCGOWAN: No, sir.

13 THE COURT: Anything from the Defense?

14 MR. DAVIS: No, sir.

15 THE COURT: And Mr. Davis, I believe you have a witness
16 in the morning. Do you anticipate calling any witnesses
17 after that witness?

18 MR. DAVIS: No, sir. I had an e-mail from the doctor.
19 He's got some business that's going to take him into the
20 evening. So I don't know that he's going to be getting here
21 --

22 THE COURT: Let's do this, let's tell the jury to come
23 in at 11:00, you want to do that?

24 MR. DAVIS: That would be great.

25 THE COURT: Tell them that 11:00 should resolve all

1 issues, weather, experts, everybody else. Just tell them
2 we're going to start at 11:00.

3 Will that work for you?

4 MR. DAVIS: Yes, sir.

5 MR. MCGOWAN: Do you anticipate having the charge
6 tomorrow?

7 THE COURT: Yes. Mr. Davis had provided some proposed
8 charges. On the same token, I don't know if y'all have any
9 or not.

10 MR. MCGOWAN: We do.

11 THE COURT: If you will provide those to us this
12 evening and let's meet about 10:00. Can y'all be here at
13 10:00 or 10:15 and we'll talk about charges?

14 MR. MCGOWAN: Yes, sir.

15 THE COURT: All right. We'll be at ease until in the
16 morning.

17 (Whereupon, Plaintiff's Exhibit No. 11 was marked for
18 identification.)

19 (Whereupon, Court was adjourned for the day to be
20 reconvened on Wednesday, January 30, 2019.)

21 Wednesday, January 30, 2019

22 THE COURT: Plaintiff ready to proceed?

23 MR. MCGOWAN: Yes, Your Honor.

24 THE COURT: Defense ready?

25 MR. DAVIS: Yes, Your Honor.

1 THE COURT: Let's bring the jury in.

2 (Whereupon, the jury enters the courtroom.)

3 THE COURT: Good morning, ladies and gentlemen. I
4 appreciate your promptness. I hope everybody was warm. It
5 was 14 degrees at my house this morning. In fact, my wife
6 and I, I think, foolishly got up and walked. I don't think
7 I'll ever do that again.

8 With that, we're ready to proceed with the case.

9 Mr. Davis, if you'll call your next witness.

10 MR. DAVIS: Yes, Your Honor. The Defense would call
11 Dr. Joshua Hornig.

12 THE CLERK: Please stop here to be sworn. Please your
13 left hand on the Bible and raise your right.

14 JOSHUA HORNIG, M.D.,

15 after being duly sworn, testified as follows:

16 THE CLERK: Please have a seat.

17 DIRECT EXAMINATION

18 BY MR. DAVIS:

19 Q Good morning, Dr. Hornig.

20 A Good morning.

21 Q State your full name and spell your last name for the
22 court reporter.

23 A Joshua David Hornig, last name H-O-R-N-I-G.

24 Q Where do you live, Dr. Hornig?

25 A In Charleston, South Carolina.

1 Q And are you married?

2 A I am not.

3 Q Do you have any children?

4 A I do have three children.

5 Q What is your present occupation?

6 A I'm a head and neck surgeon at the Medical University
7 of South Carolina.

8 Q Dr. Hornig, I have a copy of your CV I'd like to go
9 through with you.

10 A Sure.

11 Q Would you give the jury the benefit of your education,
12 please, starting with high school?

13 A Sure. So high school, I went to the Marion Graham
14 Collegiate in Saskatoon, Saskatchewan. And from there, I
15 went to the University of Alberta for a degree with honors
16 as a chemist. Then from there, I went to medical school and
17 graduated from the University of Alberta and I graduated
18 with first class distinction and honors of research, only
19 two people in my class.

20 Q Alberta, Canada?

21 A Yes, sir. And then from there, I went and did a
22 residency in ENT at the University of Alberta. And after
23 those five years, this is 13 years in post-graduate
24 education, then I went down for a fellowship at the Medical
25 University of South Carolina to specialize in head and neck

1 cancer oncology.

2 Q What is a fellowship?

3 A A fellowship is where you subspecialize in a certain
4 area of a speciality, so you come kind of a super specialist
5 in one spot. So I did the head and neck surgical oncology
6 there as well as microvascular reconstructive surgery.

7 Q And are you Board certified?

8 A I am.

9 Q In what discipline?

10 A In otolaryngology head and neck surgery.

11 Q Are there any subspecialities under that?

12 A I have a certificate and a fellowship in that, but
13 there's not a specific Board for that.

14 Q What is the certificate and fellowship?

15 A It's for the head and neck surgical oncology and
16 microvascular reconstruction.

17 Q In what states are you licensed?

18 A South Carolina.

19 Q Where do you have privileges to practice?

20 A I practice exclusive at this time at the Medical
21 University of South Carolina in Charleston.

22 Q And have you had any faculty appointments at the
23 Medical University of South Carolina?

24 A I have. So I started as a clinical instructor, then
25 became an assistant professor and, currently, an associate

1 professor. I also had a position at the veterans hospital
2 in Charleston, which I no longer work there, though. I
3 cover emergency call there.

4 Q What is an associate professor? What do you do?

5 A As part of professorship, I would teach residents,
6 medical students, nursing about the specialty, how to become
7 a surgeon, learning about head and neck cancer, how to treat
8 it, how to diagnose it.

9 Q Are you a member of any professional societies or
10 associations?

11 A Sure. Yes, I'm a member of the South Carolina
12 Otolaryngology Society. I'm a member of the American
13 Academy of Otolaryngology. I'm also a member of the
14 American Head and Neck Surgery Society.

15 Q Are you on the editorial board of any publications?

16 A Yes. I review multiple different publications, more
17 numerous than we can list here, for six to 10 different
18 journals throughout the world.

19 Q When you say review, what does that mean?

20 A When people submit papers to go into a medical journal,
21 they have experts review those -- the research to see if
22 it's of high enough standard to be included in the journal.

23 Q Of the honors and awards you've received, just tell me
24 a couple of the most important ones to you.

25 A Some that I think are, I graduated one of only two in

1 my medical class, graduated with first class distinction and
2 honors in research, so everyone wants to have that and only
3 two of us received that distinction. When I finished
4 residency, I was given the top mark in the entire country.
5 And I'm also very proud when I went to apply for fellowship
6 to specialize, the fellowship at the Medical University of
7 South Carolina is considered one of the top fellowships in
8 the country, if not the world. So it's quite an honor to be
9 trained there and it's also still quite an honor to train
10 other people who've come after me.

11 Q And you've given presentations on medicine pretty much
12 around the world?

13 A I've given presentations I've submitted. I've been
14 invited to be a speaker on many different topics, including
15 throat cancers, tonsil cancers, fibroid cancers, all related
16 to my subspeciality, which is head and neck cancer.

17 Q You've authored 16 peer-reviewed publications as of the
18 date of this proceeding; is that correct?

19 A True. There's more since then, but when that was
20 published, yes.

21 Q What is a peer-reviewed publication?

22 A So, those are research that you submit to a medical
23 journal that is then reviewed by multiple reviewers that
24 makes sure that the quality that the research that you're
25 doing is worth to be published in a medical journal. So

1 it's quite arduous and there's usually multiple revisions
2 and there's multiple times that somebody will something and
3 it will not be accepted. So it's much more likely to not
4 have something accepted than to have it accepted.

5 Q And I notice you're musically trained; is that correct?

6 A I am. That was -- my first love was to be a classical
7 pianist and I decided that was too hard, it was much easier
8 to become a doctor.

9 Q Dr. Hornig, what are your present duties at MUSC?

10 A So, I'm currently -- from a practice standpoint, I
11 treat patients that have head and neck cancers. And I
12 either will be part of the team that removes those cancers
13 and make sure that we get all the cancer out. I also am
14 very involved in the reconstruction of the cancer after it
15 is taken out. So if you remove someone's jaw or their
16 throat or their tongue, you have to rebuild that so you can
17 optimize their ability to swallow. It's a very intensive
18 part of the operation, so I do that.

19 I'm also the director of our fellowship program, so
20 everyone that's a trained surgeon that now wants to become
21 subspecialized, they're directly under my teaching and
22 supervision. And also training residents, medical students,
23 nursing staff, sitting on committees of the hospital to
24 authorize efficiency. Lots of different hats.

25 Q And how did you become to be involved in this case with

1 Mr. Miller and Dr. Wilson?

2 A I was contacted by your office to see if I would give
3 an opinion on the care that was received.

4 Q All right. Have you ever worked with me before?

5 A No.

6 Q Or my firm?

7 A Not at all.

8 Q Have we ever met?

9 A Not until this case.

10 Q And you, of course, charge for your services?

11 A I do.

12 Q How much is that by the hour?

13 A I charge a little over \$600 an hour.

14 Q And how do you reach those charges?

15 A So there's other surgeons that I work with in our
16 practice with similar level of expertise, so we looked at
17 how much we would normally charge and collect during a day
18 of surgery and that's about what it worked out to.

19 Q Okay. And when you undertook this case, what did you
20 review?

21 A Initially, I received Dr. Wilson's records from his
22 office, a portion of the veteran's documentation. And I
23 believe that was the starting point, what I first received.

24 Q And since that time, have you reviewed other material?

25 A Yes. So, at this point, I have reviewed the two

1 experts for the Plaintiff. I've also reviewed Dr. Wilson's
2 testimony, Mr. Miller's testimony and reviewed the complete
3 medical record that was given to me.

4 Q What do you understand to be the issues in this case?

5 A I believe the question is did Dr. Wilson see a tonsillar
6 lesion at the time and investigated and decided not to do a
7 biopsy and it eventually becoming cancer? So is there a
8 delay in diagnosis is the crux of the question.

9 Q And based on the information you've given us today, do
10 you feel that you're qualified to address the issues in this
11 case?

12 A Absolutely.

13 MR. DAVIS: At this point, Your Honor, I would offer
14 Dr. Hornig as an expert in head and neck surgery and
15 oncology and all things tonsillar.

16 THE COURT: Mr. McGowan?

17 MR. MCGOWAN: The last part I object to because I don't
18 know what all things tonsillar means. I have no objection
19 to head and neck surgeon and head and neck cancer.

20 THE COURT: Thank you.

21 Then I find that he is qualified to testify in the area
22 of head and neck surgery and head and neck cancer.

23 BY MR. DAVIS:

24 Q Were you able to reach any opinions in this case?

25 A Yes.

1 Q Dr. Hornig, what is an otolaryngologist?

2 A So, oto stands for ear, laryn stands for throat and
3 ologist is the study of. And in North America, we call that
4 person an ENT surgeon or ENT doctor, so it's an ear, nose
5 and throat surgeon.

6 Q And is it your understanding that's what Dr. Wilson is?

7 A Absolutely.

8 Q Did you find him to be qualified to treat Mr. Miller
9 for the condition for which he presented?

10 A Yes.

11 Q In evidence is Dr. Wilson's original file.

12 A Okay.

13 Q I'm going to hand it to you and you may refer to it if
14 you need to.

15 A Thank you.

16 Q I think that's Exhibit D2. Have you reviewed his chart
17 before?

18 A Not the original chart. You sent copies of his
19 original chart, though.

20 Q Do you have any reason to believe that there's anything
21 in the copies that you reviewed that would not be in the
22 original chart?

23 A No.

24 Q Let me ask you to turn, please, to the first visit.
25 And I believe that's March 26th of 2013.

1 A Okay. I'm looking at it.

2 Q Tell us what Mr. Miller presented with.

3 A So, it says from the note, and I'm reading verbatim, he
4 says he has an erythematous firm spot on the right posterior
5 pharynx near the superior pole of the tonsil for the past
6 three weeks. He does snore. He has nasal obstruction and
7 was previously a boxer. He quit smoking 40 years ago. He
8 denies other tobacco products. He denies unexplained weight
9 loss. He denies odynophagia, dysphagia, hemoptysis or
10 hematemesis.

11 Q Tell us what those things are?

12 A So odynophagia -- these are all medical terms.
13 Odynophagia means painful swallowing. Dysphagia means
14 difficulty swallowing. Hemoptysis means that you are
15 coughing up blood. Hematemesis means you're throwing up
16 blood. So he's specifically asked and denied any problems
17 with swallowing, no painful swallowing, no problems with
18 coughing up blood and no problems with throwing up blood.

19 Q And how would that history apply to the problems he
20 presented with?

21 A These are very common complaints if you have cancer of
22 the tonsils. That's the reason they were asked --

23 MR. MCGOWAN: Your Honor, I'm going to have to object
24 to this sort of testimony about the reason things were done.
25 It's pure speculation.

1 THE COURT: I sustain the objection.

2 BY MR. DAVIS:

3 Q The second paragraph of the history.

4 A You want me to read verbatim?

5 Q Yes, sir.

6 A Ear canals are clear. TMs are intact, which stands for
7 tympanic membranes, which is the eardrum. Interior
8 rhinoscopy shows nasal obstruction with severe septal
9 deviation in this previous boxer. He has erythematous,
10 buried right superior tonsil firm region compared to the
11 left. I do not feel any abnormal neck masses. He gags with
12 the mirror. Flexible laryngoscopy was done. Pyriform
13 sinus, epiglottis and vallecular are clear. True vocal cord
14 mobility is intact.

15 Q As a otolaryngologist, tell us what you gather from
16 reading the history presented there.

17 A This is a fairly standard examination of an ENT patient
18 that any ENT would do. So he's looked in the ears, he's
19 looked in the nose, he's looked in the oral cavity, the
20 oropharynx. He tried to examine the oropharynx with a
21 mirror and this gentleman would not tolerate that, which is
22 -- we all know, if someone sticks something way down your
23 throat, you sometimes gag. So then he performed a flexible
24 laryngoscopy, which is a more advanced examination that goes
25 through the nose, down the back of the throat into the

1 oropharynx. That allows you to examine it much more
2 completely than even with a mirror.

3 Q Based on the presentation of Mr. Miller, was that
4 examination, in your opinion to a reasonable degree of
5 medical certainty, within the standard of appropriate medica
6 care?

7 A Yes.

8 Q And did Dr. Wilson at that time come to any impression?

9 A The next line says he has -- he writes suspicious right
10 firm tonsil region.

11 Q And what does the record indicate that he did that day?

12 A That he scheduled an MRI of the base of the skull and
13 the base of the neck and he asked him to follow up in one
14 week.

15 Q Tell us, what is a differential diagnosis?

16 A So, when somebody presents, the first step is you take
17 a history from the patient and then you try to confirm that
18 history. And the whole time, you're thinking of things this
19 could be, so you're trained to think in a very broad
20 spectrum, the multiple different things that potentially
21 could be troubling this patient and then the history, you
22 try to get through all of that to guide you to a certain
23 way. And then the physical exam is then designed to try to
24 confirm or help you narrow down some of your differential
25 diagnosis. Then once you get to the end, you're left with,

1 especially with this gentleman, a plethora of different
2 possibilities this could be. And then at that point, you're
3 trying to whittle it down to get to what actually is
4 happening.

5 Q What is an MRI?

6 A So, an MRI stands for magnetic resonance imaging. It's
7 a particular type of scan that allows you to look on the
8 inside of the patient. So when we look inside someone's
9 mouth, you only can see the surface. You can't see the deep
10 tissues, the stuff that's hidden from view. It allows you
11 to see things you can't see with your human eyes.

12 Q And when a physician receives an MRI, what does it look
13 like?

14 A Nowadays, we usually look it up on a computer. You
15 will see it on the computer screen. You're allowed to look
16 through all the images. You also will receive a report
17 that's been written by the radiologist. It's the
18 radiologist's job to read those scans.

19 Q And does it ever come in a hard copy?

20 A It can. It can come on a disk. Years ago, it used to
21 come as actual films that you have, but nowadays, it's
22 usually on a disk or you can see it electronically.

23 Q When it came as films, what did the films look like?

24 A They'd be large sheets of clear paper. If you've ever
25 seen like the negative of a photograph, they would kind of

1 look like negatives of photographs, but quite large. If I
2 can just demonstrate, they would be this large and they
3 would have multiple pictures on them so you could see -- you
4 know, because there's usually 400 to 500 different images
5 that you're looking at.

6 Q It would be like a negative?

7 A Kind of looks like a negative of a photograph.

8 Q And how would you look at that?

9 A Typically, you have something we call light boxes. So
10 you would put it onto a light box, a big film, probably seen
11 them in doctor's offices, at least, older ones. You'd put
12 them on there and it has a light that shines through so you
13 can look at the pictures.

14 Q In this case, do you have an opinion as to whether or
15 not the ordering of the MRI met or exceeded the appropriate
16 standard of medical care?

17 A So at the stage we're at on this first visit, he has a
18 differential diagnosis that would be quite large. And the
19 one thing he can't comment on is, is there a mass, is there
20 something else going on.

21 So the next thing that you do and any reasonable
22 physician would order some sort of imaging. There's many
23 different choices. An MRI is one of the choices. An MRI is
24 widely considered the best choice to look at soft tissue.
25 It gives us the most sensitivity and has the best

1 resolution. So all the tests he could have ordered, this
2 one would see things -- would see something of the smallest
3 ability.

4 Q Was it appropriate in this case?

5 A Yes.

6 Q Why was it important to determine whether or not there
7 was a mass?

8 A Well, there's -- again, the differential diagnosis at
9 this stage is quite large. It can run anywhere from
10 inflammatory disorders to infectious and, of course, what
11 we're more concerned about here today in the courtroom is
12 there could be cancer. And, obviously, a cancer, typically,
13 in the vast majority of cases will present as a growth or a
14 mass or like a neoplasm or a tumor, which means a growth, a
15 mass.

16 Q The cancer, which was eventually diagnosed in Mr.
17 Miller, what kind of cancer was that?

18 A The term for it is called a squamous cell carcinoma.

19 Q Is that generally a mass?

20 A Yes.

21 Q As opposed to what?

22 A Well, you can have -- some cancers can kind of be more
23 of an ulcer, but they don't grow as a growth. Instead of
24 growing up kind of like a mushroom would grow up, it kind of
25 just like eats something away kind of like acid would.

1 Q Have you read Mr. Miller's deposition?

2 A I have.

3 Q Do you recall Mr. Miller describing the spot in the
4 back of his throat?

5 A Yes, he said he could feel it. It was the size of a
6 cigar and I think he used the term pig's snout or a pig's
7 nose.

8 Q Do you have an opinion to a reasonable degree of
9 medical certainty whether or not on his first visit it would
10 have been appropriate to biopsy this spot that Dr. Wilson
11 observed in his examination?

12 A On his first visit?

13 Q Yes.

14 A No, I would not have. I don't think anyone would
15 reasonably do a biopsy on the very first visit. There's not
16 enough information at this point.

17 Q Why is that?

18 A Well, all we have is a history and we have a physical
19 examination, which only shows the surface. And the
20 differential diagnosis at this point, most common things
21 being common, it's very likely this is some sort of
22 infection that would just clear up given time.

23 Q What about tonsillectomy, would that have been
24 appropriate in your opinion to a reasonable degree of
25 medical certainty?

1 A Not based on this history.

2 Q Did Dr. Wilson see Mr. Miller again, according to the
3 records?

4 A He did.

5 Q What day was that?

6 A Looks like he came back to see him on April 2nd, 2013.

7 Q Okay. Tell us what the findings were on that day.

8 A Okay. So again, I'm just reading verbatim from the
9 chart. It says, MRI was unremarkable of the pharynx.

10 Q What does that mean?

11 A So the MRI, basically, does not show anything in the
12 pharynx. There's no mass. There's no growths. It looks
13 like a normal scan, like anyone in the world would have.

14 Q Okay.

15 A Then he comments, he still has more erythema on the
16 right than the left.

17 Q What is erythema?

18 A So, erythema is a Latin term that means a red area.
19 Basically, saying it's still a little bit more red on the
20 right than the left.

21 Q Okay.

22 A Keep reading?

23 Q Yes, sir.

24 A Then it says, he took some sort of antibiotic in
25 January from another physician. He then comments he has

1 severe septal deviation with nasal airway obstruction from
2 previous boxing injuries. Neck has no abnormal masses.

3 Q Is that important?

4 A Very important.

5 Q Why?

6 A If you have an infection or if you have a granulomatous
7 disease or if you have an inflammatory disease or if you
8 have cancer, the first thing that may pop up is some lymph
9 nodes in the neck or lymphadenopathy of the neck. So the
10 examination of that area is a very important part of the
11 examination.

12 Q Okay.

13 A Then he comments hypopharynx is unchanged. Ear canals
14 are clear and then TMs are intact, that means tympanic
15 membranes are intact or the eardrums are intact. It goes on
16 to say Keflex with a refill was transmitted to Wal-Mart in
17 Newport. He will followup in three weeks.

18 Q Do you have an opinion to a reasonable degree of
19 medical certainty whether or not the treatment and care Dr.
20 Wilson delivered to Mr. Miller on April the 2nd of 2013 met
21 or exceeded the appropriate standard of medical care?

22 A It definitely met the standard of care.

23 Q What is Keflex?

24 A Keflex is an antibiotic.

25 Q Why was he given an antibiotic?

1 A Well, I think he's seeing that there's been improvement
2 --

3 MR. MCGOWAN: Your Honor, this is again speculation.
4 He's trying to get into what Dr. Wilson was thinking or
5 seeing.

6 THE COURT: He's testifying as an expert in this
7 particular field. I'm going to allow the question.

8 THE WITNESS: The key is he's examined the patient.
9 Part of his differential diagnosis is this could be an
10 infection. In the second visit, he has gathered some
11 additional information that Mr. Miller previously was
12 treated with antibiotic with some improvement. So I think
13 it's very reasonable given that the MRI findings are now --
14 the MRI comes -- there's nothing to see on the MRI. There's
15 no mass. The erythema, the redness has improved from the
16 last visit and you have this history that he may have been
17 treated for tonsillitis with an antibiotic and things have
18 gotten better. So it's prudent --

19 MR. MCGOWAN: Your Honor, objection --

20 THE COURT: Y'all approach.

21 (Whereupon, a bench conference was held in the presence
22 of the jury but outside the hearing of the jury.)

23 THE COURT: I sustain the objection.

24 Go ahead.

25 BY MR. DAVIS:

1 Q Do you have an opinion whether the care and treatment
2 rendered on the second visit was appropriate under the
3 standard of care?

4 A Yes.

5 Q And what is that opinion?

6 A I believe he met the standard of care.

7 Q And was there another visit with Mr. Miller?

8 A Yes, according to his records, he came back on the 23rd
9 of April, which was about three weeks after.

10 Q Okay. And tell us what the record says on that date.

11 A He says he is on Plavix now, having had three stents
12 placed last week. His throat is feeling better. There is
13 no visual or palpable pathology in the oral cavity or
14 oropharynx. Hypopharynx is grossly clear. He does have
15 septal deviation with some nasal airway obstruction. Ear
16 canals have a small amount of wax. TMs are intact. Neck
17 has no abnormal masses. He will follow up prn.

18 Q And interpret those findings for us.

19 A Well, Plavix is a very potent blood thinner, which
20 someone who's had cardiac issues and stents placed are very
21 often placed on Plavix because the stents can clot off and
22 you're trying to make sure he has enough blood moving around
23 his heart so he doesn't have a heart attack and die. His
24 throat is feeling better, so he's followed up on the
25 previous examination and things seem to have improved.

1 Then he comments that he's looked in the area that he
2 was concerned about before. And at this visit, he does not
3 see anything and does not feel anything abnormal in those
4 areas. And then he again comments on the septal deviation
5 from the airway obstruction -- that's causing airway
6 obstruction and the ears were clear. Tympanic membranes are
7 intact. Again, he comments the neck has no abnormal masses.
8 Again, which is an important finding for many things in the
9 differential diagnosis. And then he asked him to come back
10 and see him on an as-needed basis.

11 Q That's what prn means?

12 A Yeah, prn means if you have any concerns, if anything
13 changes to come back and see me. So it's kind of -- you
14 know, you never close out a visit with the patient. You're
15 like if something's different, if something changes, please
16 come back and see me. Any physician would say that.

17 Q And do you have an opinion to a reasonable degree of
18 medical certainty whether or not the third visit and
19 treatment rendered met or exceeded the appropriate standard
20 of medical care?

21 A It met the standard of care.

22 Q And do you have an opinion based on the same criteria
23 as to whether or not a biopsy should have been performed on
24 the third visit?

25 A I think it's -- so, can I expand a little bit?

1 Q Yes.

2 A I think to get to a biopsy and to order a biopsy or to
3 perform a biopsy, and in Dr. Wilson's case, he would have
4 performed this biopsy, you need many pieces of information
5 before you get there. The first statement of our
6 Hippocratic Oath is first do no harm. If you take a biopsy
7 from someone, that hurts. There's a potential of bleeding,
8 potential of infection.

9 In this particular instance, he's now on a very, very
10 potent blood thinner, so he could have a lot of bleeding and
11 a severe complication from that. You don't want to take him
12 off the Plavix because then his stents will clot off.

13 In addition, we've now gathered a lot more information.
14 He's seen him multiple times over time. He's given a
15 treatment, which was the Keflex. Things have now seemed to
16 have resolved. All the complaints have gone away.
17 Visually, he does not see anything. So at this point, I'm
18 not sure what you would biopsy. I don't think biopsying
19 something that appears normal and all the testing is normal
20 is appropriate. In fact, it's probably inappropriate to go
21 biopsy at this point in time.

22 Q The statement has been made that a biopsy is the
23 standard of care to rule out tonsil cancer. Do you agree
24 with that?

25 A If you are at a scenario where the history leads you to

1 be concerned about tonsil cancer, the physical exam findings
2 lead you to be concerned because you see a lesion, the
3 testing, the imaging they order makes you concerned about a
4 lesion, then yes, a biopsy is how you confirm cancer. You
5 would never perform a biopsy on a normal-appearing throat.

6 Q From the records that you've read, did you come to the
7 opinion that Dr. Wilson was concerned about cancer in this
8 case?

9 A Yes. I think he had a very large differential
10 diagnosis, but one of the things he was concerned about was
11 could this be cancer.

12 Q And so would you have an opinion to a reasonable degree
13 of medical certainty whether he would have been required
14 under the standard of care to perform a biopsy on any one of
15 these three visits?

16 A Well, again, getting to a biopsy is a process. You
17 just don't order a biopsy or do a biopsy without having a
18 suspicious lesion that you're worrying about, so you want to
19 make sure there's a reason you're doing it. You have to
20 have -- so all of your history and physical exam and your
21 imaging, you want all those to be confirmatory and then
22 still at that point, you're left with a suspicious lesion.
23 And once you have a suspicious lesion, then you're required
24 to do a biopsy.

25 Q Would it have been appropriate under the standard of

1 ENT care for Dr. Wilson to have required periodic checkups
2 of Mr. Miller?

3 A I think in this scenario, when you see a patient and
4 things have resolved and gotten better and there's no
5 visible lesion, the thing that you saw before is now
6 resolved, I think it's very common to say if you have any
7 other problems, please come back and see me on an as-needed
8 basis. It's not appropriate to have people come back who
9 don't have any problems.

10 Q You're familiar with squamous cell carcinoma?

11 A Yes.

12 Q Tell us about squamous cell carcinoma.

13 A Squamous cell carcinoma is one of many types of cancer.
14 It's named -- any cell in our body can cause cancer. And
15 one of the cells in our body is called a squamous cell.
16 Squamous cells are cells that line our body. So they're on
17 our skin, they're inside of our throats, inside of our
18 lungs, inside of GI tract. So any of those areas, you will
19 find a squamous cell. So squamous cell cancer is a squamous
20 cell that grows in an uncontrolled manner. So it just keeps
21 growing even though it's not supposed to be growing.

22 Q What is a P16 marker?

23 A So the P16 marker is a way that we test the cancer if
24 we were trying to figure out what caused the cancer, where
25 did the cancer come from. One of the causes of tonsillar

1 cancer -- and there's three main ones that we know about.
2 One it seems to be secondary to tobacco products, it seems
3 to be secondary to the use of alcohol and a third is from a
4 virus infection. And the P16 test is the agreed upon test
5 to test to see if this particular cancer could be caused by
6 a particular virus.

7 Q What was the particular cancer in Mr. Miller's case?

8 A In his case, the overall diagnosis would be a P16
9 positive squamous cell carcinoma of the tonsil.

10 Q And that tells you what?

11 A That tells me that it's a squamous cell, the type of
12 cell, and it also tells me that what caused the cancer was a
13 virus.

14 Q Not smoking and drinking?

15 A Well, he does have a history of smoking and does have a
16 history of drinking, but, overall, given all the risk
17 factors, it seems to be more likely than not the virus was
18 the cause of the events in this case.

19 Q And how do squamous cell P16 marker viral cancers, how
20 do they present themselves?

21 A So, usually, there's a growth that happens inside the
22 throat. It can be on the back of their tongue or in the
23 tonsil region. And often, it spreads fairly early to the
24 lymph nodes of the neck. And many times, the first way you
25 diagnose it is by noticing there's a lump in the neck and

1 then you work yourself backwards and you find it in the
2 tonsil afterwards.

3 Q A lump in the neck on the outside?

4 A On the outside. So, usually, a gentleman would see it
5 while they're shaving or see it and you could feel the
6 lymphadenopathy or the lymph node in the neck. And then you
7 work your way back knowing that it could be from the tonsil
8 or the back of the tongue and you look for a mass there.

9 Q And Mr. Miller's cancer in 2016, it was diagnosed at
10 Dorn VA Hospital; is that correct?

11 A Correct.

12 Q What type of cancer was diagnosed?

13 A Eventually, after they did all the pathology on it, it
14 was called a P16 positive or a pharyngeal carcinoma.

15 Q And do you recall approximately what size that cancer
16 was?

17 A I don't remember all the dimensions, but I think the
18 largest dimension was about 3.7 centimeters, which is an
19 inch and a half.

20 Q Does the size of the cancer, will that help you be able
21 to come to a conclusion or opinion as to how long the cancer
22 has been there or how fast it was growing? Does that help
23 you in any way, the size of the cancer?

24 MR. MCGOWAN: Your Honor, we have another issue about
25 this.

1 THE COURT: Ladies and gentlemen, we need to take up a
2 matter outside of your presence. I'm going to allow you to
3 go back to your jury room and take some time to be
4 refreshed. When we are ready, we will have you back in.

5 Everyone remain seated while this jury is excused.

6 I do remind you do not discuss the case. Thank you.

7 (Whereupon, the jury exits the courtroom.)

8 THE COURT: I think we're at the point where Mr. Davis
9 had asked Dr. Hornig about determining how long the lesion
10 or cancer may have been there and going into, I assume, the
11 possibility of when it may have started. Mr. McGowan had an
12 objection.

13 I'll be glad to hear your objection.

14 MR. MCGOWAN: May I hand up his deposition, Your Honor?

15 THE COURT: Yes, you may. Do you want me to open it?

16 MR. MCGOWAN: Yes, sir. We're going to need it.

17 THE COURT: Go ahead, Mr. McGowan.

18 MR. MCGOWAN: My objection is to the Defendant on
19 eliciting any testimony from this witness about cancer
20 growth rates, cancer rates, when it would have arisen,
21 things of that nature.

22 The basis of my objection is that we issued written
23 discovery that said identify for us your expert witnesses,
24 what they reviewed and the subject matter of their opinions.
25 I got the CV and fee schedule of Dr. Hornig. We then set up

1 a deposition of Dr. Hornig. I asked him for his opinions in
2 the case. He was very straightforward and shared with me
3 his opinions that have been shared so far in the trial,
4 which is that he believed that Dr. Wilson met or exceeded
5 the standard of care on the three visits.

6 After some discussion about other matters, I asked him
7 -- and I am on Page 31, Line 1, is where the colloquy
8 starts.

9 And I asked him, What other opinions do you intend to
10 talk about at the trial of this case? We're going to trial
11 January 29th, by the way. But what opinions do you have
12 that we haven't talked about in this case, if any.

13 And he says, I'm not sure what you're asking.

14 I then asked him, Are there any other subject matters
15 you intend to testify about the end of January in the trial
16 that we haven't gone over?

17 He asked me, That's not in the medical record?

18 I said, No, about this case. I mean, I don't need to
19 know your opinion about the current administration, but what
20 opinions you hold about this case that we haven't talked
21 about. Are there other sort of opinions about Dr. Wilson's
22 care or Mr. Miller's conduct that we haven't spoken about?

23 And then he talks about he saw a lot of other people
24 during the process. He never talks about cancer, rates,
25 back dating cancer, anything like that. It's just unfair

1 and it's improper and he should be confined to the auspices
2 of the deposition that I took, again, a discovery deposition
3 trying to be thorough in asking what his opinions were. We
4 explored all the ones he revealed and asked if there were
5 any others. He said there weren't. And now we're coming in
6 talking about back dating cancer.

7 THE COURT: Mr. Davis, I'll be glad to hear from you.

8 MR. DAVIS: If you'll notice, Your Honor, what Mr.
9 McGowan left out is on Page 31, Line 1 when he asked that
10 question about what other opinions did he have, I objected
11 to the form. And I did that because I knew what he was
12 doing. It was too broad of a question and he was putting
13 the burden on the witness to guess whatever else might come
14 out in court. This is a discovery deposition. I think it's
15 unfair for the witness to say what are your opinions in a
16 case like this. He doesn't know. He's not a lawyer. He's
17 doesn't know what's supposed to come out in court. He
18 doesn't know what necessarily, depending on the other
19 evidence, he'll be testifying to today. And for Mr. McGowan
20 to ask him a question like that, it's so broad open that
21 nobody could answer it. And that's why I objected. I put
22 an objection on the record.

23 THE COURT: All right.

24 MR. DAVIS: And I objected to the form of it and I
25 think it's unfair to limit this guy. This witness has been

1 qualified as an expert in the field. He knows this subject
2 matter. I've left Mr. McGowan's experts to it. And the
3 problem is I made the mistake of asking a more detailed
4 definition and I don't think the Defendant should be
5 punished by it.

6 THE COURT: Let's take a few minutes and let me mull
7 over it. We'll be at ease.

8 Dr. Hornig, I remind you you're under oath. You can
9 step down, but you can't discuss your testimony, anything
10 you've testified to so far or any potential testimony.

11 (Whereupon, a short break was taken.)

12 THE COURT: Here's what I'm going to do. I'm going to
13 allow in-camera for the Court, Mr. Davis, if you would ask
14 your question again, I'm going to allow him to answer that
15 question here.

16 And Mr. McGowan, I'll give you an opportunity to ask
17 him any questions once he answers that question. Then I'll
18 make a decision about its admissibility.

19 MR. DAVIS: May I ask the court reporter to read it
20 back? I forgot what it was.

21 (Question was played back.)

22 THE COURT: All right. Ask the question again, let's
23 allow him to answer it.

24 And Mr. McGowan, I'll give you an opportunity to
25 question him.

1 BY MR. DAVIS:

2 Q Dr. Hornig, does the size of the cancer that was
3 diagnosed at Dorn VA, does that give you the ability to have
4 an opinion as to the origin of the cancer and how long the
5 cancer has been there? Does it give you any information
6 about the cancer itself?

7 A There's a couple of questions there. The origin of the
8 cancer, we always try to figure out where the epicenter of
9 it was, so kind of taking the center of where everything
10 was, it looks like it would be at the junction between the
11 base of the tongue and the tonsillar pillar because that's
12 where the center part of the mass was. It's difficult to
13 say exactly where it started and where it spread to, but,
14 usually, we try to pick the center of the tumor.

15 As far as the size of the tumor giving you an idea of
16 how long it's been there, no one really has long term growth
17 curves of cancer. We don't look at cancer and watch cancer
18 over years in humans. I can speak that I do see people who
19 have cancer and there's a timeline between when I see them
20 to when I treat them doing surgery, which is usually a
21 matter of weeks and it does grow visibly in that time frame.

22 THE COURT: Mr. McGowan.

23 BY MR. MCGOWAN:

24 Q Doctor, when did you arrive at these opinions about the
25 origin and growth rate of the cancer in this case? When did

1 you come up with that?

2 A My initial review of the case trying to figure out
3 where it started and how long it potentially could have been
4 there.

5 Q You recall me asking you directly what your opinions
6 were in this case at your deposition, don't you?

7 A Yes.

8 Q In fact, I did so twice, starting on Page 8 and then at
9 the end of your deposition; isn't that true?

10 A That you asked those questions?

11 Q Yes, sir.

12 A Yes.

13 Q Do you have the deposition up there?

14 A I do not.

15 THE COURT: Let's have it marked as Plaintiff's
16 Exhibit.

17 (Whereupon, Plaintiff's Exhibit No. 12 was marked for
18 identification.)

19 BY MR. MCGOWAN:

20 Q All right. The way we're going to do this, Doctor, I'm
21 going to read my questions and you're going to read your
22 answers. All right, sir?

23 A Sure.

24 Q Let's start on Page 8, Line 3.

25 A Okay.

1 Q And it starts, Appointment for each status. Okay, I
2 got you. So tell me what your opinions are in this case,
3 please.

4 A You want me to read my words?

5 Q Yes, sir.

6 A Can you be more specific?

7 Q Not particularly because you've been hired to be an
8 opinion witness in this case and I assume you have opinions,
9 otherwise, you wouldn't be here. So I just need to know
10 what those are. I haven't been given any real -- all I know
11 is that you're going to testify in this case. That is
12 literally what I got, your name and didn't do a report and
13 that's your CV?

14 A Yeah, so in a summary?

15 Q Sure.

16 A So the Plaintiff I know has been there, has seen Dr.
17 Wilson three times.

18 Q Okay.

19 A Initially, he saw him. He had some concerned, ordered
20 an MRI, reviewed on that test, everything came back normal
21 and he said to come back and see me if there's any further
22 problems and he never came back.

23 Q Okay.

24 A So my feeling is that Dr. Wilson did everything that
25 was required of him and did an excellent job as a physician.

1 Q So you think he did an excellent job?

2 A Correct.

3 Q Okay. Any other opinions? Mr. Davis then objects to
4 the form. And you said?

5 A With regard --

6 THE COURT: We're down on Page 33 now?

7 MR. MCGOWAN: No, this is Page 9, Your Honor.

8 THE COURT: Still on Page 9.

9 THE WITNESS: I say, With regards to this case, I think
10 there's only three visits. There's not much to talk about.

11 BY MR. MCGOWAN:

12 Q And then we talk about those opinions for a number of
13 pages; is that fair?

14 A Sure.

15 Q All right. And then I want you to go to Page 31.

16 A I'm there.

17 Q Line 1. I see, okay. What other opinions do you
18 intend to talk about the trial in this case? We're going to
19 trial January 29th, by the way. Mr. Davis objects to the
20 form. But what other opinions do you have that we haven't
21 talked about in this case, if any?

22 A I'm not sure what you're asking.

23 Q Okay. Are there any other subject matters that you
24 intend to testify about at the end of January in the trial
25 that we haven't gone over?

1 A That's not in the medical record?

2 Q No, about this case?

3 A There's --

4 Q I mean, I don't need to know your opinion about the
5 current administration --

6 A Well, there is --

7 Q -- but what opinions you hold about this case that we
8 haven't --

9 A I think I made the sign of the cross at this point.

10 Q Yeah. That we haven't talked about. Are there any
11 other sort of opinions about Dr. Wilson's care or Mr.
12 Miller's conduct that we haven't spoke of?

13 A I think a lot of people saw Mr. Miller in their
14 intervening portions and so there's lot of different
15 professionals that saw him over those three years,
16 especially in the veteran's record.

17 Q And then we talk about that, right?

18 A Yes.

19 Q But we never talk about growth rates of cancer,
20 location of the cancer or anything like that, right?

21 A You and I do not talk about that.

22 Q Okay. And you held that opinion at the time, but you
23 didn't share it with me, right?

24 A I had lots of opinions on the case. It was a very
25 broad question. It's impossible to answer that question.

1 Q Well --

2 A Even yourself, you said I don't -- I don't want to have
3 your opinion on the administration of our country, like --
4 it was impossible to answer that question.

5 Q You held the opinion at the time of this deposition
6 and, in fact, with your initial conversations with Mr. Davis
7 about the growth rate, the size and the alleged origination
8 of this particular cancer in this patient; is that fair?

9 A Yes.

10 Q And you kept that -- you didn't tell me that ever, did
11 you?

12 A I did not tell you that.

13 Q Now --

14 A Your question was so broad, it was hard to tell what
15 you were talking about.

16 Q Is it your view that me asking you if you have any
17 other opinions about this case that that allowed you or you
18 took that as solace that you could keep that secret?

19 A I wasn't intending to keep anything secret. I have
20 lots of opinions about lots of the case that we didn't bring
21 up at that point. You did see the volume of this record
22 that I received. There's many different people that saw
23 him. I didn't want to spend 12 hours going over every
24 single opinion of every single person he saw.

25 Q And this is a different sort of aspect now, your

1 testimony, Doctor, the center of tumor theory. That somehow
2 you determined where it originated from from the center of
3 the tumor?

4 A Sure.

5 Q What scientific basis is there that that is reliable
6 and that is well accepted in the field?

7 A Generally, that comes from my studies that if you
8 inject some cells into a mouse, it gets bigger in all
9 dimensions.

10 Q Any other scientific basis for that claim?

11 A Just people seeing and watching and observing cancer
12 over time. It doesn't usually grow on one side and not the
13 other. It just grows --

14 THE COURT: It appears to me that we're going beyond
15 the issue on the question. That may be cross-examination
16 that you ask him -- because he's already testified to that.
17 That's in the record about the origin.

18 MR. MCGOWAN: Your Honor, the business about the center
19 of the tumor, what he's trying to say in front of the jury
20 is that the tumor was not where it was drawn on the drawing,
21 it was lower down or something.

22 THE COURT: And he's testified to that.

23 MR. MCGOWAN: Not in front of the jury. He did that in
24 here. My objection to that, Your Honor, is there's no
25 scientific basis for that testimony and should be excluded.

1 THE COURT: My recollection is that you did ask -- that
2 he was asked earlier before where we are now about the
3 origin and my recollection is that he had testified in front
4 of the jury where he thought the origin was and whether that
5 differs from what had been shown up to this point. That's
6 not for the Court to determine.

7 Anything else, Mr. Davis, as far as the motion -- or
8 his objection to answering that question?

9 MR. DAVIS: No. I just want to reiterate, Your
10 Honor -- I mean, a discovery deposition is taken at the
11 request of the attorney. He can ask anything he wants to.
12 The witness just presents himself. It's not up to a lay
13 person in legal terms to have to guess. I mean, that's
14 ridiculous.

15 THE COURT: Well, I'm going to sustain the objection.
16 And the reason is that he testified that when he was asked
17 that -- or he formed this opinion in the early part of when
18 he was examining the records of the case, that was an
19 opinion that he held. Mr. McGowan asked the question did he
20 have any other opinions at the deposition. I note that you
21 did object, however, there does not seem to be any
22 preservation or ruling on that objection of it being overly
23 broad. However, I find that that was specific enough that
24 he should have been able to answer with the opinion which he
25 gives today. And so it appears because that opinion was

1 formed well before the deposition, he did not answer the
2 question. I'm not going to allow him to answer that
3 question.

4 MR. DAVIS: Then, Your Honor, does that limit the
5 cross-examination to the boundaries of the deposition, also?

6 THE COURT: We'll have to deal with that when we get
7 there. I don't know what his questions are going to be on
8 cross, but, certainly, if you raise an objection, we'll deal
9 with those at the appropriate time.

10 MR. DAVIS: I'm really not sure --

11 THE COURT: I'm not sure what you're asking me to do to
12 limit his cross-examination. When he hasn't asked a
13 question on cross-examination yet, I don't know how I can
14 rule on that, but I'll be glad to hear from you.

15 MR. DAVIS: What I'm asking, Your Honor, is is it your
16 ruling that this witness cannot testify to anything that he
17 didn't testify to in the deposition?

18 THE COURT: My ruling is this, this specific question
19 about any opinion that he had -- when he was asked the
20 question did he have an opinion, any other opinions and his
21 answer was no, he had no other -- well, he really didn't
22 answer the question the way I see it.

23 MR. DAVIS: Well, he asked for him to be more specific.

24 THE COURT: Right. So he didn't answer the question.
25 He asked a question about more specificity and yet, the

1 Court finds that that question was not so overly broad when
2 it was asked then. He testified today that he had that
3 opinion at the time of the deposition. That's clear, right?

4 MR. DAVIS: Yes, sir.

5 THE COURT: Then I'm not going to allow him to now
6 testify about it today when he didn't answer that question
7 at the deposition.

8 Now, as far as what we may or may not limit Mr. McGowan
9 to during his cross-examination, we'll deal with that if and
10 when we get there.

11 MR. DAVIS: Well, I can advise the Court that this
12 witness may testify further in direct examination -- he may
13 answer questions that weren't asked at the deposition.

14 THE COURT: I don't know how Mr. McGowan intends to
15 handle that. We'll deal with those as well.

16 MR. DAVIS: Yes, sir.

17 THE COURT: Let's bring the jury in.

18 (Whereupon, the jury enters the courtroom.)

19 THE COURT: All right, Mr. Davis.

20 BY MR. DAVIS:

21 Q We were talking about a diagnosis at the Dorn VA in
22 2016; is that correct?

23 A Correct.

24 Q And that was the diagnosis of squamous cell cancer?

25 A Yeah, P16 positive squamous cell carcinoma.

1 Q Do you have an opinion to a reasonable degree of
2 medical certainty that there's any relationship to that
3 cancer and the spot that was observed by Dr. Wilson in 2013?

4 A I think it's very unclear that they're related.

5 Q And why is that?

6 A Because the spot that Dr. Wilson looked at resolved
7 over time. There's no MRI evidence that there was a mass or
8 growth there. And then after that, there's multiple
9 qualified personnel who looked at Mr. Miller and did not see
10 anything there. So I think it's very unlikely that these
11 two lesions are related.

12 MR. DAVIS: May I approach?

13 THE COURT: Yes, sir.

14 BY MR. DAVIS:

15 Q I'm going to hand you a copy of Defendant's Exhibit No.
16 1, please. That's part of the records from Dorn VA.

17 A Okay.

18 Q What's the date of that note? Or what is it first,
19 tell me what it is.

20 A Well, this is a progress note which was printed off
21 from the VA's medical record.

22 Q And a progress note from whom?

23 A It's an emergency department physician.

24 Q What's his name?

25 A The author is Dr. Tyzer Siddiqi.

1 MR. MCGOWAN: Your Honor, I'm going to have a whole
2 line of objection to all of these with this witness.

3 THE COURT: Ladies and gentlemen, I'm going to let you
4 go back to your jury room. We'll have you out in just a few
5 moments.

6 (Whereupon, the jury exits the courtroom.)

7 THE COURT: Let me be sure before I hear you, Mr.
8 McGowan, the objection that I ruled on simply was an
9 objection to his answering one particular question. I want
10 to be sure that everybody understands that my ruling was
11 limited to this witness' ability to testify as to his
12 opinion regarding the growth and when the cancer developed,
13 which he did not answer that question -- or did not give
14 that information in his deposition. So my ruling is simply
15 on that particular question where there's an objection and I
16 sustained the objection, so I will not allow him to answer
17 that particular question. So that was my ruling, no more,
18 no less. Everybody clear on that?

19 MR. MCGOWAN: Yes, sir.

20 THE COURT: Now, I'll be glad to hear from you.

21 MR. MCGOWAN: What I presume is going to happen next is
22 that Mr. Davis is going to go over with this witness some ER
23 record and dental record, a nurse practitioner yearly visit
24 record, a lot of medical specialities who are not ENTs, head
25 and neck cancer specialists or head and neck oncologists or

1 surgeons or what this doctor is qualified in. And the
2 purpose the Defendant is going to do that is to say that all
3 of these medical people had an opportunity and they actually
4 looked down the back of his throat and didn't see anything.

5 Now, that presumes something very important that is
6 outside this witness' expertise, and that is the scope and
7 nature of an exam done by an ER physician when there's a
8 patient probably having a heart attack as to how thorough
9 they're going to be in throat.

10 So what the Defendant is trying to do is to give the
11 jury the impression, an improper impression that all these
12 other doctors and nurse practitioners did an examination of
13 the back of his throat and because they didn't note anything
14 that therefore there was nothing there. And maybe if this
15 was an emergency room physician to say that kind of thing
16 would have been caught when you have a patient having a
17 heart attack, maybe if this witness was a nurse practitioner
18 doing a yearly visit at the VA, maybe if this witness was a
19 dentist or dental hygienist, maybe they would have the
20 qualifications to know the scope of that exam and whether
21 they would have seen it or not given what they were doing,
22 but this witness is not. This witness is a head and neck
23 cancer specialist. None of those things. And therefore,
24 cannot comment on the exam done by these other medical
25 specialties in these other circumstances would have found

1 such a lesion were it there.

2 THE COURT: Mr. Davis, I'll be glad to hear from you.

3 MR. DAVIS: Yes, Your Honor. First of all, in his
4 deposition, Dr. Hornig said in answer to a question that
5 there were a number of other specialists that looked at this
6 patient's throat as a basis for some of his opinions, number
7 one. Number two, everything that I'm going to introduce has
8 already been introduced into evidence. As you well know,
9 expert witnesses are allowed to refer to all of the records
10 for whatever purpose they may have. On cross-examination,
11 the value of his testimony is up to counsel. But I'm going
12 to have him read from the records, which are already in
13 evidence.

14 The other thing, Your Honor, I'd like to point out that
15 this is a defense witness and his purpose is to defend
16 against the case as presented by the Plaintiff. If the
17 Plaintiff's witnesses have said something in this trial or
18 in their depositions that was not exposed before his
19 deposition was taken, he'd be entitled to comment on it.

20 So the purpose of this is to put in the record the
21 findings of these particular people. Whether or not they're
22 qualified, that's up to Mr. McGowan. He can ask all the
23 questions he wants to, but their findings are already in the
24 record and I'm going to have this man read them.

25 THE COURT: All right, Mr. McGowan.

1 MR. MCGOWAN: Then if that's all that's going to
2 happen, he can read all the records he wants. What I don't
3 want and what my objection is to is words to the effect that
4 well, that would have been seen if it was there or this exam
5 should have found it. If it's just reading records, I think
6 this witness can do that all day long. If there's any
7 commentary or buttressing or opinion about those records,
8 then I think that's the problem.

9 MR. DAVIS: Yes, there will certainly be commentary
10 about the finding itself, whether or not that's important
11 and why it's important. I remind the Court that Dr. Hornig
12 has testified in laying his groundwork for his CV and
13 everything that he trains nurses and other specialists at
14 the University, not just head and neck people, so he is an
15 expert. I'm not putting him forward as that, but he can
16 read this, as any doctor would, when this record is passed
17 on to him and tell what he interprets from that.

18 THE COURT: I'm going to allow him to go into it. I
19 mean, obviously, he's been qualified as an expert. His role
20 in his occupation is that he reviews -- obviously, he
21 reviews a multitude of medical records that come to him with
22 patients for them to then determine what's the appropriate
23 care for him.

24 So I'm going to allow you to go -- to continue
25 questioning him as you intended, however, I do -- if there's

1 some particular issues where he's issuing an opinion and Mr.
2 McGowan believes that's outside of his area of expertise to
3 issue a specific opinion about, what a dentist did or didn't
4 do or anyone else, then we'll deal with those individually
5 as they come up. But on the other hand, I'll allow the
6 general use of the records and him testifying to what he saw
7 and observed in those records. I believe that's where we're
8 going. Is that correct?

9 MR. DAVIS: And what he gleans from reading the record.
10 I mean, these records are made to be passed up to other
11 doctors.

12 THE COURT: I understand that. I'll allow that in.
13 I'm going to overrule your objection.
14 Let's bring the jury in.

15 (Whereupon, the jury enters the courtroom.)

16 THE COURT: Thank you, Mr. Davis.

17 MR. DAVIS: Thank you, Your Honor.

18 BY MR. DAVIS:

19 Q You were telling us this is a progress note?

20 A Yes, sir, progress note from Dr. Siddiqi.

21 Q And he -- what medical speciality is Dr. Siddiqi?

22 A He's an emergency room physician.

23 Q This is Defendant's No. 1. Would you turn to the
24 second page of that document?

25 A (Witness complies.)

1 Q What's the date of the document?

2 A I believe that is April 16th of 2013.

3 Q 2013. And when was the last visit to Dr. Wilson?

4 A Dr. Wilson's last visit was on April 23rd of 2013, so
5 this is about a week prior to that last visit.

6 Q All right. And just a little over halfway down that
7 page, do you see something that says HEENT?

8 A Yes.

9 Q What does that mean?

10 A That is -- the HEENT stands for head, eyes, ears, nose,
11 throat.

12 Q Would you read that and if there is an acronym, tell us
13 what it means.

14 A So the next statement says all in capitals PERLL, that
15 means pupils are equal and reactive to light. And then it
16 says, again, all capitals, EOMI bilateral, which stands
17 extraocular movements intact, meaning his eyes are moving.
18 Then it says oropharynx is clear.

19 Q Now, what is the oropharynx?

20 A The oropharynx is the area that we're -- it's the
21 tonsils, the base of the tongue, the soft palate. And it's
22 mentioned that it's clear. They say no erythema or exudate
23 and moist mucus membranes.

24 Q What is exudate?

25 A It would be like pus.

1 Q Turn back to the first page. This was a presentation
2 to the emergency room?

3 A Yes.

4 Q And the purpose of the presentation, the complaint?

5 A The history, which would be taken from the patient, is
6 he's having mid-sternal chest pain on exertion with
7 shortness of breath and radiation of pain to the right arm
8 and pain is relieved with rest.

9 Q Why would it be necessary to check the oropharynx of a
10 person who reported to the emergency room with chest pains?

11 MR. MCGOWAN: Your Honor, with all due respect, that's
12 an ER opinion.

13 THE COURT: I'll overrule the objection.

14 BY MR. DAVIS:

15 Q He said you can answer.

16 A Oh, thank you. Sorry. As an emergency room physician,
17 one of the things you'd have to consider is -- especially
18 someone who is having chest pains is that they potentially
19 become very, very ill and become sick and would need to be
20 potentially intubated. When you intubate someone, you need
21 to know the anatomy before you get in there because some
22 people are very difficult intubations and as you're managing
23 an airway, you would be much more concerned with certain
24 findings. So you would definitely want to look inside
25 someone's oral cavity and their throat to make sure that

1 this was someone that in an emergent situation you would be
2 able to intubate them easily.

3 Q I hand you another progress note, which is already in
4 evidence.

5 MR. DAVIS: I'd like to have this marked as Defendant's
6 3.

7 THE COURT: Defendant's 3 marked as a progress note has
8 already been admitted into evidence.

9 BY MR. DAVIS:

10 Q Doctor, I hand you Defendant's Exhibit 3 and ask you to
11 tell the jury what that is and what's the date on it.

12 A So, this is -- are we talking about the bottom half of
13 this page?

14 Q Uh-huh.

15 A This is another progress note. This is from the
16 cardiac cath lab and it's a preprocedural note.

17 Q Who's the author of this note?

18 A Richard Bayer.

19 Q And you see at the top what Richard Bayer's designation
20 is?

21 A No, I don't see that -- oh, he's a fellow in
22 cardiology.

23 Q What would a fellow in cardiology be?

24 A So he is someone who is subspecializing in the
25 speciality of cardiology.

1 Q If you turn to the second page, about halfway down, it
2 has some sort of classification there. Would you read that?

3 A Yes. It has an ASA classification and then below that,
4 there's a mallampati.

5 Q What is a mallampati?

6 A That is a classification that's used to determine the
7 difficulty of someone's airway to intubate them.

8 Q And what does it say there?

9 A So they grade him as a class two.

10 Q Do you know what a class two is?

11 A I do.

12 Q What is that?

13 A So a class two is someone where you can see most of the
14 soft palate. You can clearly see the tonsil and the
15 tonsillar pillars and you can see the entire soft palate.

16 Q What does it say there?

17 A It says -- he's a class -- they've given him the
18 classification of a class two. And the wording they use is
19 it's a partial view of the uvula and tonsillar pillars, a
20 complete view of the soft palate.

21 Q If you'll turn to the last page there.

22 A (Witness complies.)

23 Q At the bottom, it says planned sedation. You see that?

24 A Which part?

25 Q Down there where it says sedation/consent?

1 A Yes, I do see that.

2 Q You see airway noted there?

3 A Yes.

4 Q What does it say?

5 A It says the airway is normal.

6 Q This is another progress note.

7 MR. DAVIS: Your Honor, this would be Defendant's No.
8 4, I guess.

9 THE COURT: Defendant's 4 we've marked is already in
10 evidence.

11 BY MR. DAVIS:

12 Q Tell us what this is, Doctor, and what's the date of
13 that?

14 A So this is another progress note from the Veteran's
15 Hospital. And this one is a general medicine note, an
16 internal medicine note.

17 Q What's the date of that?

18 A This is dated April 19th, 2013.

19 Q Who's the author of that?

20 A A Jenna Steel.

21 Q If you would look on the very last page and tell us
22 what Jenna Steel has.

23 A She's a D.O. and a resident.

24 Q What is a D.O.?

25 A That's a doctor of osteopathic medicine.

1 Q How is that different from an M.D.?

2 A It's just a different route of graduating from medical
3 school.

4 Q Turn to the second page, please.

5 A (Witness complies.)

6 Q And there's another designation of HEENT, you see that?

7 A I do, near the top of the page.

8 Q Tell us what that says.

9 A That one has again in all capitals, NC/AT. I'm not
10 sure what they're designating there. It again has the
11 PERRLA, and that's the pupils equally reactive to light.
12 Anicteric, they're talking about the pupils size. No
13 pallor, meaning he was not sweating. And then MMM, which
14 stands for moist mucus membranes. And it says no oral
15 lesions, so they don't see anything inside of the oral
16 cavity. And it says no, in all caps, LAD, which stands for
17 lymphadenopathy, so they feel --

18 Q So tell me what lymphadenopathy is.

19 A That would be lymph nodes or lumps in the neck. So
20 they do not feel anything in the neck.

21 MR. DAVIS: Another progress note, Your Honor, I'd like
22 to mark as a Defense Exhibit.

23 THE COURT: It will be Defendant's Exhibit No. 5,
24 progress notes which are already in evidence.

25 BY MR. DAVIS:

1 Q What's the date of that?

2 A This is another progress note dated April 19th, 2013.

3 Q Who's the author of this?

4 A A Joyle Beyhem.

5 MR. DAVIS: Your Honor, she's identified in 474 as an
6 RN.

7 BY MR. DAVIS:

8 Q And if you'd look there, there's another notation of
9 the EENT?

10 A In her assessment area, she puts EENT and says no
11 complaints.

12 Q I hand you another progress note. The date on that is
13 at the bottom; is that correct?

14 A The date I see on here is October 14th, 2015.

15 Q And who's the author of this note?

16 A It says a Stacy Eubanks.

17 Q And do you know what the training of Ms. Eubanks is?

18 A It says at the top there this is a nurse practitioner
19 note.

20 Q What is a nurse practitioner?

21 A So this is what we call -- we used to call them
22 mid-level provider, but now they're considered advanced care
23 providers. So they're someone who's able to write their own
24 prescriptions, make their own decisions on what they see on
25 examination and treat patients of their own accord.

1 Q If you'd turn to the second page.

2 A Okay.

3 Q And go down about two-thirds of the page and there's a
4 notation called Fary, F-A-R-Y, do you know what that means?

5 A Yeah, Fary is short pharynx.

6 Q What does it say there?

7 A It says pink, moist, right tonsil two plus without
8 exudate, left tonsil one plus, uvula midline.

9 Q What does right tonsil two plus mean?

10 A That's a grading system for the size of the tonsil.

11 Q And the same with his left tonsil?

12 A Correct.

13 Q And what's the date of this again?

14 A This is October 14th, 2015.

15 Q Okay. And is there a diagnosis at the bottom of that
16 page?

17 A There is. The diagnosis is acute pharyngitis.

18 Q When this cancer was diagnosed at Dorn, what was the
19 stage of the diagnosis?

20 A So to get to a stage, you need to have multiple
21 different factors that you know. One is the size of the
22 tumor with a cancer inside the throat. One is the number of
23 lymph nodes and the size of lymph nodes. And the third
24 factor, has it spread through the body. I believe at that
25 time, they staged him -- how we would speak to each other is

1 a T2N2N0.

2 Q What does that mean?

3 A So the T stands for tumor, and that's the size of the
4 actual cancer that's inside in this case, how large the
5 cancer is inside of the throat. And we grade that from 1 to
6 4. The bigger it gets, the bigger the grade becomes. So in
7 his case, he would get a score of 2 for the T, for the T
8 stage. Then the nodule stage in 2016 was just based on
9 number of nodes. So if you had more than one node, you
10 would become an N2. So we grade those from 1 to 3 with 3
11 being the worst, 0 being the best. He would have gotten a 2
12 at that point in time for that staging system. And then
13 metastatically, the M stage, was a 0.

14 Q No metastasis?

15 A Right. So at that time, the cancer had metastasized to
16 the lymph nodes of the neck, but had not spread through the
17 whole body.

18 Q Assume that the cancer existed in March of 2013, would
19 there be a way to stage that cancer?

20 MR. MCGOWAN: Your Honor, speculation.

21 THE COURT: I'll allow him to answer the question.

22 THE WITNESS: The way you stage cancer is you would
23 need to have -- you're saying there was -- there is --

24 Q Assume there was a cancer there.

25 A The way you would stage it would be your examination

1 and also a review of any imaging that was performed at the
2 time.

3 BY MR. DAVIS:

4 Q Based on the imaging in the record, can you stage that
5 cancer?

6 MR. MCGOWAN: Your Honor, this is --

7 THE COURT: I sustain the objection. The answer to
8 that question goes to an assumption.

9 BY MR. DAVIS:

10 Q Do you have an understanding of how Mr. Miller is
11 fairing now that he's had the radiation and chemo treatment
12 for the cancer that was diagnosed at Dorn?

13 A I have the medical records that were sent to me and it
14 seems like he, at this point, does not have a recurrence of
15 his cancer and he's doing well.

16 Q Do you know -- based on your education and training and
17 competence, do you know what the percentage of recurrence is
18 for a cancer of the type that Mr. Miller has?

19 A For an P16 positive oropharyngeal cancer with, I
20 believe the last CT scan in 2016 showed two or three lymph
21 nodes and a size of 3.7, with him being P16 positive, the
22 survival rate is well over 90 percent.

23 Q And is that a five-year survival rate?

24 A Five-year survival rate.

25 Q At this point, do you have an opinion as to whether or

1 not Mr. Miller had tonsil cancer in March of 2013 when he
2 saw Dr. Wilson?

3 A I think it's more likely than not he did not have
4 cancer in March of 2013.

5 Q Why is that?

6 A Well, he was examined and the lesion that was there
7 initially when he first presented went away over serial
8 visits. That's very common for an infection or inflammation
9 to settle with time. There's also MRI evidence that there
10 is no mass, there is no lymphadenopathy. And in addition,
11 there's multiple providers that have looked inside, seen the
12 exact area where this cancer is found in 2016 and no one
13 makes any mention of it. So it seems -- and cancer itself
14 does not disappear and come back. Cancer grows over time.
15 So there's never going to be a period when there's not
16 cancer.

17 Q Following up on that, does this type of cancer stay
18 dormant for three years?

19 A No.

20 Q Do you have an opinion to a reasonable degree of
21 medical certainty whether or not Dr. Wilson deviated from
22 the appropriate standard of care in his care and treatment
23 of Mr. Miller?

24 A I think Dr. Wilson did everything that was required of
25 him. He examined the patient multiple times. He took a

1 history, followed up with prudent testing, followed up, saw
2 the patient again. All those tests came back negative. And
3 there's really nothing else for him to do except for tell
4 him to come back and see him if there's any further problems
5 in the future.

6 Q Having given me that answer, do you have an opinion
7 whether or not Dr. Wilson deviated from the appropriate
8 standard of care?

9 A Absolutely not.

10 MR. DAVIS: Thank you. I don't have any other
11 questions. Answer anything counsel has for you.

12 THE COURT: Thank you. I think what we'll do -- it's a
13 good time to take a lunch break. It's 1 o'clock. Ladies
14 and gentlemen, I'm going to give you until 2:30. Be back
15 ready to go about 2:30. We have some other matters that are
16 going to be taking place in here. They should be over by
17 2:30. If you're sitting your jury room for 15 minutes or so
18 after that, we're working in here, but we should be ready to
19 go at 2:30.

20 So enjoy your lunch. Be back at 2:30. Again, do not
21 discuss the case.

22 Everyone remain seated while this jury is excused.

23 (Whereupon, the jury exits the courtroom.)

24 THE COURT: Thank you, Dr. Hornig. I remind you during
25 the break that you're still under oath. You're not allowed

1 to discuss your testimony or anything you've testified to in
2 the past or any future testimony until after you're
3 released. So just abide by that. Thank you.

4 Anything further from the Plaintiff?

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

6 THE COURT: From the Defense?

7 MR. DAVIS: No, sir.

8 THE COURT: We'll be at ease until 2:30.

9 (Whereupon, a lunch break was taken.)

10 THE COURT: Plaintiff ready?

11 MR. MCGOWAN: Yes, sir.

12 THE COURT: Defense ready?

13 MR. DAVIS: Yes, sir.

14 THE COURT: Let's have the doctor come have a seat
15 before we bring the jury in.

16 (Witness resumes the witness stand.)

17 THE COURT: Let's bring the jury in.

18 (Whereupon, the jury enters the courtroom.)

19 THE COURT: Thank you, ladies and gentlemen, for your
20 patience. The courtroom has been utilized for another
21 matter and we just got through with that. So again, thank
22 you for your patience. We're ready to proceed.

23 Mr. McGowan, this is your witness.

24 MR. MCGOWAN: Thank you, Your Honor.

25 CROSS-EXAMINATION

1 BY MR. MCGOWAN:

2 Q All right, Doctor, I want to start off with some
3 basics. I think initially you told the jury that you were
4 charging a little over \$600 an hour, is that what you told
5 us?

6 A I believe that's correct.

7 Q Was that the truth, the whole truth and nothing but the
8 truth?

9 A From what I remember that I submitted, yes.

10 Q Okay. This is your legal fees schedule; is that right?

11 A Correct.

12 Q And what this says is the retainer fees are \$2200,
13 correct?

14 A Correct.

15 Q If you've got to write a letter to an attorney, 650 an
16 hour, right?

17 A Yes.

18 Q Review of medical records, 650 an hour, right?

19 A Yes.

20 Q And then a phone call to the lawyer is \$950 an hour,
21 right?

22 A Correct.

23 Q Did you have one or more of those with Mr. Davis?

24 A I do not believe we spoke on the phone.

25 Q Okay. And then when you meet in person with the

1 lawyer, that's \$1400 an hour. Did you have one or more of
2 those with Mr. Davis?

3 A We had several office meetings, correct.

4 Q At 1400 bucks a clip? That's what you charge?

5 A Yes.

6 Q And then it says deposition preparation, minimum three
7 hours, 650 an hour, right?

8 A Right.

9 Q And then it says deposition, minimum two hours, \$1400
10 an hour, right?

11 A Correct.

12 Q And my deposition, you took 36 minutes and you got paid
13 2800 -- you charged, you will get paid, I assume, \$2800 for
14 a 36-minute deposition; is that right?

15 A That's my fee schedule.

16 Q And then the next one says a video deposition is \$2800
17 per hour, two hour minimum?

18 A Correct.

19 Q So you charge double if you're going to be on video,
20 minimum \$5600 to have a videotaped deposition two hours or
21 less; is that right?

22 A Correct.

23 Q Now, you keep going on. Court testimony for out of
24 town. Normally, you charge \$1400 an hour if it's in
25 Charleston, right?

1 A Correct.

2 Q But here, it's 650 an hour, plus expenses, 10-hour
3 minimum. That's for all the time you're away from home,
4 right?

5 A Correct.

6 Q And the minimum -- or what that comes to, \$14,000 a
7 day, right?

8 A Correct.

9 Q And so at the time of your deposition, your hours, I
10 think we wrote that down, about 20, at a minimum, 650 each,
11 right?

12 A Correct.

13 Q So that's \$13,000 minimum. Maybe more because you had
14 those in-person meetings, right?

15 A Correct.

16 Q Then we had the deposition, that's another 2800, right?

17 A Yes, that would be correct.

18 Q Then how much time have you spent prepping between the
19 deposition and trial?

20 A Since our deposition?

21 Q Yes, sir.

22 A Many hours.

23 Q How many?

24 A Eight.

25 Q So that's what, another five grand?

1 A It's \$650 an hour, so five times 650.

2 Q Well, 4800 plus -- \$5200, fair?

3 A Five times three -- five times 650 is more like \$3,000.

4 Q 5200?

5 A 650 times five.

6 Q That's eight --

7 A Oh, eight. I guess around 5,000.

8 Q Okay. 13 grand, 28, then an other five and 14 for

9 trial, right?

10 A Reask the question, I was distracted.

11 Q I think we all are. 13,000 minimum up to the

12 deposition, another 2800 for the deposition, 5,000 since the

13 deposition and 14,000 today?

14 A Correct.

15 Q Let's be honest. You're doing this for the money,

16 right?

17 A Incorrect.

18 Q Okay. I want to talk to you about --

19 A Can I respond to that?

20 Q No, you answered the question, I appreciate it.

21 A So I'm a cancer surgeon. I take care of people who are

22 dying of cancer on a daily basis. While I'm sitting here

23 today, there's an operating room that's sitting empty where

24 I could be treating someone who has cancer. I do not like

25 doing these cases. The fact that my fees are so high is I

1 don't want to be here. I'd rather be treating people who
2 have cancer who need my help. No one is getting helped
3 here.

4 Q Well, we'll see. You have two separate jobs with the
5 University; is that right?

6 A Correct.

7 Q Does this money go to you that you're charging here or
8 does it go to the University?

9 A It's both.

10 Q What do you mean both?

11 A Well, I charge a fee and I get that as a check and I
12 also report that income back to my department and I decrease
13 some of my pay that I get from that because I have to take
14 time off from work to come here.

15 Q You testified earlier in your testimony to Mr. Davis
16 that you thought that Dr. Wilson was fully qualified to
17 treat Mr. Miller; is that right?

18 A Yes, he's otolaryngologist.

19 Q Were you aware, and I don't want to be indelicate, that
20 he's suffered from mental illness, he says all of his life,
21 and that's led to his permanent and total disability from
22 any gainful employment, including to practice medicine?
23 Were you ever informed of that?

24 A When I reviewed the initial chart, no, I was not.

25 Q Now, you talked about the mallampati score, do you

1 remember that?

2 A Yes.

3 Q And that is a pretty well known way to evaluate one's
4 airway; is it not?

5 A Correct.

6 Q And the mallampati score that -- can you see that,
7 Doctor? Do you have a little screen in front of you?

8 A Oh, yeah. I see it right here.

9 Q This is what the mallampati score represents; is that
10 right?

11 A Correct.

12 Q So in Mr. Miller's situation, even in April of 2013,
13 his score was a 2, class 2, right?

14 A Correct.

15 Q So you can't see those tonsils in the same way that you
16 could for a class 1, right?

17 A Yes, class 1, you can more of the tonsils than a class
18 2.

19 Q And, in fact, if we were to look at this, you're not
20 going to see hardly any of the back of that throat without
21 some instrumentation; is that right?

22 A This is directly with someone opening their mouth.

23 Q So when somebody says it's a class 2 visualization, it
24 is true, is it not, that that does not mean that you can
25 visualize the tonsils and the areas of concern in Mr.

1 Miller? You just can't see it, right?

2 A You can see the anterior tonsil pillar, which is the
3 front structure, which is the front part of the tonsils. So
4 yes, you can see a class 2.

5 Q But the rest, you can't see?

6 A You can't see the inferior aspect of the tonsil.

7 Q Can you see the hypopharynx without a scope?

8 A You can with the mirror examination, but looking
9 through someone's mouth, you cannot see the hypopharynx.

10 Q So you have to have either a mirror or a scope?

11 A Correct.

12 Q Now, in this case, you are relying upon and only
13 relying upon what actually happened in the medical records
14 of Dr. Wilson, right?

15 A To render my opinion is what you're asking?

16 Q Yes, sir.

17 A I've reviewed all the depositions, the VA medical
18 record in its entirety as well as Dr. Wilson's, so my
19 opinion is based on all of those.

20 Q Well, you understand that in court yesterday, Dr.
21 Wilson said he has absolutely no recollection of this
22 patient, everything he knows about this patient is in those
23 medical records? You understand that?

24 A I wasn't here for court yesterday.

25 Q Did anybody tell you that?

1 A No.

2 Q Okay. I'm telling you that now. So you would agree
3 that on the 4/2 visit and the 4/23 visit, Dr. Wilson claimed
4 to have visualized the hypopharynx, right?

5 A I believe that was on his chart.

6 Q And you know as well that for Mr. Miller, the mirror
7 was not a viable way to do that because of his gagging on
8 that mirror noted on the first visit, right?

9 A It was on the first visit.

10 Q So you know that the mirror wasn't going to be an
11 option to see that, right?

12 A Sometimes you can see people with mirrors on the second
13 and third visits. They get used to the idea. But it's only
14 mentioned in the first visit.

15 Q And we know that the scope, a scope of some kind was
16 billed for in the first visit?

17 A Correct.

18 Q And we know that a scope was not billed for nor
19 mentioned having been used in the second or the third visit,
20 right?

21 A Correct.

22 Q So it is true, is it not, that if Dr. Wilson claimed
23 that he saw the hypopharynx without using a mirror and
24 without using a scope, that's just not possible, right?

25 A It would be very difficult to see the hypopharynx

1 without those two instruments.

2 Q So does that lead you to question, at least a little
3 bit, the veracity, the reliability, the truthfulness of the
4 medical records upon which you're relying?

5 A It's definitely something to take into consideration.
6 You know, no medical record is perfect, as is this one.

7 Q It's demonstrated, is it not, that the medical records
8 that have been put forth as the only rendition of what
9 happened on 4/2 and 4/23 are not reliable and adequate,
10 fair?

11 A With regards to the hypopharynx, yes.

12 Q Okay.

13 A But that doesn't disregard the entire exam or what he
14 did or the MRI. And the hypopharynx is not even in
15 question. The tonsil is in the hypopharynx. It's
16 irrelevant.

17 Q Come on, Doctor, you don't really believe it's
18 irrelevant when the issue is the reliability and the
19 veracity of the records upon which you're relying, do you?

20 A We're talking about the nose, he mentions that several
21 times, but the nose is not in question. The hypopharynx
22 does not contain the tonsil. It's not at issue here.

23 Q Well, there's a bigger issue here, isn't it, Doctor,
24 and that is that if he claimed to have seen the hypopharynx
25 and didn't do the procedure to see it that those entries in

1 that record would be false? They'd have to be false, right?

2 A There's lot of conflicting evidence throughout the
3 entire medical record that's been presented. That's a
4 downfall of the electronic medical record.

5 Q No, this is not the electronic medical record, Doctor,
6 these are hand-typed and dictated records by this doctor.
7 You understand that, right?

8 A Yes.

9 Q They were literally dictated, typed out on a piece of
10 paper and glued in the chart, right?

11 A Yes.

12 Q So it is true, is it not, that when Dr. Wilson claimed
13 that he had visualized the hypopharynx without using a scope
14 and without using a mirror that his charting is false?

15 A I wouldn't say his entire charting is false. With
16 regard to that very specific statement, I think it's very
17 questionable.

18 Q The results of his alleged examination are false, true?

19 A That's not what I'm saying.

20 Q Well, fine. The results of him claiming that he
21 visualized the hypopharynx is just not true, it's false?

22 A I think it would be very difficult to visualize the
23 hypopharynx.

24 Q So you hold the same level of veracity and truthfulness
25 and trustworthiness the rest of his record knowing that we

1 have two separate incidents where he said things in his
2 chart that you know to be false, right?

3 A I'm not sure what you're asking.

4 Q You're relying upon his findings in that third visit to
5 say there was no cancer, right?

6 A Absolutely.

7 Q Yet, does it not call into question, I don't know, your
8 trusting nature of these records knowing that Dr. Wilson has
9 twice on separate occasions in demonstrated fashion told
10 false statements, lied in the chart?

11 A I think you can also look at the MRI report that was
12 done which shows no abnormalities.

13 Q All right. You looked at Defendant's Exhibit No. 5,
14 this is a progress note -- you understand this progress note
15 was made when Mr. Miller was in the hospital with the stents
16 and heart issue, right?

17 A This is the Beyhem one, yes.

18 Q EENT, no complaints. First of all, do you expect a
19 patient who's having a heart issue to be concerned about a
20 spot in the back of his throat that he's been told is no big
21 deal when he's having a heart problem?

22 A Well, he's there for a heart problem, so, obviously,
23 that's everyone main concern at this point in time, but I
24 would have no reason -- if he was having a problem with his
25 throat, why would he not mention it?

1 Q Well, maybe because he has a bunch of stents in his
2 heart and thought he was having a heart attack and that
3 might be a little distracting?

4 A I agree that would be tough, but if he was having
5 problems in his throat and was asked and he said no. I'm
6 just reading from the medical record.

7 Q Okay. April 19th, this is the internal medicine note.
8 That's the same visit when he had heart issues; is that
9 right?

10 A I'm reading it from being April 19th.

11 Q Yeah, of 2013?

12 A Right.

13 Q So that is that lump, that mass, that firm region was
14 as small as it ever was going to get relative to the medical
15 history of this thing, right?

16 A I don't think cancer shrinks. I don't think it was
17 getting smaller.

18 Q Right, but this was at the beginning of the whole
19 process, right? Because he had seen Dr. Wilson on 3/26,
20 4/2, and had another appointment on 4/23. This is 4/19,
21 right?

22 A Are you asking me if this is between April 2nd and
23 April 23rd?

24 Q This is the beginning of the story that we're here in
25 court about?

1 A Sure.

2 Q Similarly, with the cardiac procedure notes, that's at
3 the same time, isn't it?

4 A I can barely see that on the screen, but it's the one
5 dated April 19th that you're talking about?

6 Q It's actually April 18th, same time, right?

7 A Yeah, same time period.

8 Q And then the Siddiqi ER note that you talked a lot
9 about, that was actually the day -- that was April 16th, was
10 it not, the day that he presented to the emergency room with
11 -- they were working it up for a heart attack, right?

12 A Correct.

13 Q Is it your testimony that an ER doctor working a
14 patient up for a heart attack, putting what he put in his
15 chart, rules out a mass in the right tonsil of Mr. Miller at
16 the location where it was, is that your testimony?

17 A I think it corroborates what Dr. Wilson saw. And the
18 most common reason to see a doctor or to see a nurse
19 practitioner or to see any health care provider is usually
20 some kind of a sore throat or a problem with the nose. So
21 it's very common for everyone to look in people's throats
22 and noses. It's probably the most common examination done
23 in medicine.

24 Q Not my question. My question was, is it your testimony
25 that what the ER physician reported while he's evaluating

1 Mr. Miller for a heart attack ruled out the fact that there
2 was a firm lesion in his right -- buried in his right tonsil
3 on April 16th, 17th or 18th?

4 A What his records say?

5 Q What --

6 A Is it in front of me? I don't see it, so I'm just
7 going to read to you what it wrote because that's what he
8 saw.

9 Q Well, I appreciate -- my question to you is more
10 simple. Is it your testimony that what he reports in that
11 report, in that medical record rules out that there was not
12 a buried mass in Mr. Miller's right tonsil during this time
13 frame?

14 A If there was a mass that was seeable, someone could see
15 with the human eye, I think he would have reported it.

16 Q Again, not my question. Is it your testimony that Dr.
17 Siddiqi's report rules out a buried firm region in Mr.
18 Miller's right tonsil?

19 A If there's a mass there to be seen, I think he would
20 have reported it. I'm not sure how else to answer your
21 question.

22 Q You understand it is a buried nodule, it is a buried
23 lesion in the tonsil? That's what Dr. Wilson reported,
24 right, on that second visit?

25 A I think it was on the first visit he said it was

1 actually a buried firm nodule.

2 Q Okay. Is it your testimony that Dr. Siddiqi's report
3 rules out there being a buried nodule or firm region inside
4 Mr. Miller's right tonsil?

5 A I don't think he sees anything abnormal.

6 Q Is there difficulty with my question, Doctor? I want
7 to know is it your view, is it your testimony to this jury
8 that Dr. Siddiqi's ER note during the whole heart attack
9 thing rules out there being a firm buried lesion in Mr.
10 Miller's right tonsil?

11 A I'm not sure how else to answer your question. He
12 doesn't see anything abnormal, so he doesn't report anything
13 abnormal.

14 Q Do you think that rules out anything being there?

15 A Could there be something hiding that he couldn't see,
16 sure.

17 Q Could there be something buried in the tonsil?

18 A That he can't see, sure.

19 Q Okay. Now, did you look at all the VA records?

20 A I looked at many of them. I think some of the lab
21 values, I kind of quickly perused.

22 Q Okay. These are the VA records in evidence. We've
23 gone through these many times. The ENT consult, February
24 11, 2016, reason for request, patient has had issues with
25 tonsils for years, swelling, sore to swallow, needs

1 evaluation for possible removal. Did you see that when you
2 reviewed this case?

3 A Yes.

4 Q Did you see the hematology oncology report?

5 A Yes.

6 Q And this says Miller, David Allen is a 65-year-old male
7 with hypertension, coronary artery disease, referred to the
8 ENT clinic with tonsillar cancer. Patient states that three
9 years ago, he started experiencing intermittent right-sided
10 sore throat. He states he was seen by a local ENT in Rock
11 Hill who ordered an MRI of the neck, which patient states he
12 was told did not reveal malignancy. Patient states he has
13 been placed on multiple antibiotics over the past three
14 years with minimal relief of the sore throat. You reviewed
15 that, also, didn't you?

16 A Yes. That's simply someone writing down what Mr.
17 Miller is telling them. This is not -- the history is taken
18 from the patient, so this is what Mr. Miller has provided to
19 the physicians.

20 Q And then you saw Dr. Thakkar's note, he's the radiation
21 doctor?

22 A Yes, I have.

23 Q Where it says he had some tonsillar irritation about
24 three years ago, at which time he saw an ENT in Rock Hill.
25 Workup was negative at the time. He said it persisted, but

1 it is clear it did not progress significantly until recently
2 when he sought additional input from Dr. Wells after
3 bringing this issue up with his PCP. You read that also,
4 didn't you?

5 A Yes.

6 Q Now, in your normal course of treating patients, the
7 patient's history of presenting illness is very important to
8 your medical analysis, right?

9 A Correct.

10 Q And, in fact, doctors are taught that when patients are
11 seeking care, they are extremely likely in cases like this
12 to be completely truthful because they want to get good
13 care, right?

14 A I think you always listen to the patient, that's the
15 most important, first in anything that we do when we're
16 trying to take a history and physical examination.

17 Q But in this case, it's the last thing you're doing,
18 isn't it? Because if Mr. Miller is correct, if that nodule
19 was there the whole time, then you got nothing, right?

20 A You're simply showing history of present illness that
21 the doctors have written down that Mr. Miller has said.

22 Q Not my question, if those statements are true, then you
23 got nothing?

24 A We have an MRI report that shows absolutely no
25 abnormality and followup reports and multiple other health

1 professionals have looked at this and said they don't see
2 anything.

3 Q Uh-huh, and this would be that nurse and the
4 cardiologist when he's having a heart attack?

5 A And the emergency physician.

6 Q The emergency physician when he's having a heart
7 attack. Okay. Now, I've asked you some questions in your
8 deposition and we're going to go through these. You
9 probably don't need it because it's right in front of you.
10 I'm going to ask you the same question again so we're still
11 on the same page.

12 Would you agree that in this case Dr. Wilson had a
13 concrete concern for cancer in Mr. Miller? And your answer
14 was absolutely. That is still your answer, isn't it?

15 A I'm not sure what the word concrete means, but did he
16 have a concern for tonsillar cancer and could there be a
17 growth? Yes, he did, that's why he ordered the scan.

18 Q I asked you the question and you answered with the term
19 absolutely. Isn't it, in fact, true that he absolutely had
20 a concrete concern for cancer in Mr. Miller?

21 A Can you explain why you're using the word concrete?

22 Q Just the way I did when you answered it with no trouble
23 in Charleston?

24 A From a lay person's perspective, that doesn't really
25 mean anything to me besides did he have a concern. And he

1 did.

2 Q It was a real concern based upon good reason?

3 A Yeah.

4 Q And so you would agree that he did, in fact, have this
5 concern for cancer in Mr. Miller?

6 A Yes, he did.

7 Q And I asked you this question, So does an ENT, if they
8 have a concrete suspicion of cancer in a patient need to
9 rule out cancer? And your answer was, Correct, absolutely.
10 That's your answer then and it's your answer now, isn't it?

11 A If you have a concern for someone having cancer,
12 obviously, as a treating physician, you want to make sure
13 you rule that out.

14 Q And it's not vague, it's not subtle, it's not on the
15 bubble, it's an absolute thing you've got to do, right?

16 A Yes.

17 Q Every ENT knows this, should know this?

18 A Yes.

19 Q I asked you this question, the only accepted way in the
20 ENT world to rule out or rule in cancer is by way of biopsy,
21 is that true? And your answer was, True. Right?

22 A Can I explain a little bit?

23 Q I will, but your answer then was true, correct?

24 A Yes. You're picking and choosing answers here.

25 Q Get your deposition and we can talk about it, but your

1 answer here, the only accepted way in the ENT world is by
2 way of biopsy. That is a true statement, isn't it?

3 A In someone that you're taking a history in that makes
4 you suspicious and then on physical exam findings, you have
5 a lesion that is suspicious and on imaging, you have a
6 lesion that is suspicious and it persist over time, yes, you
7 would reasonably want to get a biopsy.

8 Q All right. So are you trying to back up on this clear,
9 unequivocal statement that you made down in Charleston?

10 A We're talking about two different things here. I asked
11 you specifically during the deposition if we were speaking
12 in generalities or with this case specifically. And before
13 this question was asked, you're talking in generalities.

14 Q Isn't it, in fact, true that they way you rule in or
15 rule out cancer of the tonsil is with a biopsy, is that true
16 or not true?

17 A You do a biopsy if you have a suspicious lesion that
18 you've done an adequate history on, a physical examination
19 on and that's confirmed by imaging. If things go away and
20 the lesion that you were worried about disappears, you would
21 not do a biopsy.

22 Q And we know, of course, Dr. Wilson never ordered a
23 biopsy, never did one, right?

24 A He did not. There was nothing to biopsy.

25 Q Okay. So I asked you if what Dr. Wilson saw in or on

1 Mr. Miller's right tonsil gave Dr. Wilson a concrete concern
2 for cancer, do you believe he had an obligation to rule it
3 out and you said absolutely, right?

4 A Yes.

5 Q And Dr. Wilson never ordered a biopsy? He did not.
6 Nor did he perform a biopsy? And you said correct. Right?

7 A He did not perform a biopsy.

8 Q So we know, based upon your own testimony, you would
9 admit and agree that Dr. Wilson had a real concern for
10 cancer in Mr. Miller and never did a biopsy, right?

11 A It's much more complicated than that.

12 Q I don't think it is, Doctor. It is true that he had a
13 real concern for cancer and the way you rule it out is a
14 biopsy and he never did, right?

15 A What Dr. Wilson did was he took an adequate history,
16 did a physical examination, had a concern for cancer,
17 ordered an MRI, had the patient come back. The MRI was
18 negative. Looked, reexamined, revisited what his
19 differential diagnosis could be. The lesion is getting
20 better. He gives him antibiotics. Three weeks later, he
21 comes back and he doesn't see any of these things.
22 Everything seems to have resolved. He tells him to come
23 back. There is no reason for him to perform a biopsy on
24 someone who has a normal exam.

25 Q Your fundamental premise is that he, in fact, did an

1 exam and it was normal on that third visit, right?

2 A That's what it says in the chart.

3 Q Okay. The chart that you know contains falsehoods by
4 Dr. Wilson, right?

5 A I said it was difficult to examine the hypopharynx.

6 Q Come on, he didn't do it. You can't without a mirror
7 or a scope?

8 A It would be very difficult to do.

9 Q More likely than not, would you agree that he did not
10 examine the hypopharynx?

11 A It would be very difficult to do it that way.

12 Q You think it's more likely than not he did not, in
13 fact, do that even though he reported results of doing so?

14 A I think with regards to the hypopharynx, it would be
15 difficult for him to have seen that.

16 Q So you may not want to say it, but would you agree
17 that's a false entry in the chart?

18 A I think it would be difficult for that to have been
19 seen if he didn't do a mirror or a flexible laryngoscopy.

20 Q How do you feel about testifying for Dr. Wilson?

21 A How do I feel about it?

22 Q Yeah, you know his medical chart is false and you're
23 relying upon his medical chart. Does that give you any
24 pause?

25 A I think when you review medical records and you do

1 medical legal cases, there's often different -- some parts
2 of the record agrees with itself, some part of it doesn't
3 and it's always the gray area that you're trying to decide
4 between.

5 Q Well, this is not a gray area when you said you did
6 something and you just didn't right? That's not a gray area
7 at all, actually, that's just not being honest?

8 A There's places -- I don't think he's being dishonest,
9 first of all. Second, there's places all over the chart
10 where there's examples of -- even some of the notes that you
11 provided that were people that know he has tonsil cancer and
12 their examination shows no lymphadenopathy and no cancer
13 anywhere. So if you want to go over the chart from the VA,
14 there's hundreds of examples of the electronic medical
15 record not agreeing with itself. So having one part of the
16 record maybe not fit, that's pretty normal, pretty standard
17 practice for this.

18 Q It's pretty normal for ENTs to lie about test results
19 they didn't perform?

20 A I think it's possible to see things on an electronic
21 medical record or any record that sometimes don't agree with
22 things.

23 Q Like the truth?

24 A I don't think Dr. Wilson was purposefully lying on his
25 medical record.

1 Q Were you made aware of Mr. Miller's testimony about the
2 third visit?

3 A I read his deposition and he wasn't really sure if
4 there was a third visit.

5 Q Were you aware of the testimony that was rendered in
6 this courtroom?

7 A I know he gave testimony, but I don't know exactly what
8 he said.

9 Q Were you informed that Mr. Miller testified that that
10 third visit was conducted in an office, not in an exam room?

11 A No.

12 Q Were you aware that the testimony of Mr. Miller was
13 that there was no examination, there was no poking around,
14 there was nothing on that visit, it was to review MRI
15 results? Were you aware of that?

16 A I wasn't here for that, so how would I be?

17 Q Well, they didn't --

18 A We didn't talk about that.

19 Q They didn't tell you, okay. So let's boil phase one of
20 the standard of care down to a simple thing. If Mr. Miller
21 is, in fact, truthful and telling the truth about the fact
22 that this thing was there, it got worse over time, and we
23 went through all the treatment that he got in February and
24 all that stuff, Dr. Wilson would have been below the
25 standard of care in failing to rule out cancer initially if

1 Mr. Miller is correct; isn't that right?

2 A I would disagree with that. He looked at it, he
3 examined, the MRI is normal, repeat examinations are normal.
4 If there is no lesion -- your question is if there was a
5 lesion there. The lesion disappeared over time.

6 Q I ask you this question, So, really, this case, seems
7 to me that if Mr. Miller is, in fact, truthful and telling
8 the truth about the fact that this thing was there and it
9 got worse over time and he got -- you know, all the
10 treatment he got in February and all that kind of stuff,
11 then Dr. Wilson would have been below the standard of care
12 in failing to rule out cancer initially if Mr. Miller is
13 correct, right? And your answer was, If a lesion was there
14 the entire time. Right. And then you said, And then he did
15 not follow up on his tests, yeah, he would have fallen below
16 the standard of care. That's your testimony then and now,
17 right?

18 A Exactly. So he did follow up. He had him come back,
19 the lesion -- the lesion was not there the entire time. The
20 lesion went away in that four-week period we're talking
21 about. He ordered an MRI scan. The MRI scan, which is not
22 part of his medical record, is an independent test and an
23 image of what was going on. There is no lesion there.

24 Q But we know there was a mass there because there was a
25 mass there that Dr. Wilson, by his own admission, admits he

1 felt on the 26th and admits he felt on the 2nd and that MRI
2 was in between, right?

3 A I believe on the second visit, he doesn't say that he
4 feels it, he says that he sees a red area that's improved
5 from before.

6 Q Okay. So he sees something back there, at least, he
7 claims he sees something back there?

8 A It's better than it was before.

9 Q And, in fact, he doesn't claim that he poked it on that
10 visit, does he?

11 A He doesn't mention anything about palpating or the
12 firmness of it like he does in the first visit.

13 Q And the lynchpin of your opinion is the truth and
14 veracity of Dr. Wilson's records, especially on the 23rd; is
15 that right?

16 A And the MRI report and many other healthcare providers
17 looking inside of his throat.

18 Q The MRI does not rule out cancer, true?

19 A The MRI is by far the most sensitive imaging technique
20 we have to look for a mass.

21 Q Wasn't my question. MRI does not rule out cancer,
22 right?

23 A You're trying to get to the biopsy part.

24 Q Nope, I'm just asking a question. ENTs do not use MRIs
25 to rule out cancer, right?

1 A However, if an MRI showed that there was a mass there,
2 we would be very proactive about potentially getting a
3 biopsy, so it does lead us in a certain direction. So that
4 MRI being negative rules out many different things and kind
5 of points him to a different direction saying this is
6 probably not a cancer.

7 Q But it doesn't rule out cancer, that was my question?
8 MRI does not rule out cancer, right?

9 A It is very helpful when you're trying to rule out your
10 differential diagnosis.

11 Q It does not rule out cancer?

12 A If you see a mass on an MRI, it does. If you don't see
13 it, it really makes you look in a different direction.

14 Q Are you saying an MRI rules out cancer?

15 A It does not rule out cancer, but it sure makes you
16 think that there is something else going on besides cancer.

17 Q Or cancer not big enough to be seen yet on MRI, right?

18 A It could be a really small cancer, sure, smaller than
19 you could see with the human eye.

20 Q Let's go the second part of this standard of care
21 question, and that's the duty to inform the patient. You,
22 of course, understand and acknowledge that Dr. Wilson has
23 testified in court and in deposition that the standard of
24 care requires an ENT to inform his patient that cancer is in
25 the differential diagnosis. You, of course, agree with

1 that? You're here to help him and you agree with that,
2 right?

3 A You're asking if I agree with what he just said there?

4 Q Yes.

5 A It's impossible to sit down and tell every single
6 patient every single part of the differential diagnosis. A
7 differential diagnosis at this point, in the first visit is,
8 at least, over 30 different things it could have been at
9 that point. You're under no obligation to say what those
10 are. Now, usually, when you order tests and you do more
11 investigations, you kind of explain hey, this is why we're
12 doing it.

13 Q I'm not talking about everything, I'm talking about a
14 patient -- if your differential includes cancer, do you
15 agree or disagree that the standard of care requires an ENT
16 to inform his patient that cancer is on the differential
17 diagnosis?

18 A I don't think the standard of care requires us to tell
19 you that it's a part of the differential diagnosis.

20 Q Okay. So you and Dr. Wilson are kind of parting ways
21 on that?

22 A We have a difference of opinion on that one.

23 Q And then this other part, I assume you don't agree with
24 either, which is where he said that does the standard of
25 care require an ENT to inform his patient that an MRI does

1 not rule out cancer. You don't agree with that either, do
2 you?

3 A I think a negative MRI makes you look in a different
4 direction.

5 Q Well, that's not my question. My question is does the
6 standard of care require an ENT to inform his patient that
7 an MRI does not rule out cancer? Now, he said yes. What is
8 your opinion on that, Doctor?

9 A Does it rule out cancer? I think it would make me
10 think that there was something else going on and cancer was
11 much lower on the likelihood of my differential diagnosis.

12 Q I appreciate all of that. But let me --

13 A I think the difference is you're trying to speak lawyer
14 terms and I'm trying to speak medical terms and we're
15 probably not going to agree.

16 Q Well, just ignore line 20, and I'm going to ask you the
17 same question. Does the standard of care require an ENT to
18 inform his patient that an MRI does not rule out cancer?

19 Now, we'll just cover up Dr. Wilson's answer. What's yours?

20 A When you get a negative MRI in the context of a history
21 and physical examination and the MRI does not show a mass
22 and the mass that you felt in your office is now gone away,
23 I would think it's something else and cancer is not very
24 high on my differential.

25 Q I appreciate --

1 A Does it rule it out? Is it still on my differential?
2 Sure, but it's exceedingly unlikely now.

3 Q Not my question, Doctor. My question is -- you're here
4 -- you were asked numerous questions by Mr. Davis about
5 whether this doctor, Dr. Wilson, met the standard of care.
6 Those were the terms that were used. You remember that not
7 more than a couple of hours ago, right?

8 A Of course.

9 Q Okay. So my question is the same thing, standard of
10 care questions. You with me so far? Yes?

11 A Yes.

12 Q So my question is again, does the standard of care
13 require an ENT to inform his patient that an MRI does not
14 rule out cancer?

15 A I don't think so.

16 Q All right. So you and Dr. Wilson are parting ways on
17 that one, too?

18 A Sure.

19 Q We know for a fact, though, that Dr. Wilson never in
20 his charting or ever informed Mr. Miller that cancer was on
21 the differential diagnosis. We know that, don't we?

22 A That's not in the chart.

23 Q Right. And we also know for a fact, we know for a fact
24 that he never told Mr. Miller that the MRI did not rule it
25 out, right?

1 A I don't see that in the record anywhere.

2 Q So if Dr. Wilson on this point is to be believed that
3 the standard required him to discuss it and the standard
4 required him to tell him the MRI did not rule it out, we
5 know for a fact then, do we not, that Dr. Wilson fell below
6 the standard of care?

7 A I believe if you look at Mr. Miller's testimony, he
8 talks about them reviewing the MRI together and then when
9 the MRI was negative that this made it very unlikely that it
10 was not cancer.

11 Q Not my question.

12 A I think at that point, he was saying that the MRI
13 report being negative kind of rules it out, at least, makes
14 it very unlikely.

15 Q Well, that's even worse then. But back to my question

16 --

17 A I don't think it's making it worse. You're asking the
18 standard of care questions.

19 Q Right. And the standard of care required him to tell
20 Mr. Miller that it didn't rule it out, that's what he says.
21 That's what Dr. Wilson says, right?

22 A You're asking me to read this to you, yes, that's what
23 Dr. Wilson said.

24 Q And we know that he never did that, right? He never
25 said the MRI does not rule out cancer?

1 A In those exact words, no, but he did say, according to
2 Mr. Miller's testimony, that I'm not as concerned about
3 cancer or something to that effect.

4 Q We don't have to worry about the C word?

5 A Right.

6 Q But he never said, you know, this MRI may be
7 reassuring, but it doesn't rule out cancer?

8 A I think it's semantics.

9 Q He never fulfilled his own standard, right? If Dr.
10 Wilson is correct about what the standard of care requires,
11 that he's supposed to tell the patients what's on the
12 differential and the MRI does not rule it out, Dr. Wilson,
13 by his own words, his own testimony has deviated or fallen
14 below the standard of care, isn't that just a fact?

15 A I think -- when you're looking at this, you have to
16 look at it with multiple things. You can't look at it as
17 one particular thing involved. You have to look at the
18 history, the physical and the imaging all together. You're
19 trying to pigeon hole it down to one thing and you just
20 can't. At this point, when the lesion goes away, cancer
21 doesn't go away, it doesn't disappear, so it just makes
22 sense it can't be cancer.

23 Q How long you been doing this legal stuff, a long time?

24 A I mean, I've done cases over the last 10 years.

25 Q You're aware, of course, that as a Plaintiff, our legal

1 burden, we have to prove one or more, one or more deviations
2 or a falling below the standard of care? That's what we
3 have to do, just one or more, you know, right?

4 A I'm not a lawyer, so I don't know what you guys need to
5 do or don't do.

6 Q You do agree, though, that if the standard of care is
7 that he must tell the patient that the cancer is on the
8 diagnosis and tell the patient that the MRI does not rule it
9 out that Dr. Wilson failed to do both of those, right?

10 A I've never once said the standard of care is he has to
11 tell the differential diagnosis. I have never once said
12 that he has to say the MRI scan rules out. You're talking
13 about what Dr. Wilson said, not what I said.

14 Q Well, Dr. Wilson said that's the standard of care?

15 A I understand what Dr. Wilson has said, but that's
16 different from what I have said.

17 Q Well, if he's right about what the standard is, then he
18 would have violated that standard, right?

19 A He can hold himself up to whatever standard he wants
20 to.

21 Q Okay. So in this case, you don't agree that you've got
22 to rule out a cancer with a biopsy here? After all we've
23 been through, you don't think that's the case, right?

24 A Not after subsequent visits where the lesion goes away.
25 There's nothing to biopsy.

1 Q All right. And you don't agree that he had any
2 obligation to inform the patient here, do you?

3 A That he was concerned about cancer at some point? I
4 think he did. Mr. Miller's own testimony says that he
5 talked about the cancer and the MRI, so he knew that was
6 somewhat of a concern.

7 Q Do you believe he was required by the standard of care
8 to inform the patient that cancer was in the differential
9 and the MRI did not rule it out?

10 A I thought we just went over this. So I would say no.

11 Q Okay. It is true, is it not, that Dr. Wilson thought
12 that he could have cancer and did not -- and the test he
13 conducted did not rule it out, that is true, isn't it?

14 A Repeat the question.

15 Q Starting in March of 2013 when Dr. Wilson first saw Mr.
16 Miller, he would have had the cancer possibility on his
17 differential diagnosis at that time?

18 A Yes.

19 Q And the test that he conducted did not rule out cancer;
20 isn't that true?

21 A An MRI just gives you a picture of the inside of the
22 body, so that's what he was trying to do was get more
23 information to help him with his differential diagnosis to
24 see whether a biopsy was necessary or not.

25 Q Well, the test that he conducted did not rule out

1 cancer, is that true or is that not true?

2 A Correct, but it gives him more information so that he
3 can make an informed decision about how to proceed.

4 Q So it was on the differential, but he never ran the
5 test to rule it out, true?

6 A You can't do a biopsy on things that are normal. The
7 reason you order the scan is to give you a picture, to give
8 you more information, to help guide your decision making.
9 When you get results back that you're looking upon to guide
10 your decision making and they come back negative, that there
11 is no mass, there is no growth and your repeated
12 examinations do not show anything, and the lesion that you
13 were worried about is now going away and improving, you do
14 not need to do a biopsy.

15 If everyone that came into any doctor's office had an
16 abnormality inside their throat and it's on the differential
17 -- every single time you see someone, you come in with strep
18 throat and one of the things on the differential is that you
19 could have cancer, you don't tell people who have infections
20 that they have cancer, even though it is on your
21 differential. We're thinking about it all the time.

22 So in his scenario, he looks multiple times, brings him
23 back, gets some more information. The information comes
24 back and I think probably at a relief to him that the mass
25 that he felt before is not seen on MRI and his physical exam

1 now shows things are getting better. That would make me
2 feel really good and would definitely make me think this was
3 not cancer I was dealing with. So I would not do a biopsy,
4 especially when there's nothing to even biopsy.

5 Q You have to be relying upon the truthfulness, veracity
6 and honesty of Dr. Wilson in his note where he claims he did
7 an exam, number one; and number two, the results of that
8 alleged exam, right?

9 A That's part of it. And the MRI that shows no mass.

10 Q And you have no --

11 A So it's two different things now.

12 Q You have no reservation whatsoever saying that this
13 doctor did everything right relying upon a chart where you
14 know that there are false and fraudulent entries about the
15 exams; is that true? You have no reservation about that
16 whatsoever, do you?

17 A Not at all. Especially when I look at other parts of
18 the record that supports that diagnosis. There's multiple
19 other areas that agree with what he's done.

20 Q And your total chart is --

21 A Is the VA, the multiple other --

22 Q The \$30,000 --

23 A -- the --

24 Q -- is what you're in this case for --

25 THE COURT: Hold on a minute. We can't have two people

1 talking at once. Ask your question, give him an opportunity
2 to answer.

3 BY MR. MCGOWAN:

4 Q Does the fact that you've been paid in excess of
5 \$30,000 help to deal with any reservations you might have by
6 relying upon a doctor whose records about exams and findings
7 are false and fraudulent?

8 A I find that question insulting.

9 MR. MCGOWAN: I don't have any further questions for
10 this witness.

11 MR. DAVIS: I do.

12 THE COURT: All right.

13 REDIRECT EXAMINATION

14 BY MR. DAVIS:

15 Q Turn to the second visit, please.

16 A Okay.

17 Q What's false?

18 A What's false?

19 Q What's false? Read the report of that second visit and
20 tell me what's false.

21 A I don't see anything here that's false.

22 Q Do you know whether or not he used a mirror?

23 A He doesn't say.

24 Q Does the standard of care require him to say he used a
25 mirror?

1 A No.

2 Q Look at the third visit and tell me what's false.

3 A I can only read what's in the chart.

4 Q Is there anything there that you know is false?

5 A No.

6 Q So when you were asked these question prefaced by you
7 know are false, you don't know any of that's false, do you?

8 A That's true.

9 MR. DAVIS: Thank you.

10 MR. MCGOWAN: Nothing further, Your Honor.

11 THE COURT: Thank you, Dr. Hornig. You can step down.

12 (Witness steps down.)

13 MR. DAVIS: May Dr. Hornig be excused?

14 THE COURT: Any objection?

15 MR. MCGOWAN: No, sir.

16 THE COURT: Dr. Hornig, you're excused.

17 Mr. Davis, call your next witness.

18 MR. DAVIS: Your Honor, the Defense rest.

19 THE COURT: All right, ladies and gentlemen, the
20 Defense has indicated that they have presented all the
21 evidence that they intend to introduce during the course of
22 this trial. There's some matters we need to take up outside
23 of your presence. So I'm going to ask you to go back to
24 your jury room, refresh yourselves and we'll have you out
25 here shortly.

1 Again, even though you have heard the evidence from
2 both sides, this is still not the time to discuss the case,
3 not to talk about anything you heard or seen in court.

4 Everyone remain seated while this jury is excused.

5 (Whereupon, the jury exits the courtroom.)

6 THE COURT: Anything further from the Plaintiff?

7 MR. MCGOWAN: Ms. Harrison, I think, has some motions.

8 THE COURT: Ms. Harrison.

9 MS. HARRISON: May it please the Court, Your Honor.

10 The Plaintiff moves for a directed verdict on the negligence
11 claim on the grounds that every element has been proven by a
12 preponderance of the evidence and therefore, the Plaintiff
13 is entitled to a verdict as a matter of law as to liability
14 and request an instruction to the jury as to damages.

15 Additionally, we request an instruction to the jury as
16 a matter of law that the events of this case and the
17 evidence presented rise to the level of gross negligence,
18 recklessness and misrepresentation.

19 Very briefly, Your Honor, as to negligence, we believe
20 that there are two distinct deviations from the standard of
21 care. First, the failure to inform Mr. Miller that there
22 was cancer in his differential diagnosis and that the MRI
23 did not rule out cancer. By his own admission, Dr. Wilson
24 has stated that it is the standard of care that he has to
25 provide those pieces of information and that he failed to do

1 that. Because of that, the standard of care as well as his
2 admission that he should have done that, we believe a
3 directed verdict is proper just between those two items.

4 Additionally, as to the second, we believe that the
5 failure to perform a biopsy to rule out cancer was a clear
6 violation of the standard of care. The evidence as well as
7 the testimony shows that no biopsy was ever performed.
8 Based on these deviations, we believe that the damages
9 suffered by the Plaintiff, including getting Stage 4 cancer
10 were a direct and proximate cause of the breach based on the
11 testimony that's been presented as well as the evidence.

12 Additionally, we believe that the Plaintiff is entitled
13 to an instruction to the jury that the events in this matter
14 do rise to the level of gross negligence, recklessness,
15 misrepresentation.

16 As to the gross negligence, we believe that by failing
17 to follow the standard of care, it actually rises to a level
18 of failing to provide slight care based on all of the
19 reasons before mentioned.

20 As to recklessness, we believe the evidence
21 demonstrates a conscious disregard to the risk of cancer for
22 Mr. Miller. We base that on the failing to inform Mr.
23 Miller of the differential diagnosis. We base that on the
24 MRI that did not rule out cancer and failing to order a
25 biopsy.

1 As to misrepresentation, everything that Mr. McGowan
2 just went through as far as the visits on April 2nd and
3 April 23rd show that -- or the evidence demonstrates that no
4 procedure was performed. Mr. Miller confirms that by the
5 fact of telling his story that there was no gag reflex, the
6 mirror did not get used and no scope was performed.

7 For all these reasons, we believe a directed verdict is
8 proper and a charge as to gross negligence, recklessness and
9 misrepresentation as a matter of law should be served.

10 THE COURT: Thank you.

11 Mr. Williams or Mr. Davis.

12 MR. DAVIS: Your Honor, certainly, at the very least,
13 the dispute about what the standard of care is and whether
14 or not Dr. Wilson met the standard of care, certainly, the
15 dispute is sufficient to go to the jury.

16 Dr. Wilson can't set the standard of care one way or
17 the other. The fact that he has testified to what I call
18 black and white questions which do not include the facts of
19 this case is not sufficient to direct a verdict against him
20 on negligence.

21 As far as gross negligence goes, it's the Defense's
22 position that there is no evidence of gross negligence
23 whatsoever, except for the fact that one of the Plaintiff's
24 experts agreed with the definition and said he thought it
25 applied to Dr. Wilson. Other than that, there's no

1 testimony that the Defense thinks rises to the clear and
2 convincing standard, which would be necessary in order to
3 direct a verdict on gross negligence.

4 THE COURT: Thank you. I deny the motion to direct a
5 verdict on either of those two points. The evidence speaks
6 for itself.

7 On the issue of the instruction, we did talk about it
8 and we'll talk about that a little bit later. The Court
9 does intend to instruct on gross negligence, however, it
10 will not be as a matter of law, that's a question of fact
11 for the jury.

12 Any other motions from the Plaintiff?

13 MS. HARRISON: No, sir.

14 THE COURT: Anything from the Defense, Mr. Williams?

15 MR. WILLIAMS: Yes, Your Honor, the Defense would move
16 for a directed verdict as to both Defendants. Plaintiff has
17 simply failed to show -- their evidence is based on
18 speculation as to the violation of the standard of care and
19 that the injuries caused by Mr. Miller by virtue of his
20 cancer diagnosis in 2016 were proximately caused by the
21 alleged negligence of Dr. Wilson. Plaintiff's expert's
22 standard of care opinions are based on an assumption that
23 cancer was present in 2013 and that's just -- it's an
24 assumption. And there's really no evidence in the record
25 that backs up the fact that cancer was present in 2013 and

1 that Dr. Wilson violated the standard of care not detecting
2 that cancer in 2013.

3 THE COURT: Thank you, Mr. Williams.

4 Does the Plaintiff wish to be heard?

5 MS. HARRISON: We rely on our prior argument.

6 THE COURT: I'm going to deny that motion.

7 Anything else?

8 MR. WILLIAMS: The Defense also moves for a directed
9 verdict as to Dr. Wilson himself. Basically, most of the
10 same arguments are global. Motion for a directed verdict --
11 the Plaintiff's case is really -- it's the Defense's
12 position is based on an assumption of cancer in 2013 with a
13 lack of evidence that there was cancer in 2013 and a
14 three-year time period until anything was ever discovered in
15 Mr. Miller that resulted in injuries. We believe that
16 three-year period would break the causal chain.

17 THE COURT: You wish to be heard?

18 MR. HARRISON: We, again, rely on prior argument.

19 THE COURT: I'm going to deny that motion.

20 Anything else?

21 MR. WILLIAMS: The Defense also moves for a directed
22 verdict as to ENT & Face, P.A. And in the alternative, we
23 also make a motion to elect at this time.

24 In this case, the Plaintiff has only pled one cause of
25 action in their complaint and that's for personal injury.

1 The Defense understands that a Plaintiff can plead multiple
2 remedies and seek multiple remedies throughout the trial,
3 but by the end of trial is the time for the Court to have
4 the Plaintiff elect the remedy they wish to recover under.
5 There's a basic purpose of election of remedies in this
6 state to prevent double recovery from a single wrong.

7 All of the facts in this case are based on one act and
8 one person and that's Dr. Wilson. It's three visits. All
9 the facts are based on the same visits, the same set of
10 facts and the Plaintiff is seeking to collect from two, an
11 individual and an entity, for the same wrong. That is
12 plainly double recovery and the Court should not allow the
13 Plaintiff to be able to make a double recovery in this case.
14 And it would be confusing to the jury to allow two
15 Defendants to go before the jury in their deliberations and
16 allow them to award damages against two different defendants
17 for the same wrong based on the same facts.

18 THE COURT: Thank you.

19 I'll be glad to hear from whoever wants to speak on
20 behalf of the Plaintiff.

21 MS. HARRISON: Respectfully, Your Honor, respondeat
22 superior, it's well settled in South Carolina and election
23 is not required in this instance.

24 THE COURT: I'm going to mull on that one just a little
25 bit.

1 Anything else?

2 MR. WILLIAMS: The Defense also makes a directed
3 verdict as to Plaintiff's claims for punitive damages. The
4 burden for punitive damages is clear and convincing
5 evidence. Having the Plaintiff's expert get on the stand
6 and agree with the Plaintiff's counsel that their version of
7 events rises to the level of recklessness is not clear and
8 convincing evidence. There's been no specific clear and
9 convincing evidence.

10 And we know that clear and convincing evidence is a
11 somewhat muddy standard, but it's more than the burden that
12 the Plaintiff has their simple negligence claim and they
13 simple do not rise to the clear and convincing evidence
14 standard to allow the jury to consider punitive damages
15 against Dr. Wilson. There's simple no evidence of
16 recklessness. The jury would be confused by allowing that
17 item on the verdict form. And because the Plaintiffs have
18 failed to meet their burden, this Court should direct a
19 verdict in favor of the Defendants as to punitive damages.

20 THE COURT: Thank you.

21 Does the Plaintiff wish to be heard?

22 MS. HARRISON: For purposes of the record, we, again,
23 rely on prior arguments.

24 THE COURT: I'm going to deny the motion on punitive
25 damages, directed verdict on punitive damage as well.

1 Any other motions?

2 MR. WILLIAMS: No, Your Honor.

3 THE COURT: Let's talk about logistics. How long do
4 y'all anticipate -- here's the thing. I'm required to be in
5 Columbia tomorrow afternoon. Chief Justice Beatty has all
6 the chief admin judges ordered to be there, so I'm going to
7 have to leave at 12:00 tomorrow.

8 We can do several things. We can do closing statements
9 this evening and then I can charge the jury and send it to
10 the jury in the morning. If they haven't reached a verdict
11 by noon, then I'm going to ask them to recess and come back
12 on Friday morning and continue their deliberations.

13 If we wait and do closings and instructions in the
14 morning, if we start at 9 o'clock, I don't know how long
15 y'all anticipate arguing, but that may very well get us
16 until noon. It's a little bit awkward then to send them
17 home and tell them to come back Friday morning.

18 Do y'all have any suggestions? How long do you --

19 Mr. McGowan, how long do you anticipate you will be
20 arguing?

21 MR. MCGOWAN: I would imagine probably 30, 40 minutes
22 with both of our sides, maybe.

23 THE COURT: Well, in legal talk, that means about, at
24 least, an hour.

25 Mr. Davis?

1 MR. DAVIS: About an hour. And, Your Honor, this is
2 strange, this is my own personal preference. I don't like
3 breaking all that up. It's a burden on everyone and I live
4 the furthestest away. I'd rather do all this in one day if
5 we could.

6 MR. MCGOWAN: That would be fine with us.

7 THE COURT: When you say one day --

8 MR. DAVIS: I'm talking about doing it Friday.

9 THE COURT: Oh, I'm sorry, I assumed your burden was
10 you didn't want to have to come Friday.

11 MR. DAVIS: No, no, I'll do that rather than have the
12 jury stay here late or have to break up the charge and all
13 that.

14 THE COURT: Then that makes perfect sense to the Court.

15 MR. MCGOWAN: We have no objection.

16 THE COURT: Okay. Then that certainly gives y'all
17 plenty of time to hone your arguments.

18 MR. DAVIS: Will that be like three hours each?

19 THE COURT: I didn't say that. Hone in my language
20 means -- and I'm fine with that. It's a quarter after 4:00.
21 We've got the issues tomorrow. I'm going to apologize to
22 them. I'm going to tell them a little bit about what I have
23 on my plate and requirements tomorrow and then I'll just ask
24 them to be back here at 9 o'clock on Friday morning. And
25 then when we come back Friday morning, we'll just argue and

1 charge and send it to the jury.

2 Anything else before I bring the jury in?

3 MR. MCGOWAN: Not from the Plaintiff.

4 MR. DAVIS: Nothing from the Defense.

5 (Whereupon, the jury enters the courtroom.)

6 THE COURT: Ladies and gentlemen, we have come to the
7 point in the trial where the next step is for the attorneys
8 to have an opportunity to make closing arguments to you.
9 Once they finish that, then I will charge you on the law,
10 which, basically, means I'm going to spend probably half an
11 hour, 45 minutes reading to you what the law is.

12 It is now 4:15, so we're not going to start that
13 process today. We want to be sure everybody has ample
14 opportunity and time. As you can tell, it's not an exact
15 science. It's not necessarily a well-oiled machine.
16 Tomorrow presents an issue because I'm required by Chief
17 Justice of the Supreme Court to be at a meeting that he has
18 called for chief administrative judges in Columbia tomorrow
19 afternoon.

20 So what we're going to do, instead of breaking this all
21 up, whether it's good or bad, you're going to have tomorrow
22 off, but I'm going to ask you to be back in your jury room
23 on Friday at 9 o'clock. At that time, we will argue -- the
24 attorneys will have an opportunity to argue, I will charge
25 you and then, hopefully, at that point, you will be able to

1 deliberate. So you do need to plan on being here on Friday,
2 taking as long as necessary.

3 Again, do not discuss the case. This is an extremely
4 important case to everybody involved, so we want to be sure
5 you give it the ample time and attention that it needs. So
6 don't discuss the case, don't do any research at all, don't
7 form any opinions and be back on Friday morning at 9 o'clock
8 ready to go.

9 So with that, I'm going to allow you to leave.

10 Everyone remain seated while this jury is excused.

11 (Whereupon, the jury exits the courtroom.)

12 THE COURT: Anything further from the Plaintiff?

13 MR. MCGOWAN: The only issue would be when Your Honor
14 will have the charge and the verdict form.

15 THE COURT: I'm going to hand those to you right now.
16 Anything else?

17 MR. DAVIS: That was the only question we had.

18 THE COURT: Take those and look over those. If y'all
19 would be here about 8:30 on Friday morning, if you have any
20 questions about changes or things you want to put on the
21 record -- I'm sure there may be some things you want to put
22 on the record as far as the charge. In our charge
23 conference, there were some things requested that I'm not
24 going to charge, however, let's be back at 8:30 on Friday
25 morning. Y'all look over those charges and the verdict form

1 and if we need to make any changes, we will do that then.

2 If you look on there, we had gross negligence and
3 recklessness on Page 2 and 3, those are actually going to be
4 moved to Page 11 right before actual damages. That's where
5 I propose to read the charge on gross negligence and
6 recklessness, on Page 11.

7 Do you see that, Mr. Williams, where I intend to move
8 those?

9 MR. WILLIAMS: Yes, sir, Your Honor.

10 THE COURT: At 8:30 Friday morning, we'll iron all that
11 out.

12 We'll be at ease until 8:30 Friday morning.

13 (Whereupon, court was adjourned for the day to be
14 reconvened on Friday, February 1, 2019.)

15 Friday, February 1, 2019

16 THE COURT: Would the lawyers approach?

17 (Whereupon, a bench conference was held.)

18 THE COURT: Is the Plaintiff ready to proceed?

19 MR. MCGOWAN: Yes, Your Honor.

20 THE COURT: Defense ready?

21 MR. DAVIS: Yes, Your Honor.

22 THE COURT: Mr. Davis, I believe you had an issue?

23 MR. WILLIAMS: It's a housekeeping matter, I believe we
24 forgot to formally move Defendant's 3 through 5 into
25 evidence. We would like to do that.

1 THE COURT: Any objection to those pieces of evidence
2 being introduced?

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

4 THE COURT: Exhibits 3, 4 and 5 are now introduced into
5 evidence.

6 (Whereupon, Defendant's Exhibit Nos. 3 through 5 were
7 admitted into evidence.)

8 THE COURT: The Court had a couple of motions that we
9 were considering that were made on Wednesday that the Court
10 had not answered and not ruled on.

11 The first was a motion for a directed verdict by the
12 Defense for the Court to direct a verdict for the Defense as
13 to ENT & Face, P.A. The Court listened to arguments on
14 Wednesday on that issue, had a detailed discussion with the
15 attorneys in chambers this morning. The Court has
16 determined that the Court is going to grant that motion for
17 a directed verdict as to ENT & Face, P.A.

18 Part of the reason is, is that on the issue of
19 negligence of the corporation, the Court did entertain the
20 arguments and I'm sure Mr. McGowan is going to state that a
21 little more fully in just a moment, that under respondeat
22 superior that Dr. Wilson's negligence automatically makes
23 the corporation negligent. There was no evidence other than
24 the respondeat superior as far as Dr. Wilson's relationship
25 to ENT & Face, P.A. There was no evidence of any other

1 employee of the corporation having any contact with the
2 Plaintiff in the case other than there were -- it appeared
3 to be normal billing statements or appointment scheduling.

4 The case law as the Court looked at involving
5 respondeat superior and corporate entities, generally,
6 within the context of hospitals, nursing homes, medical
7 practices with multiple employees providing care to
8 plaintiffs in those cases. Here, the only connection
9 between ENT & Face, P.A. is the relationship of respondeat
10 superior and the Court finds that that relationship alone is
11 not evidence of a negligent act of the corporation. So
12 therefore, I'm going to grant the Defense's -- the renewal
13 of their motion of directed verdict as to ENT & Face, P.A.

14 And I do understand that Mr. McGowan believes that that
15 is error and this is his opportunity to preserve the record.

16 MR. MCGOWAN: We would like the record to reflect that
17 at the time we filed our complaint in February of 2017, we
18 alleged in Paragraph 2 that all of the actions at all times
19 relevant hereto Defendant Wilson was actively working within
20 the scope and course of his employment with ENT & Face, P.A.
21 And that on March 20th, 2017, the Defendant answered that
22 complaint in Paragraph 2 and said these Defendants admit the
23 allegations contained in Paragraphs 1 and 2 of the
24 complaint.

25 We believe that establishes as a matter of fact and law

1 in this case that ENT & Face is the principle, Dr. Wilson is
2 the agent and a judgment against Dr. Wilson would be equally
3 applicable and enforceable against the practice solely based
4 on agency theory or respondeat superior. We believe it is
5 not independent negligence of some other employee, but we
6 believe that the negligence of Dr. Wilson is directly
7 attributable to and answerable by the practice in this case,
8 Your Honor.

9 THE COURT: And let me be sure, too, that I understand,
10 Mr. McGowan, is that because of that relationship, the
11 Plaintiff is not required to produce any evidence of --
12 necessarily any evidence of negligence by the corporation in
13 and of itself, and your argument is that because he is an
14 employee of the corporation that makes him equally liable?

15 MR. MCGOWAN: Yes, sir.

16 THE COURT: As far as his negligence?

17 MR. MCGOWAN: That's exactly right.

18 THE COURT: Mr. Davis, anything in response?

19 MR. DAVIS: No, Your Honor.

20 THE COURT: Thank you.

21 So I think the other unruled upon motion was if the
22 Court had denied the motion for a directed verdict, the
23 Court would need to rule on a motion to elect. I believe
24 that takes that off the table, the directed verdict motion.
25 Is that correct?

1 MR. DAVIS: Yes, sir.

2 THE COURT: Then I think we had some other issues we
3 had discussed about charges.

4 Mr. McGowan, we had talked in chambers, and was
5 requesting an additional charge in what we had gone over
6 with the attorneys on misrepresentation and fraud. I
7 indicated in chambers that I was not going to charge on
8 misrepresentation and fraud. We are charging the jury on
9 recklessness and gross negligence and the Court had
10 indicated there did not appear to be any factual basis for
11 fraud and misrepresentation.

12 So Mr. McGowan, I'll be glad to hear you on your
13 position on that.

14 MR. MCGOWAN: Yes, sir, Your Honor. And I'll let you
15 know that I think I'm required to do this again after the
16 actual jury charge, so I'll just incorporate what I'm going
17 to say then as now.

18 We requested a charge of misrepresentation under
19 15-32-220, subpart E. There are three exceptions to the
20 noneconomic damages cap in a medical malpractice case. One
21 is recklessness or gross negligence. Two, is altered or
22 destroyed medical records. And three is fraud or
23 misrepresentation related to the claim.

24 We would respectfully take exception to the Court's
25 failing to charge the misrepresentation related to the claim

1 and failing to put a question on the jury verdict form about
2 that very issue. We believe there is plenty of evidence in
3 this record that Dr. Wilson's records on 4/2 and 4/23 were,
4 at best, misrepresentations, if not outright fraud. He said
5 he did things that procedures he performed would make
6 impossible.

7 Mr. Miller indicated that there was no examination at
8 all on 4/23. In fact, the Defendant's \$14,000-a-day expert,
9 Dr. Hornig, went so far as to say there were always serious
10 questions about these records and, essentially, admitted
11 that he couldn't have seen what he claimed to have seen. We
12 think that rises to the level of misrepresentation. That
13 should be specifically asked and charged to the jury.

14 THE COURT: Thank you.

15 Mr. Davis or Mr. Williams?

16 MR. WILLIAMS: Your Honor, the Defendants agree with
17 the Court's interpretation and ruling as to the jury charge
18 on misrepresentation.

19 THE COURT: All right. I'm going to abide by my
20 decision and ruling not to include a charge on
21 misrepresentation and fraud.

22 Anything else on behalf of the Plaintiffs?

23 MR. MCGOWAN: No, sir.

24 THE COURT: The Defense?

25 MR. WILLIAMS: Your Honor, just for the record, the

1 Defendants object to the Court's noninclusion of some
2 additional text added to the charge of actual damages. And
3 that text references and goes to what the Defendant's
4 believe in South Carolina is the principle of -- that a
5 plaintiff cannot make a double recovery for a single injury.

6 THE COURT: And I note your objection. I'm going to
7 abide by my decision in chambers and not include that in
8 that portion of the charge.

9 All right. Are we all agreed upon the verdict form in
10 the form that we have it now?

11 Mr. McGowan, I think you had an issue on the verdict
12 form. Did you want to put anything on the record with
13 regards to that?

14 MR. MCGOWAN: Yes, sir. The failure to ask a specific
15 question about misrepresentation for the noneconomic damage
16 cap in light of your directed verdict ruling, obviously,
17 you're not including it.

18 THE COURT: Anything from the Defense?

19 MR. WILLIAMS: Yes, Your Honor, on the verdict form as
20 to question number four, the Defendants disagree with the
21 Plaintiff as to the preponderance of the evidence versus the
22 clear and convincing evidence standard. The Defendant's
23 position on question four, the clear and convincing evidence
24 standard would also apply to that question as it applies to
25 question five which goes to punitive damages. The

1 Defendants understand the Plaintiffs position that question
2 four goes to the noneconomic damages cap statute, but we
3 believe that the interpretation of the case law --

4 THE COURT: Tell me again what it is you object to on
5 question four.

6 MR. WILLIAMS: The Defendants would like in question
7 four the inclusion as in question five that the conduct --

8 THE COURT: My question four now says, Was Dr. Wilson
9 reckless or grossly negligent in his treatment of David
10 Miller?

11 MR. WILLIAMS: Yes, Your Honor.

12 THE COURT: And what is the change you're asking for?

13 MR. WILLIAMS: We would ask that question four would
14 read, Was Dr. Wilson reckless or grossly negligent in his
15 treatment of David Miller to a level of clear and convincing
16 evidence?

17 THE COURT: You want that in that question and not in
18 question five? I mean, that's what we're asking in question
19 five.

20 MR. WILLIAMS: We would like it in both. We understand
21 Plaintiff's position as to why question four exist, but in
22 our position, we wouldn't need question four.

23 THE COURT: Okay, I understand. I am going to abide by
24 what we had determined was proper on Wednesday and I'm going
25 to leave the verdict form the way it is.

1 Anything else from the Plaintiff or Defendant?

2 MR. MCGOWAN: No, sir.

3 MR. DAVIS: No, sir.

4 THE COURT: I assume, Mr. McGowan, you'll be arguing
5 for the Plaintiff?

6 MR. MCGOWAN: I was going to do the first part and Ms.
7 Goodstein is going to do the second.

8 THE COURT: And who will be arguing for the Defense?

9 MR. DAVIS: I will.

10 THE COURT: Let's bring the jury in.

11 (Whereupon, the jury enters the courtroom.)

12 THE COURT: Ladies and gentlemen, thank you for your
13 patience. We are ready to resume the trial with closing
14 arguments and then I will charge you after that. Again, I
15 assure you, we have been working even though you have not
16 been in here. We have lots of issues in a trial that need
17 to take place outside of your presence. We have resolved
18 all those and are now ready to proceed.

19 So at this point, Mr. McGowan will address you, then
20 Mr. Davis will have an opportunity to give his closing, and
21 then you'll hear reply from Ms. Goodstein.

22 Mr. McGowan.

23 CLOSING ARGUMENT BY MR. MCGOWAN

24 MR. MCGOWAN: Ladies and gentlemen, we're about ready
25 to bring this case home and put it in the barn one way or

1 the other. You know, lawyers always get up and say thank
2 you for your service. You don't have a lot of choice, but
3 thank you for being here and listening to this whole thing.
4 We really appreciate it. It's more important than you can
5 probably imagine. It really matters what goes on here. It
6 matters to Mr. Miller. It certainly matters to other folks
7 in the community and it matters, obviously, to the medical
8 providers in this community as well.

9 What it's going to come down to is the verdict form.
10 And this is where the rubber hits the road and where you
11 make your decisions. We're going to go over what we're
12 asking you to do and the evidence of why we think y'all
13 ought to do it.

14 This is the verdict form that you're going to get. So
15 the first question: Was Dr. Wilson negligent in his
16 treatment of Mr. Miller by a preponderance of the evidence?
17 Now, preponderance of the evidence just means slightly more
18 likely than not. We're not trying to convict him of a
19 crime, just preponderance of the evidence.

20 Now, in legal terms, negligence for a doctor is the
21 standard of care. We use that. Doctors don't use standard
22 of care, they say what you're supposed to do under the same
23 or similar circumstances. What does a reasonable doctor do
24 when they're presented with something like this? And I
25 think that we've pretty clearly shown that. We're going to

1 go over a few of the high points.

2 But what you're going to find not in this verdict form
3 is that nobody says Mr. Miller did anything wrong at all.
4 Nobody says he did any wrong thing at all. That's not a
5 consideration in this case. That's not a consideration in
6 this trial. Not even that fellow out of Charleston says Mr.
7 Miller did anything wrong.

8 So when you talk about standard of care, there's two
9 things that are required in this case. And this is what the
10 evidence has been and I don't think there's any dispute
11 about it. The first is that if cancer's on the table, you
12 have to rule it out. And the only way you do that is with a
13 biopsy and that didn't happen. Secondly, if you're not
14 going to do the first, then you have to inform the patient.
15 Tell them cancer is on the differential, tell them the MRI
16 didn't rule it out so that the patient can then protect
17 himself. There's no doubt that that didn't happen. Either
18 one of these is a deviation from the standard of care. It's
19 negligence by a doctor. It's not being careful the way
20 they're supposed to be. We only had to prove one, I think
21 we've clearly proven both.

22 Failure to either rule it out or properly inform the
23 patient is below standard. That's been clearly established.
24 Either one is sufficient and we need not prove both. If we
25 prove one or the other or both, then we are entitled to have

1 the first question answered as yes under the law.

2 Let's talk about the first one. Must rule out cancer
3 with a biopsy. There is no doubt that cancer was on the
4 table. In fact, we heard a lot of cockamamie theories by
5 Dr. Wilson and a lot of cockamamie testimony by that fellow
6 from Charleston who said there was a million things on the
7 differential diagnosis. There were 30 things this could
8 have been. That was all false.

9 And we know it's false because what Dr. Wilson put in
10 his notes is malignant neoplasm of the tonsil. And his
11 notes is Exhibit 1. I want you to look at all the exhibits.
12 He didn't put in there 30 things. He put malignant neoplasm
13 of the tonsil. And I think Dr. Wilson made it a little bit
14 interesting when he said well, I never used the word cancer.
15 He put it on his bill. The problem is malignant neoplasm of
16 the tonsil. And he ordered that MRI. When he ordered the
17 MRI, why? Malignant neoplasm tonsil. So for him to say
18 that it could have been 30 or 40 things, that's just not
19 true. It was cancer, that's what was on the table.

20 And, in fact, their expert from Charleston, this was
21 his testimony: Would you agree in this case Dr. Wilson had
22 a concrete concern for cancer of Mr. Miller? Absolutely.
23 Why? Because that was his number one thing on the list.
24 This is their own guy. They paid him more than \$30,000 to
25 come in here and say that.

1 So what is an ENT supposed to do? And this is again
2 from that fellow from Charleston. This is what he says: So
3 does an ENT, if they have a concrete suspicion of cancer in
4 a patient need to rule it out? Correct. Absolutely. He
5 didn't hedge, he didn't hem, he just said correct, that's
6 absolutely true. And it is the absolute truth that Dr.
7 Wilson knew from the beginning of this trial and from the
8 time that he was seeing Mr. Miller back in 2013. That's the
9 truth. It just is.

10 Now, how do you do that? How did you rule out cancer?
11 Well, that fellow from Charleston helps us out again. The
12 only accepted way in the ENT world to rule out or rule in
13 cancer is by way of biopsy. Is that true? True. No
14 equivocation. That's how you do it. Never a dispute, never
15 a question outside of this courtroom if a patient may have
16 cancer, you rule it out with a biopsy. But once you're in
17 this courtroom, this they start getting all hinky with it.

18 We know for a fact -- this is Dr. Wilson's testimony,
19 absolutely. He never ordered a biopsy, never did a biopsy.
20 We all know that. If he had, we wouldn't be here. And Dr.
21 Wilson, in his testimony, we went over this, too, that's
22 what he told us. He told us on the stand, told us the same
23 thing he told us before. So he could, in fact, have had
24 cancer starting March 26th when you had first seen him,
25 right? That's when you had first formed the possibility in

1 your mind, right? And he said yes. And the test you
2 conducted did not rule out cancer? That's correct. That's
3 a deviation from the standard of care. That's negligence.
4 Under the law, that's negligence. It's not even a close
5 call.

6 Hornig goes on, Hornig is that fellow from Charleston.
7 If what Dr. Wilson saw in or on Mr. Miller's right tonsil
8 gave Dr. Wilson a concrete concern for cancer, do you
9 believe he had an obligation to rule it out? And he says,
10 of course, absolutely. This is about as clear a bright line
11 in medicine that there could ever be. And Dr. Wilson never
12 biopsied it? He did not. This is about as straightforward
13 admission from a highly paid defense expert witness that you
14 could ever get. And this is not one of those things that's
15 a judgment call, well, should I, should I not? It's not
16 that at all. You have to do it. Period. End of sentence.
17 That's all there is to it.

18 So to go back to where we started, part A, we've proven
19 that. If cancer is on the table, you must rule it out or in
20 by way of biopsy, he didn't do it.

21 The other way Dr. Wilson is negligent is by failing to
22 inform Mr. Miller that he didn't rule out the cancer. Well,
23 I can show you evidence on that. Again, this comes directly
24 out of the Defendant's mouth. Must inform the patient. And
25 this is what Dr. Wilson testified to in this court. Does

1 the standard of care require an ENT to inform his patient
2 cancer is on the differential diagnosis? And he said yes.
3 And I asked him, Does the standard of care require an ENT to
4 inform his patient that an MRI does not rule out cancer? He
5 said yes. He never did either one of those. Never did
6 either one of those. And we know that from his own
7 admissions.

8 And if you recall, he said all I know is what's in my
9 chart. I have no memory of anything, all I know is what's
10 in my chart. We know what Mr. Miller said, we know what the
11 facts are and we know what his charts says. And we know
12 that it says -- does the chart support anywhere that you
13 informed Mr. Miller the MRI did not rule out cancer? And
14 the answer to that is no.

15 We know -- I think you got the flavor or the character
16 of Mr. Miller that if he had been told hey, buddy, you could
17 have cancer and I haven't ruled it out, this MRI doesn't do
18 it, you need a biopsy, Mr. Miller would have done one of two
19 things. He would have either said well, let's do the biopsy
20 or I'm going to go somewhere that will make this happen.
21 Because he went to this fellow because he was worried about
22 the VA taking too long and not doing a good job. If he was
23 going to go outside to get this problem addressed, he
24 certainly was not going to let it ride if he was told the
25 MRI didn't rule out cancer and if he was told he may have

1 cancer and it hadn't been ruled out. That just defies any
2 common sense.

3 So first question, we think we are entitled to have you
4 check that yes box. Was he negligent? Yes. He didn't rule
5 out the cancer with a biopsy and he didn't tell him he
6 needed to get it done somewhere else or he still had a
7 problem.

8 The second question: Was Dr. Wilson's negligence the
9 proximate cause of David Miller's injuries? Yes. Now,
10 legally, we're not saying that he caused the Stage 1 cancer,
11 but we're saying that legally the proximate cause was Dr.
12 Wilson's conduct was that it went from Stage 1 to Stage 4.
13 That's the cause of the injury.

14 So the question is what is the difference between what
15 it would have been in 2013 and what it was in 2016. That's
16 the injury. That's the proximate cause. Because if this
17 guy had done his job, the same job that any other ENT would
18 have done, it never would have gotten to Stage 4, it would
19 have been treated at Stage 1.

20 And we heard from Dr. Blum about what the difference
21 was. There's no other evidence, this is just the evidence.
22 It's just the truth. In 2013, Stage 1, it would have been a
23 tonsillectomy, no further treatment would have been required
24 and he would have had a 70 percent plus cure rate. In 2016,
25 we know it's Stage 4, he got the radiation and all those

1 side effects and future problems of salivary glands gone,
2 taste buds are gone, the scarring and the burning.
3 Chemotherapy and all those future risks and a less than 30
4 percent cure rate. That's just the truth. It's just
5 medical science. There's no other evidence to say anything
6 else. It's just the science.

7 And we know -- I think somebody said they weren't
8 convinced it was the same spot. The image on the left is
9 from Dr. Wilson's chart and the one on the right is from the
10 VA in 2016. The uvula, that little -- this little area
11 corresponds with this area here, so it's got the tumor
12 growing in the same area that this was drawn. They're
13 saying it's just coincidental.

14 So we think we have proven to you that his negligence
15 was the proximate cause. It was the proximate cause. If he
16 had just done his job, Mr. Miller wouldn't be here and y'all
17 wouldn't be here. He wouldn't have the Stage 4 cancer. He
18 wouldn't have gone through everything he went through.

19 The next question you'll be asked is what are the
20 damages. And that's the hard part. The medical bills are
21 economic. You'll see there's two options here, one is
22 economic and one is noneconomic. Economic is the things you
23 put a number on and that's Exhibit No. 7. And you'll have
24 it. And this is the medical bills for the radiation and the
25 chemo and the port to get chemo. It's not for anything

1 else. It's just for those things that were required. We're
2 not asking for any of the medical care providers anywhere
3 else or anything else, just the radiation, the chemo and the
4 port that were required. And that number is \$221,451.74.
5 The Carolina Blood & Cancer was chemo, Rock Hill Radiation
6 was radiation and the PMC, that's Piedmont Medical Center,
7 that was to get the port put in and the port to be taken
8 out. That's what that was for.

9 The noneconomic damages are a more difficult question.
10 I think you might have been a little surprised when I said
11 in opening about what we were asking for there, but, you
12 know, what we heard in this trial was that this what he went
13 through. The orange dots is the radiation and the yellow is
14 the chemo. And so he went through all of those treatments
15 for all of those months. And it wasn't just the time, it
16 has lasting and important impacts on his life.

17 So I think we can all agree that we exist more than
18 just to live and breathe and work. And a lot of one's
19 enjoyment of life is just not being impaired. You know,
20 being able to taste things and break bread with your friends
21 in celebrations. A lot of our society involves food and
22 fellowship. Our culture is that way.

23 He's got permanent cotton mouth, dry mouth. He's got
24 the scarring. He was literally bolted to the table, this
25 mask that was formed around his face and he was screwed into

1 the table so he couldn't move while the radiation was
2 burning him. And he was there on that table getting burned.
3 And it wasn't the burning that day. It was what it was
4 going to do tomorrow. Because it may feel a little funny
5 when it's happening, but the effects start immediately
6 thereafter and they build day after day after day.

7 And on day 20, when you're burned and your skin's gone
8 and your throat is raw and your hacking up phlegm and you
9 know you have 15 more days, you have 15 more times it's
10 going to get worse, 15 more times, 20 more times. And on
11 the 30th day, you know you have to sit there and be bolted
12 down five more times. And that burn is only going to get
13 worse. That scar is going to be with you. It does take a
14 toll on you. And I mean with this with no -- with peace and
15 love and great admiration for David, but this is what he
16 looked like before the radiation and before the chemo.
17 That's what radiation and chemo can do to you.

18 And I think we all know that once we're sort of pushed
19 down the aging spectrum that we don't come back. We don't
20 miraculously get younger and we don't wake up with less pain
21 in the morning or less impairment in the morning. It only
22 gets worse. And if you're young and you're energetic and
23 you have a dog named Buddy that you love to walk and you're
24 engaged with your friends and you're able to live your life
25 as you deserve to be able to live it and something like this

1 happens, you're pushed further and quicker down the road to
2 being infirm and in pain and sick.

3 Now, the noneconomic damages is up to you. It's
4 completely up to you. We mentioned the word eight million
5 dollars in opening, but it is a hundred percent up to you.
6 And I want to just give you some context. And I'll be frank
7 with you, I don't know that I've ever run into a witness
8 quite like Dr. Hornig, but I just did some quick math.
9 Apparently, Dr. Hornig thought his time to come here from
10 Charleston was worth \$14,000 a day. I didn't know York
11 County was so bad, you had to get paid \$14,000 to come from
12 Charleston. But if you just look at that -- I mean, this is
13 insane what this guy was doing. If he lives on 13 years,
14 80, 81, at Dr. Hornig's rate of pay, 66 million dollars.
15 We're not asking for that. That's just some context of what
16 folks will do and I think what some folks will require them
17 to pay to say certain things.

18 The next question -- what you would do is you would
19 write in economic, which we would ask to be what's in
20 Exhibit No. 7, 221. And then the other is noneconomic and
21 that is 100 percent up to y'all. Y'all decide what's right
22 and appropriate.

23 The next question is whether Dr. Wilson was reckless or
24 grossly negligent in his treatment of Mr. Miller. Now,
25 we're going to ask you to check that question yes as well.

1 You're going to see a pattern, everything is going to be yes
2 from our perspective.

3 Now, recklessness is two types, one of two types. What
4 the judge will tell, we expect the judge will tell you is
5 that the actor knows or has reason to know of facts which
6 create a high degree of risk of harm to another and
7 deliberately proceeds to act or fail to act in conscious
8 disregard of or indifference to that risk.

9 So what does that mean? If a doctor knows that his
10 patient could have cancer and knows that cancer untreated
11 and undiscovered can be very, very bad and doesn't do
12 anything about it, that's recklessness. That's
13 recklessness. It might be a different question if Dr.
14 Wilson didn't say, you know, you could have cancer because
15 clearly, he knew it was cancer or could be cancer and didn't
16 do anything about it. That's recklessness, that's conscious
17 disregard.

18 So what do we have to prove on that? What are really
19 the questions on these things? Did Dr. Wilson know or have
20 reason to know of facts which create a high degree of risk
21 of harm to another? Well, we know for a fact that he knew.
22 And we know that by his own testimony. This is what he
23 said, So you had a conscious concern on that day about Mr.
24 Miller having a malignancy or cancer in his tonsil, yes?
25 Yes. Conscious concern, that means he knew for a fact, he

1 knew. So that first element is yes. Did he know? Yes.

2 The second question is, Did he deliberately fail or
3 have a conscious disregard or indifference to that risk?
4 Indifference is I don't care, it's not my cancer. It's not
5 my tonsil, what do I care? Clear evidence out of his own
6 mouth that that is true. So he could, in fact, have had
7 cancer starting March 26th when you would have first seen
8 him, right? That's when you would have first had that
9 possibility in your mind, right? Yes. And the test you
10 conducted will not rule out cancer? That's correct. That
11 is conscious indifference. That is, you could have cancer.
12 No big deal to me.

13 And he went on to testify that he knows that the only
14 way you get it ruled out is with a biopsy. So with this
15 lesion, the way to rule it in or rule it out is by looking
16 at your tissue, the pathologist does that; is that true?
17 True. So he knew how he was supposed to do that. The only
18 way to rule it out is biopsy. He knew that. Did you ever
19 order one? No. None of this should be a surprise. This is
20 what he said.

21 So he knew cancer was in there. He knew what it could
22 do. Everybody knows what cancer can do, especially a
23 doctor. And he knew that he didn't do anything to rule it
24 out. That's conscious indifference, that's recklessness.

25 So the second part of option one, did you deliberately

1 fail to act in conscious disregard or indifference to that
2 risk? Yes, of course, he did.

3 The other option, which the judge will instruct you on,
4 is did he know or have reason to know of facts which create
5 a high degree of risk of harm to another but does not
6 realize or appreciate the high degree of risk involved? The
7 answer to that is yes, also. We only have to prove one or
8 the other. Did he know the facts which create a high degree
9 of risk to another? Yes, he knew this could be cancer in
10 Mr. Miller because he put it in his chart and he admitted
11 it. Because it was true.

12 And did he not realize that or appreciate it. Who
13 knows? Who knows what was going on in his mind. We know
14 that he knew it and we know that he didn't do what he was
15 supposed to do to rule it out. That is by definition
16 recklessness. So we'd ask for your checking this box yes as
17 well.

18 The next question is on the next page. And that is,
19 Was his conduct reckless or grossly negligent to a level of
20 clear and convincing evidence. That's legal talk. We've
21 heard about criminal stuff on TV, beyond a reasonable doubt.
22 And civil stuff is preponderance of the evidence. So
23 preponderance is slightly more than half, 50 percent plus
24 one. Reasonable doubt is so that you have no doubt of the
25 reason behind it, they're a criminal, you're going to put

1 somebody in jail. Clear and convincing is in between, you
2 have to be clearly convinced that what is sought to be
3 proven is true. And I think that if we listen to this
4 fellow, he's proven the case. There's no dispute, there's
5 no doubt, there's no I don't know, maybe. So we believe
6 we've proven this clearly and convincingly from the
7 testimony of Dr. Wilson himself and, again, that fellow out
8 of Charleston.

9 The next part is should punitive damages be awarded
10 against Dr. Wilson. Question five, it says legally, we'd be
11 entitled to have you consider that. But number six is
12 completely up to you as well. The purpose of punitive
13 damages is not to compensate Mr. Miller. That is done
14 through the economic, noneconomic. That's to send a message
15 to say listen, this ain't right. It's to punish and deter
16 this guy and others like him in the community.

17 Now, you may not realize it, but people pay attention
18 to what happens in courthouses. And if you were to render a
19 verdict that says listen, Dr. Wilson, this is beyond pale,
20 this is nuts, this is crazy, you can't do this. Then other
21 doctors are doing to say oh, no, we've got to be careful. I
22 don't want to be that guy. I don't want that to happen.
23 That's what punishment and deter means.

24 Now, whether this Defendant has the ability to pay it
25 or not is not something to be considered. Whether it's

1 purely message or purely just saying what you need to say,
2 you need to be reasonable in this. And we would ask if you
3 get to this point, obviously, we want you to do this because
4 we think it's important, not so much for Mr. Miller, but the
5 next guy. We ask for punitive damages, again, something
6 reasonable and no more than three times what the noneconomic
7 and economics are. I mean, you don't need to go crazy with
8 it, but just be reasonable.

9 So what is really the defense here? Well, they say the
10 spot was there and then it disappeared and then came back in
11 the same place. You've seen the pictures. You've heard the
12 testimony. That's just, quite honestly, bogus.

13 We know that Mr. Miller has been consistent and
14 truthful from the beginning based on the medical records.
15 We know that the first ENT consult says patient has had
16 issues with tonsils for years. We know that the
17 hematology/oncology consult -- this is all in the VA
18 records, progress notes, there's a whole section there.
19 They're in date order latest to first -- last to first. If
20 you want to see all those, they're in there. There's a
21 section that's around Page 300 or so, you'll see on the top
22 a big thing that says progress notes in the VA record, Dorn
23 VA, which I think is No. 2, Exhibit No. 2. Around Page 300,
24 you'll see all these progress notes. You can read them for
25 yourself.

1 And the hem/onc one says: 65-year-old male with
2 hypertension, coronary artery disease referred from ENT
3 clinic for tonsillar cancer. Patient states that three
4 years ago, he started experiencing intermittent right-sided
5 sore throat. He was seen by a local ENT, that's Dr. Wilson,
6 in Rock Hill, who ordered an MRI of the neck, which patient
7 says he was told did not reveal malignancy. Placed on
8 antibiotics, et cetera, et cetera. One thing you may
9 conclude about Mr. Miller is that he's consistent.

10 Same thing in the radiation notes. This is Exhibit No.
11 5, Dr. Thakkar. Delightful 65-year-old nonsmoker, Marine
12 veteran presenting with a large tonsillar cancer. Notes
13 tonsillar irritation about three years ago, saw an ENT in
14 Rock Hill. Workup was negative. Symptoms persisted, but
15 he's clear they did not progress significantly until
16 recently when he sought additional input from Dr. Wells
17 after bringing this issue to his PCP.

18 So if their argument is that the spot was there and
19 disappeared, then what that means is -- and I don't know if
20 they're going to be quite this straightforward because I
21 don't know that they are ready and willing to go this far
22 out on a limb. But what they're going to have to say is
23 that Mr. Miller is a liar and he lied to the doctors that
24 were treating him. And every chance he got to lie to the
25 doctors, he was lying to the doctors. That's their defense.

1 They don't want to say it, but that's their defense.
2 Because Mr. Miller was completely consistent, told all of
3 this to the doctors who were treating him because it was
4 going to be important, going to be important.

5 So what do they look at? Well, we've seen this, this
6 is the ER records. This is Dr. Siddiqi. Again, this is
7 actually Page 327, you'll see it in there. And you'll see
8 where it says progress notes, that what they are in the
9 records. This is from April 16th, 2013, when the spot was
10 at its smallest and he's having a heart attack in the
11 emergency room. And they're saying that because Dr. Siddiqi
12 looked down in there and didn't see a spot, therefore, it
13 wasn't there. That's something.

14 Well, let's continue down this road for a minute
15 because there's something very important in the CT scan that
16 I think it's been hidden from you so far. Internal medicine
17 note, this is when he was down at the Charleston VA. He's
18 getting heart stents. The internal medicine person said his
19 throat was fine, so that means there was nothing there.

20 This one is good. Oh, this is from a nurse down in
21 Charleston who says EENT, no complaints. Now, this is while
22 he was in the hospital with his heart problem. And this is
23 while he's being seen by Dr. Wilson. So their theory, their
24 argument is well, because Mr. Miller said he had no
25 complaints, therefore, he had nothing wrong with his throat,

1 even though this was in between the second and third visit
2 with Dr. Wilson. Come on. Even in the cardiologist
3 procedure note. That's from Charleston, also.

4 But what's important about this is a couple of things.
5 One is his mallampati score. See this? And what we went
6 over -- what that looks like is this. You can't really see
7 down in there. So even on his best day, this was the
8 smallest it was going to be because it was in between the
9 second and third visits. You can't see down there anyway
10 and they're saying because these doctors were worried about
11 his heart and worried about emergency room, therefore, it
12 wasn't there.

13 Well, here's where the scan occurred. And I can
14 promise you that Dr. Hornig knew this and I can promise you
15 that Dr. Wilson knew this because it's in the medical
16 records and they're medical people. I don't think Mr. Davis
17 knows about this. I don't think he's been told this, but
18 we'll see. This is the CT scan. It's a CT scan result.
19 And it's from February of 2016. And I'm going to put that
20 up there. And here's what it says. There's a mass in the
21 right palantine tonsil, begins below the level of the soft
22 palate. The soft palate, as we learned, is the tongue. And
23 when you stick out your tongue, all you can see is the soft
24 palate. And this tumor began below that, so you couldn't
25 see it. They knew you couldn't see it. Even when it was in

1 February of 2016 because it began below the level of the
2 soft palate.

3 Now, I don't expect y'all or lawyers to know that, but
4 I expect some fellow from Charleston charging \$14,000 a day
5 to know that fact. And I would expect the Defendant double
6 Board certified in ENT and facial plastic surgery to know
7 that, yet, they persisted, they persisted in trying to tell
8 you that because they couldn't see it, it didn't exist, when
9 they knew all along that the CT scan, when it was at its
10 biggest said it began below the level you could see, below
11 the level of the soft palate. That's pretty bad. That's
12 pretty bad.

13 Then they go on and they -- this one is a doozy,
14 frankly, where that fellow from Charleston well, Dr. Wilson
15 said he didn't see or feel anything on that second or third
16 visit. Now, I think this witness was a little reluctant
17 ultimately to admit that he was relying upon records that
18 are clearly fraud, cleared faked by Dr. Wilson.

19 Let's start with how we know that, what the evidence is
20 -- well, this is the first visit, March 26th. This is in
21 the record as Exhibit No. 1, you'll get to see it. And one
22 thing that we can point out, none of y'all have seen this,
23 but this is the original chart. This is what his chart is.
24 Now, on computers, we all know about cutting and pasting.
25 Well, this is literally cutting and pasting. He would get

1 these typed up, cut them out and glue them in the chart.
2 What does that mean? It means we have no idea what the
3 truth is. These could have been put in whenever. It's not
4 like an EMR where it's dated and timed. We think it was
5 probably generally around that time.

6 And it says right here, he gagged with the mirror.
7 Remember his testimony was he couldn't do it. He just
8 couldn't do it with a mirror. Couldn't look in there. So
9 what did he do on his first visit? Well, he stuck a scope
10 down there, a laryngoscopy scope. That's what you're
11 supposed to do because if you can't see it with a mirror,
12 you've got to see it somehow. And if you do that, you're
13 billed for it. The bill's in there, too. The bill is in
14 Exhibit 1, you'll see it. And he charged him for a new
15 visit and the scope, so we know he did it on the first one.

16 Going to the second visit, 4/2. He then claims
17 hypopharynx is unchanged. Hypopharynx, y'all recall, is way
18 down in there. There's no way to see that. There's no way
19 to know that unless you do a scope or a mirror. Mirror is
20 not an option because he's not having it. We know he didn't
21 do a scope because he never said it and he never billed for
22 it.

23 Now, we can the records are questionable and all that,
24 I would respectfully submit that the doctors are going to
25 get their bills right. They may not get their charting

1 right, but they're sure enough going to get their bills
2 right. If it wasn't billed for, it wasn't done. You can
3 look at the bill and see on that visit, which for forever
4 reason, they billed it nine days later on 4/11. It says
5 established standard low complex, \$110, there's no scope.
6 You'll see it for yourselves. And for whatever reason, it
7 was billed nine days later. But we know he claims it was
8 unchanged, but you can't see it without a scope, you just
9 can't.

10 And then on the 23rd, this is the one that they really
11 rely on. Same thing, he says the hypopharynx is mostly
12 clear. You don't know unless you scope and he didn't scope.
13 There's never any mention of scoping, he didn't bill for a
14 scope. We also know that that visit was in the office where
15 he told Mr. Miller, well, you don't have to worry about the
16 C word. You'll see it again. Says established standard low
17 complex, there's no scope on the bill. Check my work. It's
18 in there.

19 This is the same visit Mr. Miller said was in his
20 office, the consulting office where I think Dr. Wilson said
21 he consulted with plastic surgery patients. It's not an
22 exam room, so there was no ability to do any of this stuff.
23 So this record is exactly consistent with what Mr. Miller
24 testified to.

25 But the import of that is even bigger, that this is guy

1 is willing to say things in his medical records that are
2 just false, just not true, not true at all. And then you
3 get this guy from Charleston coming in, who's paid \$30,000,
4 and the best he could do was to say that the records are
5 sometimes questionable.

6 So we know that these records are not right and we know
7 that their only hope and only defense is to say well, I
8 examined him and it wasn't there. I guess the question is
9 do you feel like you need to believe Dr. Wilson on that
10 point when he is -- good evidence suggest that he's not
11 believable on any point.

12 Now, I'm done. I've done everything I can for Mr.
13 Miller. This is up to y'all. What's going to happen next
14 is Mr. Davis is going to get up, he'll have a chance to
15 speak with you and then my colleague, Ms. Goodstein, will
16 have the final words. This His Honor will give you the law
17 and then y'all will have to decide the case, have to figure
18 out what the right thing to do here is.

19 I hope you know that we feel that we've done everything
20 we can for Mr. Miller. If I came across too harsh
21 sometimes, he's my guy. I'm protecting my guy. That's what
22 we do. Hold that against me, not him.

23 Again, thank you for your attention. I'm sure Mr.
24 Davis and I will share in our admiration for what you've
25 done and will do in this case. Thank you.

1 THE COURT: Mr. Davis.

2 MR. DAVIS: May it please the Court, Your Honor.

3 CLOSING ARGUMENT BY MR. DAVIS

4 MR. DAVIS: Good morning. The way the rules work is
5 this is the last time I get to address you. The Plaintiff
6 gets to go last because they have the burden of proof. So
7 on behalf of Dr. Wilson and all the defense team, I want to
8 thank you for the attention you've shown to us and,
9 particularly, your patience because of the way court has had
10 to work. I promise you it's not usual where we get a day
11 off during the middle of the trial. But I appreciate that
12 very much and Dr. Wilson does, too.

13 You know, in these type of cases, Mr. McGowan and I
14 agree on one thing, you are what some people refer to as the
15 voice of the community, the conscious of the community in a
16 case like this. Your verdict goes out there and people do
17 hear about it and they hear about what you've done and it
18 may or may not impact the way people operate their business.
19 In this particular case, it may or may not impact the
20 medical community. But you should be aware it probably will
21 because people will hear the verdict in this case and people
22 may conduct themselves accordingly. So I'm going to take a
23 few minutes because I only get one time to speak with you
24 and this is my last time to point out to you some of the
25 things I think are important for the Defense case.

1 You know, obviously, by now that these cases are made
2 up of two forms of evidence. One of those is records and
3 the other one is testimony. When I did my opening
4 statement, I mentioned to you that I considered this as the
5 tool that you need. You know, jurors come from all works of
6 life. And they come in a case, particularly a medical case,
7 which can be somewhat technical, have some foreign terms in
8 them and things we aren't used to seeing or hearing in our
9 everyday lives and it's kind of tough. So I think the
10 lawyers owe you the tools that you need to come to the
11 decisions that we want you to come to. Mr. McGowan
12 obviously represents his client and has done so well and,
13 hopefully, we've done that for Dr. Wilson. So I consider it
14 our job to sort of give you the tools you need to decide for
15 one side or the other. And that's the evidence.

16 Now, the first form of evidence is the records.
17 There's no question about that. You can see the records
18 which are here. These records are all records of medical
19 witnesses. They're records of people who have treated Mr.
20 Miller at one time or another throughout the period of his
21 life which concerns this cancer. Dr. Wilson's records are
22 there. There are records from the VA Hospital and there are
23 records from the cancer treatment center.

24 As I told you at the beginning of this case, though,
25 there's only one treating physician who's going to testify

1 and that treating physician is Dr. Wilson, who has
2 testified. All of the other physicians who diagnosed,
3 treated and took care of Mr. Miller throughout this case,
4 none of those people will testify. No live witness who
5 actually had his hands on Mr. Miller and treated Mr. Miller
6 was called to testify in this case.

7 What those records contain are simply the notes of
8 physicians who treated Mr. Miller. Those notes are not made
9 for trial. They aren't made for lawyers. They're made
10 because other doctors might pick up the care and treatment
11 of a particular patient. So that's doctor speak that's in
12 there. It's not lawyer speak. And sometimes it's tough for
13 us to understand and we need doctors to explain it and I
14 think that's been done in this case. There's certain things
15 that we'll talk about later on that may be implied by those
16 records because one doctor would know what another doctor
17 had done. So from the defense side, we take those records
18 at face value. We're not saying that any person who saw Mr.
19 Miller at the VA or anywhere else is necessarily lying or
20 trying to mislead anybody. Why would they? They have no
21 reason to. So we take those records at face value.

22 If the Plaintiff would have wanted you to hear from
23 those doctors, they could have had them in court. As we
24 talked about in opening statement, the Plaintiff has the
25 burden of proof. It's their job to give you those tools and

1 to bring those witnesses to you to testify. In this case,
2 all we have is the records. We have their comments and
3 history on how they treated, but we'll never have their
4 opinions because they weren't brought to this court. And
5 like Dr. Wilson testified to, his testimony from the Defense
6 side, we think you need the whole picture of what happened.

7 In Dr. Wilson's records, for instance, there's a lot of
8 agreement between Dr. Wilson and Mr. Miller. Mr. Miller
9 shows up with a spot on his tonsil and that's written in the
10 record. What is odd in this case -- and it's really not odd
11 when you think about it, is Dr. Wilson has no memory of this
12 patient. If you think about it, why would he?

13 From his standpoint and what the records show, a
14 gentleman came in his office with a spot on his tonsil. He
15 saw him two times within the week and the spot started to
16 clear up. Then he didn't see him for three weeks. And when
17 he came back, according to the records, the spot was gone.
18 He had taken an MRI and the MRI showed no mass on the
19 tonsil. And he asked him to come back, to followup if
20 necessary.

21 I don't know about you, but I'm sure there's some
22 people who have had that experience with their physician
23 where they've gone in and the doctor says I want you to go
24 home and if you have any more problems with it, come back.
25 Mr. Miller never came back. I'm certain that Dr. Wilson

1 would have thought this patient is fine because he didn't
2 come back to see him. And all that took place within a
3 month, one month.

4 So what we're left with is the fact that Dr. Wilson
5 only saw this person three times, on three visits, for a
6 total of a month. And now, because cancer was diagnosed
7 three years later, he's being held responsible for it. It
8 would be nice if he had some kind of memory of it. Believe
9 me, we would like it on the Defense side. He could get up
10 there and say to you -- if he was as dishonest as Mr.
11 McGowan would like for you to believe, he could have said
12 oh, yeah, I remember doing this, I remember doing that. I
13 recall telling him this. He didn't do that. He told you
14 right off the bat. I don't remember. I have to go by these
15 records.

16 All medical records, I assure you, are imperfect.
17 Doctors made medical records and put them in different ways.
18 Some doctors include some things in medical records that
19 some people don't. There's no rule they go by. It's just
20 pretty much to cover where you can pull out somebody's chart
21 to know what was done on what day in general terms. And
22 that's what you have here.

23 This is interesting. What Dr. Wilson saw on the first
24 day, as I said, comports with exactly what Mr. Miller said.
25 There was a spot on his tonsil. The interesting thing is

1 that throughout this trial, throughout the discovery,
2 throughout the depositions and everything, Mr. Miller has
3 been completely consistent that he could see this spot, that
4 he could put his finger on the spot, and the spot was always
5 there and never went away.

6 So it's intriguing to me now that Mr. McGowan in his
7 argument to you would pull out a medical record that says
8 oh, by the way, you couldn't see it. Oh, this CT shows that
9 you couldn't see it. Well, if we couldn't see it, we
10 couldn't believe anything that his client says because one
11 thing he's been very consistent about is this was always,
12 always, always visible.

13 Now, you can talk about the medical training of the
14 different people we've introduced their records, the
15 different medical providers, you can talk about their
16 training if you want to. But I submit to you that it's
17 completely within your purview to believe that if Mr. Miller
18 can see it, these people can or should. And when they
19 don't, that gives us reason to disbelieve that it's there.

20 In Dr. Wilson's record, I want you to pay close
21 attention if you will to how this thing is written up. And
22 you'll see that he calls it an erythematous spot. And then
23 if you care to, if you look over the records, there's a
24 diagram there. And you saw that on the screen. If you turn
25 over to the diagram, you see there's no circle drawn,

1 there's no spot there. It's hatched like this. It's more
2 like a rash than anything else. And you'll see that in the
3 drawing. He drew exactly what he saw. He can't tell you
4 today what he remember about it, but he can tell you from
5 that drawing what his feelings were about what he saw on
6 that particular day. So it's just more like a rash.

7 But he examines the man on the first day and orders an
8 MRI. There's no question, nobody's questioned the fact that
9 an MRI can diagnosis cancer. It cannot. But an MRI is a
10 tool that's used in order to get to the point where you can
11 diagnose cancer. It determines whether or not there's a
12 mass there. So while Dr. Wilson may start out on the first
13 visit with a suspicion -- some physicians call it an index
14 suspicion, in other words, looking at different things here,
15 differential diagnosis. He may start out with a suspicion
16 that there's a mass there, the MRI leads him away from that.
17 He gets back a negative MRI. The radiologist reads it and
18 says I don't see a mass here.

19 Now, the question becomes what do you biopsy if you
20 have no mass? Where do you cut? You've got to be careful.
21 Some of the witnesses for the Plaintiff have said oh, well,
22 you only take a little bitty piece of skin. It only takes
23 about five minutes. There's really nothing to it. You
24 ought to just go ahead and do it anyway. It will be fine.
25 Look what happened to Mr. Miller when he did have a biopsy.

1 It got infected. He got sick. He explained it to you
2 better than anyone. That's the risk of a biopsy. That's
3 why you don't want to do it on first blush. You don't want
4 to go into a sore throat and start taking skin. That's why
5 you do an MRI, or the VA did a CT scan, to determine if
6 there's something there I actually want to cut. And then in
7 the meantime, if that index of suspicion lead you towards
8 cancer, now you've got a picture, if you will, from the MRI
9 that tells you the machine doesn't see a mass. It doesn't
10 see anything to biopsy.

11 So now, the second visit was with the erythema clearing
12 up, but not yet clear, a negative MRI. I'm certain the
13 index of suspicion is lower now. So you don't go tell your
14 patient I think you might have cancer. Because now you're
15 being lead on the road that's different from, away from
16 cancer. You're being told as a physician this might not be.

17 When Mr. Miller returns to the third visit, we've got a
18 negative MRI and the report says the erythema has cleared
19 up. There is no erythema anymore. That's when Dr. Wilson
20 allows him to leave and tells him to come back if he has any
21 other problems. That's three visits, that's it. One month.
22 And then three years later, all of a sudden cancer shows up.

23 The Plaintiff's case is, is that Dr. Wilson violated
24 the appropriate standard of medical care. You get to decide
25 what that is. You get to decide what his duty was at that

1 point. What should he have done.

2 You've heard testimony from the Plaintiff's experts who
3 said that he should have done more. You've heard testimony
4 from Dr. Hornig, who we'll talk about in a little bit, who
5 said what he did is exactly what we would have done at MUSC
6 and exactly what an ordinary physician would do. But
7 there's more to the standard of care violation than just
8 that. The Plaintiff also has to prove that that violation
9 led to or caused some kind of problem for the Plaintiff.

10 Now, their case starts out assuming the cancer was
11 present in 2013. The Defense's position is that it was not.
12 We simply don't believe medically speaking and just from
13 clear common sense that a squamous cell carcinoma existed in
14 2013 and sat completely dormant, completely dormant for
15 three years, did not metastasize to any other part of the
16 body other than the lymph nodes in the neck, just sat there,
17 and then all of a sudden, sprung up in January of 2016.
18 That makes no sense. It makes no sense logically and it
19 makes no sense medically.

20 We've heard that the standard of care for ruling out
21 cancer is a biopsy. There's no question about that. No
22 question. I don't know that anybody in the courtroom, any
23 witness testified it wasn't. But that's an oversimplified
24 question. There is no cookbook in medicine. Doctors treat
25 patients by the patient. Every patient is different. Every

1 disease is different in a different patient. There's just
2 no cookbook to go by.

3 So what you need to think about is this, what Dr.
4 Hornig's testimony told us is this, you just can't answer
5 that question yes or no. Ultimately, the answer is yes, but
6 the other question is when do I do a biopsy and why do I do
7 a biopsy and when do I need to rule out cancer? Those are
8 all the questions to be asked under the standard of care.

9 So generally speaking, the answer is yes, but the
10 physician's judgment comes in, too. When, as in this case,
11 you've got an erythematous spot that originally made you
12 very concerned about -- made the physician very concerned
13 about cancer and all of a sudden, it's clearing up and all
14 of a sudden, you've got a negative MRI, now the index of
15 suspicion is telling you you better not cut just yet.

16 What would have happened, what would have happened if
17 he had an infection to a biopsy taken by Dr. Wilson when he
18 had his cardiac event? Thank goodness, he didn't. Thank
19 goodness, he did not do that. Thank goodness, he did not
20 have a biopsy that was infected when he had the cardiac
21 event.

22 I don't know, most of us go at one time or another in
23 our life to a dermatologist. How many times have they said
24 to you, I don't really like that spot on your neck or I
25 don't like that spot on your head. Watch that thing and

1 tell me if it turns red or if it gets irregular or whatever,
2 come back to see me. You don't have to biopsy everything
3 when you first see it. You just don't have to do that.

4 Now, we certainly don't want to send a message to the
5 community that says every swollen tonsil, every growth on
6 someone that looks a little strange, doctor, you better cut
7 that thing down, otherwise, you'll be in this courtroom in
8 York County if something happens three years later. That's
9 not the standard of care today. It's not the standard of
10 care we want. It's not the message I think that you want to
11 send.

12 There was talk in the questioning of the witnesses
13 about the MRI and about the MRI being negative and whether
14 or not there's any value to knowing there wasn't a mass. It
15 occurred to me that while the MRI is not diagnostic, it's
16 sort of like a mammogram. It's not really diagnostic
17 either, but we sure are happy when our wives or our
18 daughters or our loved ones who are females come home with a
19 mammogram that is negative. That's not diagnostic. No
20 biopsies are being performed, but physicians are relying on
21 them to lead them toward other conclusions.

22 The third visit by Mr. Miller is the visit that causes
23 the problem in this case because that's the visit where the
24 records show there was no erythematous spot. You may have
25 heard when Mr. Miller testified that I asked him questions

1 from his deposition. Because at his deposition, he couldn't
2 remember if there was a third visit, to the point of denying
3 there was a third visit almost. He couldn't remember it at
4 all. But we get in court, we get to court and all of a
5 sudden not only does he remember the third visit, he
6 remembers what room he was in and he remembers what was said
7 to him on the third visit.

8 And why was the third visit such a problem? It's
9 because if the third visit is believed, if the erythematous
10 spot was cleared up and if the MRI was negative, there was
11 no cancer there. It was gone. The spot was gone. There
12 was no cancer. If there was no cancer, there's no violation
13 of the standard of care. That's a real problem for the
14 Plaintiff. So what do we have to do? We have to get rid of
15 that third visit some way. At his deposition, he didn't
16 even remember it even happening, but he sure remembered it
17 in this courtroom. And he told you what happened when he
18 was in the room with a desk.

19 I believe he said -- if I'm wrong, you rely on your
20 memory, but I believe he said that Dr. Wilson put the MRI
21 down on the desk, put the film down on the desk and started
22 shuffling them around and showing him about the MRI. Well,
23 you know, it's strange, just as an aside, I asked Dr. Hornig
24 what about an MRI. He told you now they come on disk and
25 come on the computer or whatever. But back then, they came

1 in hard copies. And he told you that you hold it up to a
2 light. You can't see an MRI on the desk. That's why
3 they've got light boxes in physicians' offices because it's
4 not possible to lay an MRI down on a desk and start showing
5 it. It didn't happen. Did not happen. So that third visit
6 is trouble. It's a lot of trouble.

7 There's no question that Mr. Miller had cancer.
8 There's certainly no question that he had a tough time
9 dealing with the treatment of that cancer. Nobody questions
10 that. But as Mr. McGowan told you, the Defendant didn't
11 give him cancer, he had cancer. It's up to you to decide
12 how much treatment he would have had if the cancer had been
13 there in 2013. I suggest to you that it's just not likely,
14 even by common sense or by medicine, that this cancer just
15 sat there for three years. We'll talk about that in a
16 minute.

17 Keep in mind this, that at all times, all times, Mr.
18 Miller insist that this cancer was about the size of the tip
19 of your finger, it was about the size of the end of a cigar
20 and I believe he described it about the size of a pencil
21 eraser. Just about that right there. Now, that's not very
22 big from where you sit right now. But if you put it in a
23 confined place like the throat where someone is looking into
24 your throat and you see it, it -- you can see it. Mr.
25 Miller says he can see it. Therefore, I submit the trained

1 medical personnel should have seen it, too, but they didn't.

2 When we talk about the dispute in the records versus --
3 particularly with regard to the third visit versus what Mr.
4 Miller now says his memory was, you know, you can judge the
5 credibility of witnesses. That's your job as jurors to do.
6 One of the ways you judge credibility is you judge by who's
7 got something to gain by it? Why would they be willing to
8 say something that might not be true? Who would have a
9 reason to not be credible?

10 Now, Dr. Wilson can't be because he's told you he has
11 no memory. His records are the record, it's what they are.
12 So he has nothing else he can say to you about that. It's
13 unfortunate for the Defense, but that's what it is. That's
14 why you've got medical records. Probably if we called some
15 of these VA doctors to the stand, they couldn't remember the
16 faces either. They'd have to just look at the record. But
17 that's pretty normal.

18 Mr. Miller, he remembers. Why does he remember? Well,
19 he remembers because he's asking you for eight million
20 dollars. That's what they said in the opening. It's
21 probably gone down a little bit now, but still, it's a lot
22 of money. It's important to remember when you're asking for
23 a lot of money. On the other hand, on the other hand, if
24 you want to question those records, ask yourselves why would
25 those records be false? What reason back in 2013 would

1 there have been to falsify those records? Because I want
2 you to pay attention when you read those records -- excuse
3 me just a minute.

4 On this side of the records are fax cover sheets.
5 These are where the law firm that represents Mr. Miller
6 requested the records. These records were requested on
7 April the 18th of 2016 and they were faxed twice. That's
8 three years after the treatment. Up until that time, for
9 three years, this chart was in Dr. Wilson's office with no
10 reason whatsoever to even look at it because the patient
11 never came back. No reason whatsoever to worry about
12 whether or not this chart needed to be falsified to defend
13 himself in court. No reason whatsoever. On April the 18th
14 of '16, that was before Mr. Miller started his treatment.
15 He contacted a lawyer before he even got treated and these
16 records were sent. Dr. Wilson found out he was being sued
17 when he got the papers. There was no reason for him to
18 change these records, no reason whatsoever. And from April
19 the 18th of '16 on, Mr. McGowan's firm had a copy of these,
20 so it couldn't be changed. So you can ask yourself who has
21 something to gain here.

22 I do want to address just briefly the issue of the
23 second visit. On the first visit, if you will recall, the
24 records revealed that Mr. Miller gagged when the mirror was
25 inserted and that Dr. Wilson had to use the laryngoscope.

1 You also recall that he was asked on cross-examination about
2 the bill. You have to bill for that laryngoscope. And
3 frankly, it's expensive.

4 So on the second visit, it just says that the area that
5 was being looked at was clear. It doesn't say whether he
6 used a mirror or not, it just doesn't say. And why is that?
7 Well, possibly the mirror worked and that time he didn't
8 gag. You don't always gag. He didn't use a laryngoscope.
9 And I submit to you if he was going to falsify the records,
10 he would have said he used the scope because he could charge
11 for that. He didn't charge for it. I think it's very
12 important, it also says what his blood pressure it and it
13 doesn't say that he used a blood pressure cuff. Doctors
14 would just assume that when they read these records. And
15 that's the way they have to be read in this courtroom.

16 Now, back to the witnesses. As I mentioned in opening
17 and talked to you a minute ago, there are no witnesses in
18 this courtroom who treated this man except for Dr. Wilson.
19 Through the testimony, we heard this, we heard Dr. Thakkar,
20 Dr. Naidu, Dr. Borhanian, Dr. McKie a lot of doctors who
21 treated Mr. Miller. I think Dr. Thakkar and Dr. Naidu were
22 the ones that treated him for his cancer. They're the ones
23 who would know about the burning you've heard about.
24 They're the ones that would know about the mass you've heard
25 about. They're the ones who would know about his prognosis.

1 The Plaintiff has asked you to go back and give him money
2 for how much he suffered before the treatment, through the
3 treatment and after the treatment. These doctors could tell
4 you that. They could tell you that, but they aren't here.

5 These doctors could tell you if they have an opinion as
6 to whether or not this cancer had been there three year.
7 But they aren't here. And Dr. Thakkar and Dr. Naidu, and I
8 believe Dr. Borhanian, they're somewhere around Rock Hill.
9 There are many other doctors in that notebook right there.
10 Some of them -- you've got evidence that the Defense has put
11 forth of them actually looking in Mr. Miller's throat. Mr.
12 Miller agreed with me, they're 70 miles down the road at the
13 VA Hospital, Exit 9. Haven't heard from any of them. They
14 could tell you what they saw, they could tell you what they
15 didn't see, they could be cross-examined, they could be
16 examined by Mr. McGowan. They've actually looked in his
17 throat. Not one is here. You can ask yourself why.

18 As I said before, the burden of proof is with the
19 Plaintiff and they owe you that. It's up to you to decide
20 if they do. What's the best evidence? Who's the best
21 witness that could be here? How about Dr. McKie, he's the
22 one diagnosed him. Could he tell us he was looking at a
23 three-year-old cancer? I don't know. We'll never know.
24 We'll never know.

25 Dr. Myssiorek was here, though. He's never examined

1 Mr. Miller. He's never treated Mr. Miller. He's never
2 talked to anybody that treated Mr. Miller. But he's here.
3 The records don't support his conclusions, he admitted that.
4 You know, you've got to disregard that third visit if I'm
5 going to come to my conclusion. Otherwise, I can't get to
6 where I need to go. And he admitted it, too. Then he came
7 up with reasons why to ignore it.

8 But the problem happened with the record of Dorn, what
9 we called 327, Defendant's Exhibit 1. I didn't hold it
10 back. I didn't wait until the Defense case to bring that
11 out. I took it straight to Dr. Myssiorek and I said all
12 right, here's somebody else who saw him, who saw him before
13 the third visit and this person says there's no erythema.
14 It's cleared up. This is somebody who, essentially, doesn't
15 know Dr. Wilson. He doesn't know about this lawsuit
16 probably. He has no reason for that to be in his record
17 other than that's what he believed.

18 And what the record said, if you'll look at Defendant's
19 Exhibit 1, oropharynx, that's where the tonsils are,
20 everybody has agreed on that, clear. And that's all it
21 really needed to say. But it goes on to say no erythema.
22 The same thing Dr. Wilson would say about a week later.

23 So the Plaintiffs, in order to prove their case,
24 they've got to get rid of that record, too, or, at least,
25 somehow disparage that record. So how do they do it? What

1 they do is they tell you that an emergency room doctor who
2 wrote this is, according to Dr. Myssiorek, well, that's just
3 a triage nurse. Pardon me, but triage nurses are important.
4 ER doctors are important. And they say well, this was a
5 cardiac event, so they wouldn't even pay much attention to
6 the throat. That is wrong 180 degrees and you heard Dr.
7 Hornig tell you why. That's because a person comes in with
8 a cardiac event, they have a great possibility of being
9 intubated, a real good possibility. And one of the things
10 this ER doctor has got to do is make sure that pathway is
11 clear. They call it ABC, airway, breath and circulation.
12 And the first thing that needs to go is the airway. If
13 there's anything this ER doctor is going to be sure about,
14 it's that that airway is clear. That he's taken a good look
15 at it.

16 And he's reported it well, too. He hasn't just said
17 oh, that's good. He's gone on and looked at it and he said
18 no erythema. Why would he say that? He would say that
19 because if there was erythema that was described by Dr.
20 Wilson, when that tube goes down, it could -- if that's
21 scraping like it looks like on that drawing, when that tube
22 goes down and it hits that scraping, then there's blood.
23 And this man is -- if he's got a cardiac event, he's about
24 to get blood thinner and we've got a real problem.

25 So it is highly -- as Dr. Hornig said, it is most

1 important to check that airway. That's why Defense 1 is
2 such an important exhibit in this case. Because we know of
3 all the rest of them, there was a good solid reason this
4 doctor, who's a medical doctor, an ER physician, who,
5 apparently, Dr. Myssiorek doesn't respect at all, to do what
6 he did on the report because the next doctor in the next
7 room is going to pick that paper up and run with it and he's
8 going to count on it being right.

9 Again, if that note of Dr. Wilson on the third visit is
10 correct, there's no case here because there's no cancer in
11 2013. And there's no standard of care violated. And the
12 importance of Defense Exhibit 1 is it confirms that. It
13 confirms it. This man saw that throat before Dr. Wilson saw
14 it the last time and said the same exact -- same words, no
15 erythema.

16 Dr. Myssiorek is so interested in finding cancer in
17 2013, so interested in it that he ignores all the other VA
18 records. He says this nurse doesn't know what she's talking
19 about or this doctor doesn't know what he's talking or this
20 doesn't mean anything. All we can show is the record, I
21 don't know these people. I can only bring you what they
22 said in the medical record, what they intended future
23 doctors to depend on. Because when they write those
24 records, they intend on a doctor four years from now to pick
25 up that record and look at it and believe it and operate by

1 it, treat the patient by it. So I submit to you unless
2 they're the worst kind of bad, these doctors make sure those
3 records are correct because they don't know if they're going
4 to be around when that record is needed. That's his medical
5 history right there.

6 Dr. Myssiorek just wants to challenge the integrity of
7 every single person who gets in his way. This record is in
8 his way, oh, that's no good, the doctor's not qualified.
9 Oh, that was written by a nurse practitioner, that's no
10 good. Nurse practitioners in this state can write
11 prescriptions. They're highly trained people. Maybe not as
12 high as Dr. Myssiorek sees himself, but they're highly
13 trained people. The Defense is not telling you that about
14 anybody. You can judge the credibility the way you want.

15 What's interesting about Dr. Myssiorek is that after he
16 gets through telling me how bad all these people are,
17 they're a nurse practitioner, they might be a D.O., they
18 might be an emergency room doctor, whatever, when he gets
19 through telling you that, then he tells you well, these
20 people are kind of like filters that send him patients. He
21 doesn't want you to believe them in this courtroom, but
22 he'll take patients from them. And that's what he said,
23 because he's not a primary care physician, all these
24 patients were referred. And they were referred from the
25 same people he sits in this courtroom and runs down, tells

1 you not to believe them.

2 You know, when I finally asked Dr. Myssiorek about that
3 third visit, I said, assume, Dr. Myssiorek, the record is
4 correct, just assume the record was correct on the third
5 visit, what would Dr. Wilson biopsy? And his answer was, I
6 think I wrote this down correctly, probably nothing. That's
7 what he said.

8 Then Dr. Blum testified. Dr. Blum, again, never talked
9 to any of these people. He came and testified. And
10 interestingly enough, this is an aside, it's kind of
11 humorous, I think, Dr. Blum stated that he trained at the
12 VA. After Dr. Myssiorek had told us it's not really a place
13 you want to get treated, Dr. Blum said he trained there, he
14 trained at the VA Hospital.

15 And he also told us, and I think this was very
16 important, he was not on that stand to give you any standard
17 of care testimony. And I asked him, I said, Dr. Blum, you
18 don't want this jury to interpret anything you said to
19 indicate any negligence on the part of Dr. Wilson? And he
20 said, That's correct. And why? Because he's an oncologist.
21 He was here -- his primary purpose was to tell us that
22 cancer had been in Mr. Miller's mouth since, at least, 2013,
23 all the way to 2016 and then all of a sudden, in early 2016,
24 it revealed itself sufficiently that it would be operated
25 on. That's what he's here to tell us.

1 But he was told when he was hired, he was told to
2 assume that there was a misdiagnosis. Dr. Blum, I just want
3 you to assume this. I want you to assume that the Defendant
4 is already negligent and now let's work from there. So
5 that's where he started his inquiry, assuming that Dr.
6 Wilson was negligent. It sure makes his job easier, that's
7 for sure.

8 Incredibly, incredibly, after all this testimony, he
9 has no problem telling you that this cancer lay dormant in
10 the mouth of Mr. Miller for three years. And as you've
11 heard from the record, Mr. Miller wasn't complaining about
12 it for three years. Now, once the cancer is diagnosed --
13 that's what you've heard here. You've seen the machine here
14 and the pictures on the screen of the different medical
15 records where Mr. Miller said I've had this cancer for two
16 years in one of them, in another one, he says I've had it
17 for three, in another one, he says I've had it I think
18 further back than that, I've had this problem in my throat.
19 He says all that. But he says it when the cancer is
20 diagnosed. That's not something that appears along and
21 along in his medical records.

22 Up until then, Mr. Miller, I believe, if you remember
23 correctly, agreed on the stand that up until then, he made
24 no complaint about it for three years, had no problem with
25 it, although he could still see it and touch it. And he had

1 certainly not been to any physician about it. You can look
2 at this annual checkups if you want to. It sounds like it's
3 not important where you see that thing that says HEENT and
4 he says no complaints.

5 The only reason that is there is to show you he wasn't
6 complaining about it when he goes in for his annual checkup.
7 And what we do at an annual checkup is the physician or the
8 person who's checking you up, well, how is it going? Are
9 you having any problems? And he says no. He says no. So
10 not only did he not come back to Dr. Wilson, he didn't go to
11 any doctor. Now, what does that tell you?

12 The interesting thing, though, is that when the
13 oncologist testified, Dr. Blum, and I hope you remember
14 this, at first, he says what I just told you. It's
15 perfectly within his expertise to say that a cancerous
16 squamous cell carcinoma can be present for three years in
17 this man's mouth and not reveal itself at all, then all of a
18 sudden, just say here I am. But then, then when he says
19 that he believes that there should have been a tonsillectomy
20 performed, I believe is what he said, or -- yeah, a
21 tonsillectomy. If I wrote this quote down correctly, he
22 said, it probably should have been removed because this
23 cancer has a tendency to spread. Which is it, Dr. Blum?
24 Does it sit there three years or does it have tendency to
25 spread? Come on, help us out here. And he couldn't do it.

1 And why couldn't he do it? Because he admits, too,
2 both experts admit that they have to ignore that third visit
3 recorded in Dr. Wilson's chart. They can't get to where
4 they want to go if that's true. And in doing that, they
5 have to ignore the finding in April of '13 at the VA
6 Hospital that there was no erythema on that tonsil. Well,
7 gosh, that's easy. I mean, that's easy. Just throw it out.

8 What the Plaintiff's case is this, you need to believe
9 everything that Mr. Miller says, you need to ignore the
10 records of Dr. Wilson or assume that they're fraudulent and
11 you need to ignore the records of all the other providers at
12 the VA Hospital who have said something they don't like. Do
13 all that and then give me the money I've asked for. That's
14 the Plaintiff's case. Just pick and choose. If you don't
15 like this record right here, just throw it out and we won't
16 count that. It just doesn't work that way. At least, I
17 hope it doesn't.

18 Now, the Defense case only had two witnesses. Dr.
19 Wilson was one. You needed to hear from him. Even though
20 he doesn't remember anything about this case, he could read
21 from his records. He could try to tell you what the record
22 said and put himself back in that time period and let you
23 know what he intended for that record to say and he did
24 that. You know, it's been almost six years now. And those
25 records were made contemporaneous with the visits as far as

1 we know. He said they were.

2 And at the time they were entered, remember this, at
3 the time they were entered, there was absolutely no reason,
4 none, none has been offered, there was no reason for Dr.
5 Wilson not to put the truth in there. For all we know, he
6 expected Mr. Miller to come back if he had a problem. He
7 said come back prn. That's if you have a problem or if you
8 need to come back. He just never did. Then in April of
9 '16, he sent a copy of those records to Mr. McGowan's law
10 firm. Didn't even know then he was going to be sued.

11 It's not a violation of the standard of care, that's
12 good medicine. Come back when you need to see me, even if
13 it's tomorrow. But the problem cleared up, really, in two
14 visits. On the third visit, it was clear.

15 The other witness was Dr. Joshua Hornig, MUSC, head
16 associate professor in the department of head and neck
17 surgery. MUSC is probably the flagship medical school in
18 this state. Cursory care hospital where cases are referred.
19 You heard his qualifications. 15 years of education before
20 he would practice medicine. 15 years from the start of
21 medical school until he got his specialty done and started
22 practicing. And yet, they attacked what Dr. Hornig was paid
23 or will be paid. You know, these people don't work for
24 free. People make more than that playing sports these days.
25 This man saves lives. One thing I would ask you, if

1 anybody's concerned about what that man makes, we should ask
2 the last person who's life he saved or who's a member of a
3 family life was saved what should he make. That's what
4 should we ask. What should this man be paid?

5 I know these specialists are expensive. I didn't even
6 ask the Plaintiff's experts what they made. I assume they
7 make the same thing. They've got the same qualifications
8 pretty much, at least, Board certifications. They get paid.
9 Somehow, somehow they want you to believe that that will
10 make a man lie. He can make that money without ever coming
11 here. That's what he gets paid for surgery. Why would he
12 come here? Why would he enter an arena he's clearly not
13 familiar with, probably not comfortable with? Just to lie?
14 I don't think so.

15 Why is he here? He's here because I have a duty. I
16 have a duty to my client and I have a duty to you to bring
17 you the best, most qualified expert I can, and I did that.
18 The same thing we would do for any member of our family,
19 same thing you would do for anybody you love, we'd get the
20 best there is.

21 MR. MCGOWAN: Your Honor, I object to this.

22 THE COURT: Sustained.

23 MR. MCGOWAN: It's improper.

24 MR. DAVIS: So let's talk about Dr. Hornig's testimony.
25 What he said, in essence, is he doesn't believe this cancer

1 was there in 2013. And he told you why. The records of Dr.
2 Wilson, confirmed by the records of the VA and, most
3 importantly, by his years and years and years of experience
4 and education of knowing about squamous cell carcinoma,
5 knowing how it works and acts. That's how he knows. It
6 doesn't come and go. It doesn't go dormant. And it wasn't
7 there in 2013.

8 He told you the MRI is pretty much the standard of care
9 to identify whether or not there's a mass. He also told you
10 there was no violation of the standard of care in not
11 performing a biopsy or a tonsillectomy. And he also told
12 you telling Mr. Miller to followup was, again, the standard
13 of care.

14 He also told us that this cancer gets bigger the longer
15 that it's there, which means that if it had been there in
16 2013 -- each time you read the record in the VA records
17 about how it's not seen by someone in 2014, 2015, understand
18 that, supposedly, if it was there, it was getting bigger and
19 bigger and bigger. It's still not seen. But Mr. Miller
20 would tell you that he could see it all along, that it was
21 always there.

22 October 15th of 2015, Mr. Miller had a throat problem
23 and he went to the VA Hospital. He was diagnosed with acute
24 pharyngitis. And that medical provider went further than
25 that, because if you read those records, we know that she

1 looked at the tonsils because she tells you that one of them
2 was swollen larger than the other and gives you a rate. So
3 we know she looked dead at the tonsils and said absolutely
4 nothing about any erythema. Nothing. And then about six
5 months later is when Mr. Miller is diagnosed, which comports
6 exactly with how Dr. Hornig described the progress of these
7 cancers. If Mr. Miller could see it, I submit to you that
8 any of these trained medical providers could have seen it.

9 Let me say to you, one of the things the Plaintiff has
10 asked for in this case besides money for negligence is
11 they've asked you to punish Dr. Wilson. To punish him by
12 finding that he was reckless in his three treatments in the
13 one month that he had Mr. Miller for his patient. That he
14 was reckless in what he did and therefore, he should be
15 punished. And they say to you this, they say, but this is
16 not about giving money to Mr. Miller, this is about sending
17 a message to the community. Well, guess where the money
18 goes? It goes straight to Mr. Miller.

19 MR. MCGOWAN: Your Honor, I object to that, too,
20 because that's -- it's just wrong.

21 THE COURT: Sustain the objection.

22 MR. DAVIS: It's simply another way of putting more
23 money in the pocket --

24 MR. MCGOWAN: Your Honor, he's doing it again. We
25 object.

1 THE COURT: That's not admissible. I sustain the
2 objection.

3 MR. DAVIS: Recklessness is a careless disregard -- I
4 don't know exactly how the Judge is going to read that, but
5 I submit to you that's not the case here. You will find
6 there was good medical care rendered to Mr. Miller at all
7 times. No reckless conduct. Listen to the Judge's charge.
8 Also, listen to the fact that Mr. McGowan alluded to, the
9 standard is different with punitive damages. You do have to
10 find clear and convincing evidence.

11 It's your job to judge the weight of the evidence and
12 you are the conscious of the community. I submit to you
13 there are three things important to this Defendant. One is
14 that you consider the medical records in their entirety.
15 You take a good look at the Defendant's chart, the medical
16 chart and take a good look at the report from April of 2013
17 at the cardiac event and see what the medical doctor wrote
18 about the clearness of the airway and the fact that there
19 was no erythema. And then the next thing I want you to
20 consider most of all is why in the world is it that we have
21 not heard from any physician who treated this patient except
22 Dr. Wilson? What is it they would say the Plaintiff doesn't
23 want you to hear? We may never know.

24 I appreciate very, very much on behalf of Dr. Wilson
25 and the Defense team all of the time you have put in this

1 and the consideration and courtesy you've shown the Court
2 and attorneys. I thank you very much. Hopefully, once you
3 have considered all the evidence in this case, you won't
4 have a problem coming back with a verdict for the Defense.
5 Thank you so much.

6 THE COURT: Ladies and gentlemen, you've been sitting
7 here for about an hour and a half. Before we hear reply and
8 charge, I'm going to allow you to go back in your jury room
9 and take about a 15-minute break. We'll have you back in
10 here in about 15 minutes.

11 Again, do not discuss the case at all.

12 Everyone remain seated while the panel is excused.

13 (Whereupon, the jury exits the courtroom.)

14 THE COURT: We'll be at ease for about 15 minutes. Let
15 me see the lawyers back in chambers.

16 (Whereupon, a short break was taken.)

17 THE COURT: Bring the jury in.

18 (Whereupon, the jury enters the courtroom.)

19 THE COURT: Thank you, ladies and gentlemen.

20 Ms. Goodstein.

21 CLOSING ARGUMENT BY MS. GOODSTEIN

22 MS. GOODSTEIN: Mr. Foreman and ladies and gentlemen of
23 the jury, we are almost to the end. You will hear the
24 charge from Judge Hall and then you will deliberate. I
25 clerked for one of our senior trial judges in the state and

1 he told each and every juror that jury service is the
2 greater service that one can render to one's country in
3 times of peace. I share those sentiments and I would be
4 remiss if I didn't repeat that quote to you today. You've
5 been very attentive and David and I thank you for that.

6 Now, David did everything he was supposed to do.
7 Despite everything the Defense just told you, David did
8 everything he was supposed to do. He went to the doctor
9 immediately when he noticed a spot in the back of his
10 throat. Not only did he go to the doctor, he made an
11 appointment outside of the VA system. David is entitled to
12 lifetime medical care because he has a service connected
13 disability. Wanting to have an answer quicker, David went
14 outside of the system.

15 The Defendant failed to do the very basic test that any
16 ENT would do to rule out cancer. You have heard over and
17 over again and even from the Defendant himself that the only
18 definitive way to rule out this kind of cancer is with a
19 biopsy. Cancer was on the table and he failed to rule it in
20 or rule it out.

21 And what's worse, he told David -- or he failed to tell
22 David that the MRI didn't rule out cancer. Because we know
23 David does what's right. He does what he's supposed to do.
24 Had the ENT just said, David, I did an MRI. It doesn't rule
25 out cancer and if he wasn't willing to do a biopsy himself,

1 David would have gone somewhere else and would have
2 immediately gotten a biopsy.

3 Now, you've heard some argument that the spot in 2013
4 was different than the cancer in 2016. Ladies and
5 gentlemen, I want to talk about the very foundation of this
6 defense. It was there in 2013, it was there in 2014, it was
7 there in 2015 and in 2016, it was still there and the VA
8 determined that it was cancerous.

9 Now, you didn't check your common sense at the door
10 when you walked in this courtroom. You brought it right in
11 here with you. And we showed you pictures of the drawing
12 that Dr. Wilson made back in 2013 and an image from the VA
13 in 2016. You don't need to be a doctor to see that that's
14 in the exact same spot. Just clearly, the spot persisted
15 from 2013 until 2016.

16 Now, you also heard from Dr. Blum. And Dr. Blum said
17 that unless you are looking for this cancer, you are likely
18 not to see it. Now, you just heard well, because David was
19 able to see it that all of these other providers should have
20 seen it, too. Let's talk about the providers who looked
21 into David's throat and did not note something was back
22 there.

23 For example, we have a provider who was concerned that
24 David was having a heart attack. Dr. Blum testified that if
25 you are not looking specifically for the buried mass, you

1 wouldn't see it. Now, David saw it because he took a mirror
2 and a flashlight and he could feel it himself. He was
3 looking for it. He knew it was there. The reason David
4 didn't bring up the fact that he had a buried mass when he
5 thought he was having a heart attack is because a doctor
6 already told him it was nothing to worry about. You're
7 worried about having a heart attack, you're not going to
8 talk about a tonsil that you've already had examined by a
9 specialist. David went to the right kind of doctor.
10 Unfortunately, he went to the wrong doctor, but he went to
11 the right kind of doctor, an ENT. Throats are what they do.
12 That's their specialty.

13 Now, Mr. Davis argued to you that David did not come
14 back to Dr. Wilson. Dr. Wilson told him to come back and
15 David didn't come back. Let's talk about that for a second.
16 Here's what we know. We know that at some point in 2015,
17 this doctor stopped practicing medicine. He saw David in
18 March of 2013. We're talking about a period of less than
19 two years. I submit to you that you do not walk away from a
20 practice on a whim. Ladies and gentlemen, this doctor
21 failed David. And while we all, I'm sure, sympathize with
22 anyone suffering from mental illness, especially to the
23 extent it makes a physician walk away from their practice
24 and throw away years of training, but he took an oath to do
25 no harm. He had no option but to do one of two things, o

1 either biopsy the mass or tell David for whatever reason he
2 couldn't and let David go somewhere else. What should never
3 have happened was David should not have left Dr. Wilson with
4 the false belief that he should not worry because he didn't
5 have cancer.

6 Now, ladies and gentlemen, the decision for you to make
7 is if you believe this doctor, who is no longer practicing,
8 or David, who is a good and decent veteran. Who do you
9 believe? I submit to you that this is the easiest question
10 to answer in this entire case. The Judge will tell you, it
11 is appropriate for you to observe the manner in which the
12 witnesses acted on the witness stand. I saw you paying
13 attention and I am so grateful that you did. I will tell
14 you that just given the normal experience you all walked
15 into the courtroom with and that you use every single day to
16 decide if what someone is telling you is credible or not,
17 those are the skills that you need to determine here who you
18 believe. The Judge will tell you another word for
19 credibility is believability.

20 The Defendant has admitted that he has no memory,
21 however small of David. I gather David was insignificant to
22 him for whatever reason. The same is not true for David.
23 When a person is terrified that they have cancer and
24 terrified that what they thought was what they fear the
25 most, their focus is laser-like. And when the doctor tells

1 you you do not have cancer, in essence, giving you back your
2 life and your health with those words, you're going to
3 remember that event.

4 Ladies and gentlemen, the Plaintiff, David, has far
5 exceeded his burden of proof. All he must do is tip the
6 scale ever so slightly and he has gone far beyond that.
7 David is entitled to a verdict.

8 Dr. Blum is one of the creators of the chemotherapy
9 that is specific for head and neck cancers. He knows the
10 treatment is terrible. In fact, to use his words, if you
11 remember, he said, There's no around it, it just sucks.

12 David lost his hair and his full beard. Some of you
13 understand more than I do. He lost his saliva glands. He
14 lost his sense of taste, his ability to enjoy a good meal
15 with good friends. He has lost his ability to trust in his
16 tomorrows, but this lovely man has not lost his sense of
17 humor. He ought to be celebrated. He ought to be made
18 whole. The Defendant violated the standard of care.
19 Personally, you may wish him peace, but for you to do what
20 is right, you must make David as close to whole as you
21 possibly can.

22 How do you do that? Well, this is what David wants.
23 He wants to have the confidence that he is going to live
24 long enough to get another dog. He wants his health back.
25 He wants his sense of taste back. He wants his saliva

1 glands back. He wants his skin, hair and beard back the way
2 they were. He wants to have a conversation without being
3 tethered to a water bottle. He wants to enjoy a good meal
4 with friends. He just wants his health back. You can't
5 give him that and I venture to say that each and every one
6 of you would if you could give it back to him.

7 So what's left? Our law says the only thing that is
8 left is money. You can give him back his money that he
9 spent on healthcare. But how do you make him whole? Ladies
10 and gentlemen, in addition to his medical bills, you must
11 also compensate him for the pain. A burn is one of the most
12 painful injuries a human being can suffer. It is
13 unrelenting. It is searing. You must compensate him for
14 every single tick of the clock he agonized as a result of
15 the radiation, for every time he was bolted to the table,
16 every time he threw up, his throat already raw and seared
17 from radiation.

18 In order to do the right thing, you must compensate him
19 for the loss for the rest of his life the ability to taste,
20 to swallow properly, to eat properly, to have a joyous meal,
21 to enjoy the company of a dog. To compensate him for the
22 ability to enjoy the wonderful simple pleasure of good meal
23 spent with dear friends. This Sunday is the Super Bowl.
24 It's one of the greatest celebrations in American culture.
25 Many of us will gather with family and friends for fun

1 around Super Bowl snacks and drinks. But because David
2 can't eat nachos or wings or many other things so many will
3 enjoy Sunday, to go is just embarrassing. He ought to be
4 compensated for that. And it's called compensation for loss
5 of enjoyment of life. It is the simple pleasure derived
6 from everyday life.

7 Ladies and gentlemen, for these damages, which are
8 actual damages, you must focus on the loss suffered by
9 David. That's where your focus must be. You must ascertain
10 his loss, the value of that loss. And there are two
11 categories of damages. One category is called actual
12 compensatory damages and the other category is called
13 punitive damages. Now, we'll talk about punitive damages in
14 a bit.

15 The actual damages for David are the following:
16 Medical and hospital bills, his permanent injury, his
17 disfigurement, his loss of enjoyment of life, pain and
18 suffering, his mental anguish for the past, the present and
19 the future.

20 Now, there's another kind of damages and you've heard
21 some about them already, but those are called punitive
22 damages. Those damages -- these damages are exemplary
23 damages. And for those damages, you need to think for our
24 community going forward, what must we have from those people
25 who are charged with the responsibility to give care for a

1 price? Do you want to send a message? Do you want to say
2 to all of the doctors in this community that this conduct is
3 unacceptable and if you are stressed, you are having anxiety
4 or cannot perform the test, you've got to send your patient
5 to someone who can or, at the minimum, tell them the
6 information they've got to have. The way you send this
7 message is through what we call punitive damages.

8 So at the end of the day, the number is up to you. But
9 I submit to you when you consider his medical bills, his
10 loss of enjoyment of life, his pain, his suffering, and he
11 has suffered, his permanent injury that will follow him the
12 rest of his life every single day, it is without one bit of
13 embarrassment or hesitation that I tell you that this man
14 has been damaged and injured and the only amount of money
15 that will fully compensate him, although that is your
16 decision, I submit to you that the only amount of money that
17 will make him whole for the rest of his life is eight
18 million dollars. I tell you without flinching for a moment
19 that is the number I submit to you. I submit to you that if
20 you find eight million dollars in punitive damages, you will
21 send a message that will resonate throughout this community
22 that this community will not tolerate its citizens not being
23 treated with care when cancer is on the table.

24 Now, you heard from Mr. Davis that on that third visit
25 that couldn't have happened at a table, at a desk to view

1 the MRIs. So when you're at your own Super Bowl Sunday
2 celebrations, you're going to think about David. Make sure
3 today that you do the right thing so that when you think
4 about him on Sunday, you're going to know that you did
5 justice. Thank you.

6 CHARGE ON THE LAW

7 THE COURT: Ladies and gentlemen, we have now come to
8 the point where -- I told you earlier I was going to
9 instruct you on the law. Basically, what that means is I'm
10 going to read the law to you. So if I have my head down, I
11 don't mean to be showing you any disrespect. I want you to
12 listen very carefully. I'll be reading the law to you.

13 I remind you that during this trial, you and I have
14 certain duties to perform. As the trial judge, it is my
15 responsibility to preside over the trial of this case and I
16 also have the duty to rule on the admissibility of the
17 evidence offered during this trial. You are to consider
18 only the evidence before you. If there was any testimony
19 ordered stricken from the record during the trial, you must
20 disregard that testimony. You're to consider only the
21 testimony which has been presented from this witness stand,
22 any exhibits which have been made a part of the record in
23 this case and any stipulations of counsel.

24 I have the additional duty to charge you the law
25 applicable to this case. It is your duty as jurors to

1 accept and apply the law as I now state it to you. If you
2 think you have any idea as to what the law is or what the
3 law ought to be and it does not agree with what I tell you
4 the law is, you must forget that idea because you are sworn
5 to accept the law and apply the law exactly as I state it to
6 you.

7 In every case tried in this court before a jury, the
8 jury becomes the sole and exclusive judge of the facts. A
9 trial judge cannot comment on or make any statement about
10 the facts in a case. Since you are the sole judges of the
11 facts, do not think by anything I have said during the trial
12 that I have any opinion about the facts in this case. The
13 law does not allow me to have an opinion about the facts.

14 The burden of proof in this case is by a preponderance
15 of the evidence. A preponderance of the evidence simply
16 means the greater weight of the evidence. It is evidence,
17 which as a whole, shows that the facts sought to be proved
18 is more likely true than not.

19 This can be illustrated by imagining a set of scales.
20 When the case begins, the scales are even. After all the
21 evidence has been presented, if the scales remain even or if
22 they tip even slightly in favor of the Defendant, then the
23 Plaintiff has failed to meet the burden of proof and would
24 not be entitled to recover in this case. If on the other
25 hand, the scales tip even slightly in favor of the

1 Plaintiff, the Plaintiff will have met the burden of proof
2 and you should return a verdict for the Plaintiff. The
3 preponderance of the evidence is not determined by the
4 number of witnesses, instead, it must be determined by the
5 greater weight of all of the evidence.

6 There are two types of evidence generally presented
7 during a trial, direct evidence and circumstantial evidence.
8 Direct evidence is the testimony of a person who claims to
9 have actual knowledge of a fact, such as an eyewitness. It
10 is evidence which immediately establishes the main fact to
11 be proved.

12 Circumstantial evidence is proof of a chain of facts
13 and circumstances indicating the existence of a fact. It is
14 evidence which immediately establishes collateral facts from
15 which the main fact may be inferred. Circumstantial
16 evidence is based on inference and not on personal knowledge
17 or observation. It is proof that does not actually
18 establish the fact in question, but that asserts or
19 describes something else from which you may either
20 reasonable infer the truth of the fact or, at least,
21 reasonably infer an increase in the probability that the
22 fact is true.

23 For circumstantial evidence to be sufficient to warrant
24 the finding of a fact, the circumstances must lead to that
25 fact with reasonable certainty. The facts and circumstances

1 should be considered in light of ordinary experience and
2 common sense. The existence of a fact cannot be based on
3 speculation, surmise or conjecture. The law makes
4 absolutely no distinction between the weight or value to be
5 given either direct evidence or circumstantial evidence, nor
6 is a greater degree of certainty required of circumstantial
7 evidence than of direct evidence.

8 Necessarily, you must determine the credibility of
9 witnesses who have testified in this case. Credibility
10 simply means believability. It becomes your duty as jurors
11 to evaluate the evidence and determine which evidence
12 convinces you it is true.

13 In determining the believability of witnesses who have
14 testified in this case, you may believe one witness over
15 several witnesses or several witnesses over one witness.
16 You may believe a part of the testimony of a witness and
17 reject the remaining part of the testimony of that same
18 witness. You may believe the testimony of a witness in its
19 entirety or reject the testimony of a witness in its
20 entirety. You may consider whether the witness has an
21 interest in the result of the trial, whether the witness is
22 prejudiced toward either the Plaintiff or the Defendant, the
23 opportunity for the witness to have seen the matters and
24 things about which the witness may testify and the way the
25 witness acts on the witness stand.

1 The rules of evidence ordinarily do not permit
2 witnesses to testify to opinions or conclusions. An
3 exception to this rule exist for witnesses we call expert
4 witnesses. A witness who by education and experience has
5 become an expert in some art, science or profession may give
6 an opinion as to the subject the witness claims to be an
7 expert in and may also give the reasons for the opinion.
8 You should consider any expert opinion given by a witness
9 and, like any other evidence, give it the weight you think
10 it deserves.

11 If you decide that an expert witness' opinion is not
12 based on sufficient education and experience or if you
13 decide that the reasons given in support of the opinion are
14 not sound or that the opinion is outweighed by other
15 evidence, you may disregard the opinion entirely. An expert
16 witness' testimony is to be given no greater weight than
17 that of other witnesses simply because the witness is an
18 expert. And you do not have to accept an expert's opinion
19 even though it is uncontradicted.

20 The Plaintiff claims that the Defendant committed
21 medical malpractice, which is a form of carelessness or
22 negligence. In order to recover from medical malpractice,
23 the Plaintiff must prove by a preponderance or greater
24 weight of the evidence the standard of care, a breach of the
25 standard of care, proximate cause and damages. The

1 Plaintiff must prove the standard of care the Defendant owed
2 to the Plaintiff in treating the Plaintiff.

3 When a doctor treats a patient, the law does not
4 require perfection. The law does require that the doctor
5 use that degree of knowledge, care and skill ordinarily
6 possessed and used by doctors in good standing in the
7 doctor's field of medicine under the same or similar
8 circumstances and that the doctor followed the general
9 accepted practices and procedures in the profession.

10 Next, the Plaintiff must prove that the Defendant
11 negligently departed from this standard of care in treating
12 the Plaintiff. Negligence is the failure to do what an
13 ordinarily careful doctor in the Defendant's field of
14 medicine would have done under the same or similar
15 circumstances, or the doing of something that an ordinarily
16 careful doctor would not have done under the same or similar
17 circumstances.

18 A doctor is not an insurer of a cure or even a positive
19 result. Therefore, the mere fact that the treatment does
20 not benefit the patient or that it even harms the patient
21 does not in and of itself mean that the Defendant was
22 negligent. A bad result, injury, death or failure to cure
23 is not by itself enough to show that the Defendant was
24 negligent.

25 Similarly, a doctor's mistake or error in making a

1 decision alone does not constitute negligence. If, however,
2 a doctor fails to gather information reasonably available
3 which a reasonable doctor would have gathered before making
4 a decision, the doctor fails to comply with the recognized
5 standard of medical care which would be exercised by a
6 similar doctor under similar circumstances.

7 The fact that a doctor acts on the advice of another
8 doctor who is a specialist is not an absolute defense for
9 the claim that the doctor failed to use the required skill
10 in treating the patient.

11 The difficulties and the uncertainties in the practice
12 of medicine and the unpredictable variations and the
13 response to treatment are such that no doctor can guarantee
14 results. Where there is more than one recognized diagnosis
15 or treatment and no one of them is used exclusively and
16 uniformly by all doctors in good standing, it is not
17 negligence for a doctor in making a decision to choose one
18 of the approved methods even when the choice later turns out
19 to be a wrong selection.

20 Qualified doctors and experts may differ as to what
21 constitutes the best course of treatment and these
22 differences do not amount to malpractice. Where doctors in
23 good standing disagree or when medical authorities are
24 divided with regard to a specific course of treatment or
25 care, then the doctor is bound only to exercise his best

1 judgment in determining which course on the whole is best
2 for the patient. Just because another doctor might have
3 used a different course of treatment does not make the
4 Defendant negligent. However, if a doctor does not have the
5 degree of learning and skill required or if the doctor does
6 not use the care required, it is no defense to a charge of
7 negligence that the doctor did the best that he could.

8 In considering whether the Defendant made a reasonable
9 decision, you must consider the decision in relation to the
10 facts as they existed at the time and not in the light of
11 what hindsight may reveal.

12 Finally, the Plaintiff must prove that the Defendant's
13 negligence proximately caused the Plaintiff's damages.
14 Proximate cause is something that produces a natural chain
15 of event, which in the end bring about the injury. It is
16 the direct cause of the injury. To prove the Defendant's
17 negligence proximately caused the Plaintiff's injury, the
18 Plaintiff must first prove causation and fact. This is
19 proven by showing that the injury would not have occurred
20 but for the Defendant's negligence.

21 The Plaintiff must also prove legal cause. Legal cause
22 is proven by showing that the injury was foreseeable. This
23 means that the injury occurred as a natural and probable
24 consequence of the Defendant's negligence. The Plaintiff
25 must prove that some injury from the Defendant's negligence

1 was foreseeable, but does not have to prove the particular
2 injury that occurred was foreseeable. However, the
3 Defendant cannot be held responsible for something which
4 could not be expected to happen.

5 Proximate cause does not mean the only cause. There
6 may be more than one proximate cause. The Defendant's act
7 can be a proximate cause of the Plaintiff's injury if it
8 was, at least, one of the direct concurring causes of the
9 injury.

10 In this action, for the failure to diagnose and treat,
11 the Plaintiff must prove that the Defendant's negligent
12 failure to discover and treat the disease or condition of
13 which the patient suffered most probably caused the
14 patient's suffering. The Plaintiff is not required to prove
15 conclusively that the patient would not have suffered from
16 the injury. However, a mistaken diagnosis by itself will
17 not support a verdict for malpractice. A bad result or
18 failure to cure or diagnose properly is not by itself
19 sufficient to raise an inference or presumption of
20 negligence on the part of a physician. A medical
21 malpractice case must involve charges of deviation from the
22 standard of care.

23 A patient who is treated by a doctor is entitled to a
24 careful evaluation. The evaluation should be made with the
25 diligence and methods of diagnosis that are usually approved

1 and practiced by doctors of ordinary learning, judgment and
2 skill acting under the same or similar circumstances.

3 In order to prove the Defendant was negligent, the
4 Plaintiff must prove that one, the patient's physical
5 condition required a careful doctor to investigate further
6 before continuing a course of treatment or care; two, the
7 Defendant did not make this investigation; and three, as a
8 direct and proximate result of the Defendant's failure to
9 investigate, the patient received improper treatment or care
10 from which the patient later suffered injury.

11 If you decide that the Plaintiff is entitled to a
12 verdict, your next step would be to decide how much money
13 the Defendant should be required to pay. Actual damages are
14 to compensate the Plaintiff for the Plaintiff's injuries or
15 loss and to put the Plaintiff as near as possible in the
16 same position that the Plaintiff was in before the incident
17 occurred. In other words, actual damages would be the
18 actual losses and expenses which the Plaintiff has suffered
19 because of the Defendant's negligence.

20 Pain and suffering compensates the Plaintiff for
21 physical discomfort and emotional response to the sensation
22 of pain caused by the injury itself. There is no definite
23 standard by which to compensate the Plaintiff for pain and
24 suffering. You have the authority to determine the amount,
25 if any, to be allowed for pain and suffering using calm and

1 reasonable judgment to ensure that the damages are just and
2 reasonable in light of the testimony and evidence presented
3 in the case.

4 Loss of enjoyment for life compensates the Plaintiff
5 for limitations on the Plaintiff's ability to participate in
6 and derive pleasure from the normal activities of daily
7 life.

8 Mental suffering, apprehension, shock, fright,
9 emotional upset, humiliation and anxiety, either present or
10 expected in the future can be properly considered as an
11 element of damages. The amount of damages for mental
12 suffering cannot be exactly measured.

13 If you find that the Plaintiff was permanently injured
14 as a result of the Defendant's actions, you must then decide
15 how, if at all, that injury will affect the rest of the
16 Plaintiff's life. A person's life expectancy is determined
17 by the life expectancy table, which is part of the laws of
18 this state. The life expectancy table is only an estimate
19 of the probable average remaining length of the life of all
20 persons in our state of a given age.

21 The Plaintiff in this case is a 68-year-old male with a
22 life expectancy, according to the life expectancy table of
23 14.68 years. This fact is to be considered by you along
24 with any other facts and circumstances in evidence bearing
25 on the Plaintiff's life expectancy, including occupation,

1 habits and health at the time of the injury in deciding the
2 amount of damages to be awarded to the Plaintiff.

3 Recklessness is the knowing failure to exercise
4 reasonable care under all of the surrounding circumstances.
5 An act is reckless if it is committed in a manner and under
6 circumstances which a person of ordinary reason and prudence
7 would know would invade the rights of the injured person.

8 Gross negligence is the failure to exercise a slight
9 degree of care. A person who is so indifferent to the
10 consequences of his conduct as to not give a slight care as
11 to what he is doing acts with gross negligence.

12 If you award actual damages, you may also consider an
13 award of punitive damages. Punitive damages are intended
14 to punish the Defendant for extraordinary and outrageous
15 misconduct and prevent the Defendant and others from
16 committing similar acts in the future. Punitive damages can
17 only be awarded when conduct from the Defendant has been
18 something more than mere negligence. The evidence must
19 establish the Defendant's acts were reckless, willful and
20 wanton, meaning there was a conscious failure to exercise
21 due care or a conscious indifference to the rights and
22 safety of others of a reckless disregard thereof.

23 If you find that the Defendant's conduct was willful,
24 wanton or reckless, you may award the Plaintiff punitive
25 damages. To support an award of punitive damages, the

1 Plaintiff must prove by clear and convincing evidence that
2 the conduct complained of included a consciousness of
3 wrongdoing at the time of the conduct.

4 Clear and convincing is more than just a preponderance
5 or greater weight of the evidence, which requires only proof
6 that persuades you that a party's claim is more likely true
7 than not. On the other hand, clear and convincing proof is
8 not as high a standard as the burden of proof in criminal
9 cases, which is proof beyond a reasonable doubt. Clear and
10 convincing proof leaves no substantial doubt in your mind.
11 It means that the evidence is not ambiguous, doubtful,
12 equivocal or contradictory. Convincing means persuading by
13 proof or argument causing one to believe in the truth of
14 what is asserted. Clear and convincing proof establishes in
15 your mind not only that the fact is probable, but that it is
16 highly probable.

17 Before awarding punitive damages, you must consider and
18 weigh four elements which may be pertinent to the facts of
19 this case. You must first consider the relationship between
20 any punitive damage award and the harm caused. Any penalty
21 imposed should take into account the reprehensibility of the
22 conduct, the harm caused, the Defendant's awareness of the
23 conduct's wrongfulness, the duration of the conduct and any
24 concealment. Thus, any penalty imposed should bear a
25 relationship to the nature and extent of the conduct and the

1 harm caused, including the compensatory damage award made by
2 you.

3 Secondly, any penalty imposed should take into account
4 as a mitigating factor any other penalty that may have been
5 imposed or which may be imposed for the conduct involved,
6 including any criminal or civil penalty or any other
7 punitive damages award arising out of the same conduct.

8 Next, you should consider whether the amount of any
9 punitive damages award may deprive the Defendant of any
10 profits derived from the improper conduct and whether the
11 ill gotten profit should be properly awarded to the
12 Plaintiff.

13 Finally, any award of punitive damages must be limited
14 to punishment and thus, may not affect economic bankruptcy.
15 To this end, the Defendant's ability to pay any punitive
16 damage award should be considered. However, the economic
17 bankruptcy factor is not an absolute bar to an award of
18 punitive damages.

19 Punitive damages may only be awarded for injuries the
20 Defendant caused to the party in this action. Although it
21 may be appropriate to consider the reasonableness of a
22 punitive damages award in light of the potential harm the
23 Defendant's conduct could have caused, that potential harm
24 is harm potentially caused the Plaintiff, not all other
25 potential victims. Evidence of actual harm to nonparties

1 may show the reprehensible nature of the Defendant's actions
2 and that the conduct which harmed the Plaintiff also posed a
3 substantial risk of harm to the general public. However,
4 the jury may not use a punitive damages verdict to punish
5 the Defendant directly for harm it allegedly caused to
6 nonparties.

7 Ladies and gentlemen, in just a few moment, we're going
8 to allow you to go to your jury room. All 12 of you must
9 agree on the verdict. Your verdict cannot be based on
10 sympathy, passion, prejudice, emotion or any other
11 consideration not in evidence in this case.

12 We will send back with you the verdict form and any
13 items that were entered into evidence in this case. The
14 verdict form has a number of questions and I'll briefly go
15 over those with you.

16 The first is: Was Dr. Wilson negligent in his
17 treatment of David Miller by a preponderance of the
18 evidence? There are two lines. The first is no. If no,
19 sign below and deliberate no further. If yes, then you
20 would go to question two.

21 Question two is: Was Dr. Wilson's negligence the
22 proximate cause of David Miller's injuries? If the answer
23 to that is no, then sign the verdict form below and
24 deliberate no further. If yes, you will go to question
25 three.

1 Question three then asked: As a result of David
2 Miller's injuries, we find the following actual damages.
3 They are divided between economic and noneconomic.

4 Four: Was Dr. Wilson reckless or grossly negligent in
5 his treatment of David Miller? If no, sign below and
6 deliberate no further. If the answer is yes, then you'll go
7 to question five.

8 Question five states: Was Dr. Wilson's conduct
9 reckless or grossly negligent to a level of clear and
10 convincing evidence? If your answer is no, then again you
11 would go no further. If it is yes, you will go to question
12 six.

13 Question six would then be: Should punitive damages be
14 awarded against Dr. Wilson? Again, if the answer is no,
15 deliberate no further. Or yes, then you would go to
16 question seven.

17 Question seven: Punitive damages are awarded in blank
18 amount.

19 The order in which I read these and the answers yes or
20 no has no significant whatsoever. You simply have to put
21 one before the other on the verdict form.

22 I need to take up some matters with the lawyers in the
23 case before you begin deliberating, so I'm going to allow
24 you to go back to your jury room, wait there. Once we
25 handle those matters, we will then send the verdict form and

1 any evidence back to you and you can begin deliberating.
2 When you're deliberating -- it is 12:08 on my clock. We
3 will provide lunch for you probably around 1:00 or so, if
4 need by. We will have that ordered. In York County, that
5 lunch is pizza.

6 If anybody leaves the jury room to go to the bathroom
7 or step out, Mr. Foreman, you are to cease deliberations.
8 You can only deliberate when all 12 people are in the jury
9 room. If you should have any questions for the Court, you
10 have a pad and pen back there, write that down, knock on the
11 door, hand it to the bailiff and he'll bring that to the
12 attention of the Court.

13 With that, I'm going to allow you to be excused to your
14 jury room. Again, do not discuss the case until we knock on
15 the door, hand you the verdict form and the evidence. At
16 that point, then you can discuss anything you want to about
17 the case.

18 After you have answered the question or questions on
19 the verdict form, Mr. Foreman, if you would sign your name,
20 date it. Again, your verdict must be unanimous. Once you
21 reach the point of reaching your verdict, knock on the door,
22 tell the bailiff that you've reached a verdict. Keep the
23 verdict form in your hand and bring it back out here. When
24 you come in, we'll ask you to pass the verdict form to the
25 bailiff who will then pass it up to the Court.

1 So with that, I'm going to allow you to go back to your
2 jury room.

3 I'm going to ask the two alternates to stand -- we're
4 not putting you in the corner to punish you. If you'll just
5 stand over here beside the bailiff while these 12 folks go
6 to the jury room.

7 Everyone remain seated while the jury is excused.

8 (Whereupon, the jury exits the courtroom.)

9 THE COURT: If y'all would shut that door and then ask
10 the alternates step outside the door a minute.

11 Anything further from the Plaintiff as far as the
12 charge?

13 MR. MCGOWAN: Yes, Your Honor, we would take exception
14 to the Court's failure to include a definition and
15 instruction on misrepresentation pursuant to 15-32-220,
16 subpart E, the third element of the noneconomic damage
17 statute where it says fraud or misrepresentation related to
18 the claim.

19 Additionally, respectfully, we would object to the
20 verdict form not having that specific question on it as
21 well.

22 THE COURT: Do you wish to be heard, Mr. Davis?

23 MR. DAVIS: On that, no, sir.

24 THE COURT: I note your objection, however, I stand by
25 my decision to not include that in the charge.

1 Anything else?

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

3 THE COURT: Anything from the Defense?

4 MR. WILLIAMS: Just, Your Honor, the arguments we made
5 earlier. The Defendants object to the noninclusion of the
6 language offered to the Court before the actual damages
7 charge regarding the prohibition against double recovery.

8 THE COURT: I note your objection as well, however, I
9 will stand by my decision not to include that.

10 Let me state, too, before the jury gets all the
11 evidence and the verdict form. I met with the attorneys
12 after Mr. Davis had finished his argument and informed them
13 that I had reconsidered my motion on the directed verdict as
14 to the Defendant ENT & Face, P.A. I have concluded after
15 considering the motion and what I believe is applicable law
16 that that was error for me -- for the Court to direct a
17 verdict. It appears that the Court -- again, that was
18 error.

19 He was clearly, undeniably and admittedly an employee
20 of the corporation even though the corporation had very few
21 -- had limited number of employees and even though those
22 other employees had no direct contact, it appears, with the
23 Plaintiff in this case. However, the Court is convinced
24 under the applicable law of this State that it would be
25 error to -- because of respondeat superior that it would be

1 error to direct a verdict for the Defendant ENT & Face. So
2 again, my decision is to reverse that. I deny that motion
3 for directed verdict.

4 I did state to Mr. Davis in chambers if he wished to
5 have an opportunity to address -- if that changed anything
6 or needed to add anything to his closing statement, I would
7 give him an opportunity to do that before the Plaintiff's
8 reply and he indicated in chambers that he did not wish to
9 exercise that.

10 Anything y'all want to put on the record as far as the
11 directed verdict motion from the Defense?

12 MR. WILLIAMS: Just that the Defense disagrees with the
13 reversal.

14 THE COURT: And your objection to that reversal is
15 noted for the record as well.

16 All right. If y'all would make sure what goes --
17 Let's do this. Let's bring our alternates back out.

18 (Whereupon, the alternates enter the courtroom.)

19 THE COURT: Gentlemen, I appreciate your patience. I
20 am sure it hasn't been the most comfortable thing this week.
21 But we are through with you. You are relieved from your
22 service for the rest of the day. And, actually, this is one
23 of the few trials that I've had lately where we did not have
24 an alternate have to step in because of various issues with
25 jurors. But that did not take place in this case.

1 You're free to discuss the case with anybody you want
2 to. Sometimes lawyers may call you, they often like input.
3 That's perfectly legal for them to do that. On the other
4 hand, you're not required to talk to them. You don't have
5 to say a thing to them. However, you're free to discuss
6 this case with anybody that you wish.

7 With that, thank you for your service and the bailiff
8 will show you the way out.

9 (Whereupon, the alternates were released.)

10 THE COURT: We'll be at ease.

11 (Whereupon, the jury began deliberations at 12:20 p.m.)

12 (Whereupon, Court was in recess awaiting a verdict.)

13 (Whereupon, Court's Exhibit Nos. 1 through 4 were
14 marked for identification.)

15 THE COURT: I have a note from the jury that simply
16 says: We have a verdict.

17 (Whereupon, Court's Exhibit No. 5 was marked for
18 identification.)

19 (Whereupon, the jury enters the courtroom.)

20 THE COURT: Ladies and gentlemen, thank you for your
21 diligence.

22 Mr. Foreman, has the jury reached a verdict?

23 THE FOREMAN: Yes, sir, we have.

24 THE COURT: If you'll pass the verdict form to the
25 bailiff.

1 Madam Clerk, if you'd publish the verdict.

2 VERDICT

3 THE CLERK: The State of South Carolina, County of
4 York, in the Court of Common Pleas, 16th Judicial Circuit,
5 in the case of David Miller vs. ENT & Face, P.A., and Brian
6 Wilson, M.D., case number 2017-CP-46-302.

7 Question one: Was Dr. Wilson negligent in his
8 treatment of David Miller by preponderance of the evidence?
9 The answer is no. Signed this day, February 1st, by
10 foreperson Matthew Willoughby.

11 Ladies and gentlemen of the jury, if this is your
12 verdict, please indicate so by raising your right hand.

13 (All hands raised.)

14 Thank you.

15 Let the record reflect all hands were raised.

16 THE COURT: Anything further from the Plaintiff?

17 MR. MCGOWAN: No, Your Honor.

18 THE COURT: From the Defense?

19 MR. DAVIS: No, Your Honor.

20 THE COURT: Ladies and gentlemen, this has been a
21 longer than anticipated trial at the beginning of the week,
22 but thank you for your diligence. You are free to talk
23 about the case with anybody now. Sometimes attorneys, after
24 a case is over, will call and want to get information.
25 That's often helpful to them in assessing their cases. You

1 can talk to them, that's allowable. They're allowed by law
2 to contact you. On the other hand, you do not have to talk
3 to them at all or anybody else for that matter. Again,
4 you're free to discuss it with anybody. On the other hand,
5 you're just as equally free not to say anything if that's
6 what you wish.

7 Thank you for your diligence this week. You are
8 excused. We don't have another trial for you this week.
9 You can go home and enjoy your weekend. The bailiff will
10 show you the way out.

11 Everyone remain seated while this jury is excused.

12 (Whereupon, the jury was excused.)

13 THE COURT: Anything further at this point from the
14 Plaintiff?

15 MR. MCGOWAN: May we have 10 days to file posttrial
16 motions?

17 THE COURT: Yes, you may.

18 Anything at this point from the Defense?

19 MR. DAVIS: No, Your Honor.

20 THE COURT: That concludes this matter. Hope you all
21 have a good weekend.

22

23

24

25

CERTIFICATE OF REPORTER

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

STATE OF SOUTH CAROLINA)
COUNTY OF AIKEN)

I, PENNY M. JOHNSON, Official Court Reporter for the
Second Judicial Circuit of the State of South Carolina, do
hereby certify that the foregoing is a true, accurate, and
complete Transcript of Record of the proceedings had and the
evidence introduced in the trial of the captioned case,
relative to appeal, in the Court of Common Pleas for York
County, South Carolina, for the week of January 28th, 2019.

I do further certify that I am neither of kin, counsel,
nor interest to any party hereto.

May 7, 2019

Penny M. Johnson
Penny M. Johnson
Official Court Reporter