The story behind the story (how we got case 2 and other interesting tidbits...):

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The story behind the story (how we got this case… and other interesting tidbits):

This is the case that got the whole thing going. We had several cases initially presented on EM RAP (chapters 4 and 8) and were able to reproduce additional information to keep the interest of those familiar with the program, but that was not close enough for a whole book. We had 2 requirements: the original ED chart plus deposition or trial testimony. But it was dead-end after dead-end.

I was at Chautauqua, NY on vacation with the family, staying in a late 1800's house and sitting on the beautiful front porch. It was late afternoon and I was going through some of the appeals decisions and trying to find additional information with ever variation of google search I could think of. I had the realization the attorney's names were right on the top of the page. It was easy to find the attorney's phone number with a search so I gave it a try. Well, unlike us shift workers, they actually have offices with secretaries. It was late afternoon and I first called Neil Frued, the defense attorney. He was interested and remembered a lot about the case. He came up with many of the details, detailed briefly toward the end of the chapter. I next tried Dwight Brannon, but got a voice mail and left a message. Within 20 minutes my cell rang, Dwight on the line. He not only offered to bring the information to me in Columbus, but to come to SanFrancisco and present the case at Essentials, all on his own dime (when Mel heard about this he arranged for Dwight's flight and hotel).

A few weeks later we met during a shift – I ran out to the parking lot and loaded my Prius to the top with posters from the trial and box after box of deposition and trial testimony. I learned more about how an attorney prepares a case from these records than from any other case – there were hundreds of numbered file folders with financial statements, testimony and family photos. I was reminded that Dwight and David Lykins, the patient, had been friends. This was not just about winning a case – this was personal.

Dwight and I met one crisp fall morning at a Bob Evans in Springfield Ohio and I learned even more about trials and about Dwight. He has been touched by this diagnosis, first by the death of his friend, and then by the numerous cases he had tried with others with the

same diagnosis. He came to SanFrancisco to prevent others from misdiagnosis… and to try his hand again in front of a jury of doctors, mid-level providers, and nurses…

TESTIMONY OF ED DEFENDANT TIMOTHY VAUGHN:

Examination my Mr .Brannon (plaintiff attorney) and Neil Freund (defense attorney)
Q. Do you go [to the conference of the American College of Emergency Physicians] every year?
A. No, sir, I don't.
Q. On March the 2nd, you --who was the other --was there any other emergency room physician but yourself?
A. At that time of the morning, there would have been one other physician, and I don't recall who that is.
Q. That other physician had nothing to do with the care and treatment of David Lykins, did he?
A. That is correct.
Q. All right. And you could not read the nurse's triage notes from March the 2nd, could you?
A. I don't recall, sir. Again, during our deposition, the copies were not clear.
Q. Well, you did indicate to me that you do not well, let's --the copy was this -do you have the original with you?
A. No, sir, I don't.
Q. Do you know where the original is?
MR. FREUND: We have it, Your Honor.
BY MR. BRANNON:
Q. Did you go back and read the original note?
A. Yes, sir.
Q. And you are saying that you couldn't read the copy that I had on the date of the deposition but you could read the original?
A. I don't recall if I could read it on that day. I am just saying that I could not read the copy that was given during my deposition.
Q. You never read the triage nurse's note about David Lykins before he was discharged, did you?
A. I --when a physician assistant presents a patient to us, it's my practice to look at the chart. I like to look at vital signs, medications, allergies, and I will glance at the triage note.
Q. You did not read the triage note on David Lykins on March the 2nd, did you?
A. I don't recall, sir.
Q. And when you attempted to read it, you said you weren't able to make out anything but complaint of left shoulder pain, correct?
A. If that is from my deposition, I would have to review that.
Q. Right. I'll let you look at your page ten of your deposition. Excuse me just a second while I get it.
MR. BRANNON: And just so the ladies and gentlemen of the jury know --I'm sorry again. I apologize, but I just want to show them all. May I approach the witness, Your Honor?
THE COURT: Sure. BY MR. BRANNON:
Q. First of all, Dr. Vaughn, is that a true and accurate copy, at least an enlargement, of what you looked at on the date of your deposition?
A. Yes, it is.
Q. Are you representing that that copy is not as good as the original as far as legibility?
A. Yes, sir.
Q. And you're representing the reason that you couldn't read it during the time of your deposition is because the copy that we see here is not nearly as good as the original?
A. Yes, sir.
Q. When I asked you what the triage nurse had said in her report on March 2nd, you indicated you did not know unless you read the report; am I correct?
A. I'm sorry. I don't follow your question.
Q. Well, when I said what did the triage notes tell you about David Lykins on March the 2nd, forgetting about the copies, what did you tell me?

A. I'd have to look at my deposition, sir.
Q. Did you tell me that you had no independent recollection other than the medical records?
A. I don't understand your question.
Q. All right. Tell me today, tell the ladies and gentlemen of the jury, what did the nurse's triage note say about David Lykins without looking at the report.
A. He had left shoulder pain, fever, chills. He was pale.
Q. Did you know that on March the 2nd when you treated David Lykins?
A. Sir, I'm not sure what I recall about reading that chart.
Q. I gave you one copy, and Mr. Freund says my copy is a little better. If you can't read his, read from mine.
MR. FREUND: Are you on page ten, Dwight?
MR. BRANNON: Page ten. BY MR. BRANNON:
Q. You then took Mr. Freund's copy and this is what you said (providing). Would you read your answer to the ladies and gentlemen?
A. The best I can tell in this, there is a complaint of --complaint of left shoulder pain, then the next thing I can pick up is symptoms started yesterday afternoon. That's all I can read.
Q. Now, just so we' re clear, the original reports are with the hospital, aren't they?
A. They would have been at that time. I believe that my counsel has them now.
Q. All right. And you are aware that the hospital kept those records, we had to get copies, are you not?
A. I'm not aware of that.
Q. Okay. So that was the best you could do from the copy given to you by your own counsel; is that correct?
A. No. I believe you gave me the copy_
Q. Well, did Mr. Freund provide me with that copy?
A. I'm not sure where the copies came from, sir.
Q. Take a look at the deposition (providing) .
A. (Witness complied.)
(Pause in proceedings.) BY MR. BRANNON:
Q. Did Mr. Freund hand you the copy?
A. Mr. Freund indicated that his copy was a little bit better.
Q. You don't recall us using his copy, then, for you to read from?
A. No, sir, I don't.
Q. Do you deny that that happened?
A. I'm not sure whose copy I was reading from at the time.
Q. Well, you are not implying that at the time of your deposition in November of 2000, somehow there was some kind of trickery by showing up with copies you couldn't read but you could the original?
A. That's no~ what I'm implying, sir. You asked if I could read those. I could not read the copies.
Q. Doctor, do you recall the treatment of David Lykins independently of the records?
A. Yes, I do.
Q. And how many times did you physically examine David Lykins?
A. I remember being back with Mr. Lykins on one occasion and may have stopped back to recheck or to talk to Mrs. Lykins at another time.
Q. So you examined your patient on one occasion?
A. That is correct.
Q. And was Mrs. Lykins with him?
A. Yes, she was.
Q. And did Mrs. Lykins ask you to perform a CT scan?
A. No, sir.
Q. Did she ask you to do laboratory work?
A. No, sir.
Q. Did Mr. Lykins ask you to do laboratory work?
A. No, sir.
Q. Did Mr. Lykins ask you to do a CAT scan?
A. No, sir.
Q. Now, if he had asked you, you would have done those things, wouldn't you?
A. Every time I evaluate a patient, I certainly respect their wishes and their desires, and if a patient feels very strongly about a certain thing, especially a blood test, would certainly enter that into my decision-making process.
Q. But you are not saying you would give them a CBC if they asked for one, are you?

A. That's not what I am saying. I said I would enter that into my decision-making process. If the patient felt strongly that they would feel more comfortable with a certain test, especially a CBC, I probably wouldn't hesitate.
Q. So if Mrs. Lykins says she pleaded and protested and wanted a blood test or lab work done or a CAT scan, that wouldn't be true, at least to you?
A. From my recollection, I had a very pleasant interaction with both Mrs. Lykins and Mr. Lykins, and there was --I don't recall any demanding of anything.
Q. Did you understand that the triage nurse had no reported injury of his shoulder?
A. No, sir.
Q. You heard her testify to that, didn't you?
A. I heard the nurse say that he did not mention anything about an injury.
Q. And you also heard her say that if he --she asked him, and if he would have said something, she would have recorded it. Did you hear her say that?
A. Yes, sir. On the triage note, there was nothing about an injury, which is commonly the negative that would be recorded if that were answered.
Q. And he didn't appear critically ill on that date, did he?
A. On March 2nd, he did not appear ill. He appeared uncomfortable.
Q. Okay. Did he appear --from your examination and care and treatment, he did not appear to have any organ failure, did he?
A. I saw no indication of organ failure on March 2nd.
Q. No indication of sepsis on March 2nd, correct?
A. That's correct.
Q. You saw excruciating pain, did you not?
A. I saw a gentleman with severe left shoulder pain, correct.
Q. Well, let's describe it. Let's describe it. I won't use my word. How did he seem to convey himself in regards to the amount of pain that he was in?
A. He seemed to be in severe pain when the shoulder was moved.
Q. Did he appear to be overreacting?
A. No, sir, I would never make that assessment.
Q. It's in your medical records, isn't it?
A. I did not dictate that. I would never make that assessment of a patient. I've been doing this for nineteen years, and I've never accused anyone of overreacting or faking.
Q. Didn't Dr. I'm sorry --Mr. Heller come to you and say that he had talked to his family physician and that this patient sometimes tends to overreact to his medical needs?
A. At the end, sometime after Mr. Lykins had left and I saw Mr. Heller again, he did mention that that telephone conversation had occurred.
Q. Did that help you close the book on your diagnosis here?
A. No, sir.
Q. And, in fact, your diagnosis of shoulder sprain/strain was not correct, was it?
A. At the time, that was the diagnosis that I had arrived at, yes, sir.
Q. Was that the correct diagnosis that you had arrived at?
A. At that time, that was the correct diagnosis.
Q. SO it's your testimony here today that you can state within terms of a reasonable medical probability that David Lykins had no septic process such as necrotizing fasciitis ongoing on March the 2nd of 2000?
A. If that process was occurring, then there were there were no external signs that would give us that indication.
Q. Well, is vomiting a sign?
A. Vomiting is a sign, yes, sir.
Q. And past fever is a symptom?
A. That would require some clarification. Many patients present to the emergency department complaining of fever.
Q. That's fair enough. Did you go to him and talk to him and say, now, I've heard that you have had this past fever; can you clarify it for me and tell me what happened? Did you do that?
A. Yes, sir, I did.
Q. And w at did who did you talk to, Mrs. or to David?
A. I don't recall. Maybe both of them were giving some information.
Q. Well, what information did they give you about the past fever?

A. Whenever I see that in a complaint or hear that a patient has a fever, many patients present with the complaint of fever; however, when you ask them if they have actually taken the temperature, my next step is to ask them what the temperature recording was. Many patients just feel like they have a fever and never really check the temperature.
Q. Could we talk about David Lykins? Because you cared for him, didn't you?
A. Yes, sir.
Q. And you agree that you gave him your individual attention?
A. Yes, sir.
Q. That you didn't just put him in a mix of statistics and just took the most likely diagnosis? Can we agree with that?
A. I examined Mr. Lykins and came up with a diagnosis.
Q. And in regards to Mr. Lykins, he did have a reported fever, did he not?
A. I asked if there was a fever, when I dictate no fever, what that means to me is the patient never checked it or the temperature was less than a hundred degrees, which I don't feel is clinically significant.
Q. Did you ask either Mrs. or David if they had taken a temperature for fever?
A. Yes, I did.
Q. What did they tell you?
A. My --my response to that is twofold. When I ask a patient if they have had a fever, the first question is; have you checked it? If they haven't checked it, I would document no fever. If they have checked it and it is less than a hundred degrees, I would still document no fever. I don't feel that is a clinically significant temperature.
Q. Would you then ask if they have taken any medication for fever?
A. I had reviewed the chart, and there was no medications listed.
Q. Did you ask the patient, did you ask David Lykins or Mrs. Lykins if he had taken any medication for the fever?
A. That is asked at triage. I don't specifically ask that question again.
Q. And at least at triage, they didn't report that he had Phenergan that day, did they?
A. That's correct.
Q. That would have been something for you to know?
A. Yes, sir.
Q. But you never asked the patient if he had had any medication, did you?
A. I don't recall if I had asked or not.
Q. All right. Now, chills and sweats, would that be an important thing to know about?
A. In the face of a fever, yes.
Q. Or in the face of a past fever?
A. I wasn't aware of any sweats. The triage note mentioned chills. I don't know about sweats.
Q. I'm sorry. Maybe I am wrong. Let me look and see a second here. Chills, fever. Symptoms started yesterday. I apologize to you. Let me ask you this: How about pale? Does a person look pale when he's sick sometimes?
A. I think pale is a very subjective symptom or sign if somebody is going to use that.
Q. Now, you would agree with us, would you not, that David Lykins was having an emergency medical condition on March 2nd of 2000, would you not?
A. I would disagree with that. I mean, all patients that present to the emergency department technically have an emergency medical condition.
Q. So you didn't consider David Lykins' case any different than all patients that presented with an emergency?
A. I evaluate all patients and listen to all patients' histories and obtain physicals on everybody.
Q. And in this case, in this particular case, I want you to explain to the ladies and gentlemen of the jury, first of all, what are some of the reasons a person would vomit or throw up?
A. Just in general?
Q. Yes.
A. I think we can start at the head and work down. Patients with headaches, with head trauma, patients with pneumonia, sore throat, urinary tract infection, abdominal injuries. problems,
Q. Infections?
A. Patients -people with infections can vomit. It's not necessarily related to the infection.
Q. I'm not saying necessarily, but if you are considering throwing up, isn't it more likely that someone would throw up in general, if you want to go back to that, because they have an infection than because they have a shoulder sprain or strain?
A. Not at all, sir. We see many people with orthopedic injuries with nausea and vomiting.
Q. We? How many have you seen throw up from a shoulder sprain and strain?
A. Again, sir, I -I don't keep -I don't keep numbers. I evaluate everybody individually.
Q. All right. Now, up here, is this a correct dictation of what you said (indicating)?

A. I --yes, sir, it is.
Q. Would you read it to the ladies and gentlemen of the jury?
A. The patient is vomiting, and I do not have a good clue as to the cause of this other than the pain from his shoulder.
Q. Did you do any laboratory work to rule out any other process that could be ongoing?
A. No, sir. That was not indicated.
Q. Did you see the Urgent Care form?
A. No, sir, I didn't.
Q. Did you see the phone form?
A. No, sir.
Q. Did you see any indication that Mrs. Lykins had brought David into the emergency room to rule out either a septic arthritis or a septic joint? Did you see that?
A. At some point during our interaction, the Lykins and I had discussed a septic joint. I'm not sure where that had come up. have it dictated in my note, so we talked about it.
Q. And they didn't mention that we're here because of the doctor sending us straight down from Urgent Care to rule out a septic joint or arthritis or some kind of infection?
A. Again, sir, I don I t recall where that information came from.
Q. So you don't deny here today in front of the jury that either one of the Lykins or both told you they had come in to have an infection ruled out?
A. That I don't recall.
Q. You've seen Urgent Care forms before, haven't you?
A. Yes, sir.
Q. And you have read them and used them, haven't you?
A. If the patients give them to us, we read them.
Q. And you are saying you never got this?
A. I never saw the Urgent Care form.
Q. But I believe that you have indicated previously there was nothing on the Urgent Care form that would help you; is that correct?
A. I believe what I said was I **--**it would have been nice to have known if the patient had received Phenergan at the Urgent Care.
Q. But as far as Dr. Roth's work-up, working diagnosis and request for lab work, CAT scan that was either on the form or called in, that would be of no assistance to you, would it?
A. As far as the physical exam, I did the whole entire physical exam myself, so Dr. Roth's physical exam would not have been helpful, and there was no mention of CAT scan or CBC on the Urgent Care form.
Q. Said laboratory work, didn't it?
A. No, I don't believe it did.
Q. Lab work?
A. No, it didn't, to the best that I can tell. I'd have to look at it again. I don't recall.
Q. So what you are telling the ladies and gentlemen of the jury, after you have had an opportunity to review the facts of this case, review your own notes and your own care and treatment and independent recollection, you could totally have disregarded Dr. Roth's form even if it was available to you and it would have had nothing to do with your standard of care?
A. When I receive a patient from an Urgent Care, I take the responsibility. If there was a request for a test that was ordered, I would be the one who would be responsible for doing that, so I feel that it's my obligation to make sure that I reevaluate the patient and agree. So based on **--**based on Dr. Roth’s note, there would be nothing else that I would need.
Q. Just a moment, please. And you would not do anything different if we went back to March 2nd, 2000, than you did on that date for David Lykins, would you?
A. Sir, I've had a long time to think about this case, and I can say that I would not have changed anything as I go back and look.
Q. And you will not change anything in the future as a result of it, correct?
A. That's correct.
Q. Okay. I'm going to show you the Urgent Care form. Now, you have seen the Urgent Care form, haven't you?
A. Yes, sir.
Q. [What does it say?]
A. Severe left shoulder pain. Septic arthritis needs ruled out.

CROSS-EXAMINATION OF DEFENSE EXPERT WITNESS DAVE TALAN BY PLAINTIFF ATTORNEY MR. BRANNON:

Q. Good morning, Dr. Talan.
A. Good morning, sir.
Q. I understand you have a plane to catch, and I know that the Court and the jury don't want me to belabor this too much, but I do have a few questions I would like to ask you.
A. (Nodding head up and down.)
Q. First of all, would you go back to the easel, could I trouble you, and take your [print out of the] CBC that you have in front of you and -
MR. BRANNON: May I help, Your Honor?
THE COURT: Sure. BY MR. BRANNON:
Q. If you would, I want you to start with the first CBC, if you would, sir, below this line (indicating), if you would.
A. What would you like me to do, write the numbers?
Q. I would like you to put the total white blood count.
A. Okay.
Q. The neutrophils and bands. Is there anything else there just on that part of it?
A. I see 6.9.
Q. What time is this?
A. This is at 10:49 on March 3rd.
Q. Okay.
A. And neutrophils is 93.2.
Q. Uh-hum. Bands?
A. And there's no bands.
Q. Zero bands?
A. Zero bands.
Q. All right. Let's go to the next time, please.
A. Okay. We have 1540.
Q. 1540. What's the white blood count there?
A. 3.39.
Q. Uh-hum. Neutrophils?
A. Neutrophils are --hold on a second --twenty.
Q. And bands?
A. Sixty-seven.
Q. All right. Let's go to the next time.
A. 2122, 3.6 and sixty-three --well, no. I'm sorry. Twelve and sixty-three.
Q. Twelve and sixty-three?
A. Right.
Q. Okay. Now, if I understand you correctly, the creation of these bands has to take place over a period of time; is that correct?
A. That's how we think about it.
Q. It just doesn't happen in an hour or two, does it?
A. Probably not.
Q. Okay. So if we assume that your test there shows zero bands, and some you help me do the calculation, Doctor, what is that, some five, six hours later --let's see --six, seven hours later it's sixty-seven, is that more probably than not accurate that it was zero at that time?
A. It –it –
Q. Zero.
A. It very well could be zero.
Q. You honestly --in your professional opinion --
A. I don't think it's a mistake. I've seen changes like that happen.
Q. Okay.
A. And it --I'll tell *you,* just to back up, in his condition and with the infection we know he had, it is unusual but not undescribed that the white count wouldn't be higher or the band count wouldn't be higher but that, indeed, was how his body reacted to this infection.

Q. But, Doctor, you would agree within realms of reasonable medical certainty, it would be highly unusual, if that band count zero is accurate, to go to sixty-seven in that period of time, correct?
A. No. I think I've seen that many times.
Q. Okay. Now, what if I told you that they didn't take a band count, that that zero was just the machine didn't differentiate between it and it didn't differentiate the number of bands in that 93.27 Please assume that.
You wouldn't know what the bands were, would you?
A. No.
Q. So you couldn't make a determination if there's a left shift, could you?
A. Right.
Q. Now, let's take a look and see if this white blood count or the CBC --and you see later, do you see that the original was a machine count and the rest of them were hand counts?
A. Let me see. Right. Well, they're not reported.
Q. Tell the ladies and gentlemen of the jury, then, how many bands were here to show the ladies and gentlemen of the jury what his left shift was?
A. Well, you can't say for certain except that they didn't report any bands. There may have been bands, I'll concede that, but none are reported there.
Q. Well, what if they had forty bands? Would that be good?
A. Would that be good in what sense?
Q. Would that be a left shift?
A. Yes.
Q. I think you said even twelve would be a left shift, wouldn't it?
A. A slight one, yes.
Q. Sure..And let's take a look at the white blood count. Obviously his white blood count is dropping, correct?
A. Yes.
Q. Can we agree, Doctor, that probably his infection started on 12/1 --I'm sorry on 3/1? I don't know where I came up with 12 --on March the 1st?
Is that basically what you would say?
A. I don't recall exactly. I think we know he injured himself -
Q. Well, do you know that?
A. --around that time.
Q. Okay. You are assuming --your testimony and your opinion today assumes an injury, doesn't it? A. Yes•
Q. Without the injury, your testimony is not correct, correct?
Well, not all --your opinions are not accurate if he didn't have an injury. Would you agree with that?
A. Well, I don't know about that. I mean, what I'm saying is this: Injury or no injury, he reported that he was doing some heavy lifting, So we'll just take that as a given.
Q. Okay. If we -
A. We'll call that a history that would be consistent with an injury. That's all.
Q. Well, okay. If the patient reported that he didn't injure himself, I didn't hurt myself lifting, and the doctor just assumed the lifting caused him to be hurt, that wouldn't be an injury, would it?
A. Well, I'm not exactly sure what you are saying. I'm confused by your question.
Q. I'll get to that in a second. As I understand --and please, I understand, you are the doctor. I'm just a lawyer, but if understand from some of the publications --andI think you have worked with Dr. Infectious Diseases Expert and Dr. Henry yourself in other cases, haven't you?
A. I think Dr. Henry, at least one case and Dr. Infectious Diseases Expert, two or three.
Q. You have been teams together on these kind of cases, haven't you?
A. I'm not always sure that we've been on the same side.
Q. But you have deferred to Dr. Infectious Diseases Expert when it comes to infectious disease, have you not, to his expertise?
A. In the specific area of group A strep infection, yes.
Q. Sure. And looking on March the 1st, let's go --and I'm going to ask you to bear with me.
We know that at some point in time, Tina Lykins took a temperature of David Lykins later on March the 1st or early March 2nd. Can we agree on that, sir?
A. At some point there was a --someone felt there was a fever. It's not entirely clear to me if and how it was taken.
Q. Well, are you doubting Mrs. Lykins sitting there (indicating), got a fever of a hundred degrees, Doctor?

A. I'm not doubting anybody. All I can say is that I rely most on the contemporaneous medical records and secondarily on people's reference, and there is a contradiction here where there's specific dictation at the time that this happened that there wasn't a documented fever.
Q. Well-
A. So that's --I'm trying to take into account every --all the --all the facts fairly, and I would say, yes, it seems that that was the report, and it certainly could be consistent with Mrs. Lykins taking a temperature.
Q. So we don't know that his temperature wasn't much higher and had started to fall before she took it, do we?
A. No, I guess we can't know that.
Q. Sure. And as I understand this issue, that you may have a high temperature, once you start failing, your temperature drops, like it did on March 1st, below normal; is that correct?
A. Look, as --as infections become very, very severe and people become moribund, like ready to die, they get colder.
Q. Uh-hum.
A. He subsequently, if I may, continued to have fevers all throughout his course for two weeks.
So in patients who rapidly die, you know, of course when a person expires, their -all systems shut down and their body temperature drops.
I don't think your analogy completely applies here, but I'll acknowledge that temperatures can be low with severe infection, but on the other hand, we know from his course he was capable of generating high temperatures.
Q. But he was getting treatment afterwards. You're not saying that he couldn't have just taken a dive on the temperature if he continued to fall, are you (indicating)?
A. I'm not --I don't understand why you presume that.
Q. What if he had -
A. I said just the opposite, actually.
Q. Well, why is it not conceivable as we understood the testimony from the other experts that he had a hundred and three, hundred and four, sweating and chilling, he --his fever started to fall because the septic process was beginning to take effect on him and his systems were beginning to be attacked, and they took it at a hundred and it continued to drop?
A. Well, look, anything's possible. It's really strange that in the condition he was in, his white blood cell count was not abnormal on the 3rd
Q. Well-
A. Let me just finish. But on the other hand and, again, I think I've answered this question two or three times now. The reason to believe that he was not the type to just have a low temperature because of his severe infection is because he had a very severe infection for two weeks after this and mounted substantial fevers, so that would be the --that would be the facts that would go against that being a likely possibility.
Q. Well, let's go back. As I understand both you and Dr. Infectious Diseases Expert, it's not unusual when this infection begins that you get a very high, high white blood count that starts to drop; is that correct?
A. Well, I wasn't here for Dr. Infectious Diseases Expert' testimony, but I'm well versed in his writings, and his writings actually --although certainly that can happen with severe infections in general and maybe he testified to that, in this specific infection, a high total white count is not often observed.
Q. Okay. But we don't know that he didn't have twenty and then ten and then twelve and 6.9 and 3.9 and 3.6, do we? You don't know that?
A. We can't --you can't know that because those tests weren't done.
Q. Well, whose obligation was it to get tests done? Would it be the physician's or the patient?
A. Well, I think you framed that question wrong. I don't think it was their obligation in this case. I don't think they were clinically indicated.
Q. All right.
A. And, of course, it wouldn't be the patient's obligation to get a test.
Q. Dr. Talan, would you agree with us here today that your opinions that you have expressed are only as good as the facts that you have assumed in evidence to be true?
A. No, I wouldn't say that. I would say that my experience and training also have great bearing on this.
Q. Okay. And it's your testimony here today that you would not have had an indication of suspicion for David Lykins sufficient enough to observe him before he was released from the hospital based on what you know about the case; is that correct?
A. Well, are you talking about my own personal standard or the community standard? I thought that's what I was here to address.

Q. Well, aren't we talking about the same? We're talking about your testimony. Are you testifying to the standard of care or do you practice at a higher standard than these doctors?
A. No. I --frankly, even considering the fact that I focus on these things almost every day, I think I could have easily missed this diagnosis and probably would have, but I just wanted to make sure I understand that we're talking about, you know, not me with my three boards, but a reasonable doctor in the community.
Q. Well, does any of - does Physician's Assistant Heller have any boards at all?
A. No, not medical boards.
Q. And I believe that Dr. Vaughn only has an emergency an emergency doctor's degree or board; is that correct? Emergency doctor?
A. I'm --I wouldn't characterize it as
Q. Emergency physician?
A. --I wouldn't characterize it as only. I think that's more than sufficient to work in an emergency department.
Q. Well, sufficient. We're talking about meeting standards of care here. Okay? But my question to you -
A. I think it meets the standard of care, just to be clear with you.
Q. Okay. Just so they have got a license, they meet the standard of care?
A. I think his experience and training meets the standard of care, let me be entirely clear on that, if that was an issue in this case.
Q. All right. Well, Doctor, let me just ask you again, based on your training, experience, and education and the history that you have received, you, too, would have discharged David Lykins with a shot of Phenergan and a note to return in two to three days with instructions concerning a sprain/strain based upon all the symptoms that he had?
A. Yes.
Q. All right. Now, let me go back, Doctor. Let me ask you, if you will bear with me, to assume the following things.
MR. BRANNON: And if you will get that chart, that would help a little bit, the chart of the signs and symptoms.
MR. BRANNON:
Q. This helps me remember. If I could, Doctor, while Debbie is doing that, you did review the Urgent Care form, didn't you?
A. Yes.
Q. Did you read Mrs. Lykins' deposition?
A. Yes, I did. Q. And did you read all of the March 2nd and March 3rd emergency room records, sir?
A. Yes.
Q. Did you read the phone form concerning the call-in by Dr. Roth?
A. No.
Q. Did you ever hear about that?
Yes.
Q. OK. Now, I'm going to ask you to assume some things here. I'm going to ask you to assume David Lykins was quite healthy, quite active, and had a very high pain tolerance; that he had visited his doctor, as you have seen, some ten times in six years and his own doctor, as you saw in the deposition, described him to be in excellent physical and mental health.
I want you to assume that he got off work from doing his normal duties, nothing different, usual lifting of patients as a paramedic.
You did know he was a paramedic, didn't you?
A. Fire fighter/paramedic, right.
Q. Okay. Captain?
A. Dh-hum.
Q. Chief of police?
A. (Nodding head up and down.)
Q. I want you further to assume this is a man that knew something about his health. A paramedic learns about their health, don't they?
A. Well, I don't know, but he would be --he would have extra training about health-related matters.
Q. Sure. And you would agree with us that listening to the patient is the most important part of a diagnosis, correct?
A. Often the history is the most important.
Q. SO the history includes more than just the patient, it includes all the information provided to you by anyone else that's provided any kind of health care to the patient.
Would you agree with that?
A. It can. It depends on in what circumstances that's really critically important.
Q. Well

A. I don't think I know what you are building up to. I won't steal your thunder.
Q. No, no. Don't steal my thunder. When is it? When can you throw the history out and when can you -
A. Well, let's just talk about this, because I know we've discussed it in the deposition.
There was a phone record recorded from Dr. Roth. There was a discharge sheet apparently given to Mrs. Lykins which she conveyed, and they said something to the effect rule out septic arthritis.
In circumstances where that information would add to my independent assessment, would help me evaluate the case, that would certainly be important to attend to, retain maybe for matters like this. I don't think in this case it would add anything, and I think the records themselves demonstrate that septic arthritis was a consideration, and my understanding from Mrs. Lykins' deposition was that she felt that she conveyed this information verbally to the care providers. I don't think --to me, that information, the piece of paper, whether it was conveyed or not was not really important in evaluating whether the standard of care was provided here.
Q. Well, you are wrong. That wasn't where I was going, so try to listen --watch for the lightning instead of listening for the thunder. All right.
A. All right. I gave you your Heller.
Q. Well, you have already explained away something I wasn't going to ask you. But, let's go on to something else. Is it important to listen to the patient?
A. Absolutely.
Q. When a patient since you brought it up, is it important to listen to what another doctor thinks who is a board certified internist?
A. Again, sometimes that can be very important. Other times, it will not be particularly important.
Q. So the standard is whatever you want
it to be for that particular time or is it consistent all the time, Doctor?
A. Well, you are making a generality, and unfortunately, medicine isn't practiced in terms of generalities and cases like this aren't decided based on sort of general things. We have to look at specifically what happened and why they might be important.
Q. Usually it's based on whether the patient is exhibiting signs that he's sick. Would you agree with that?
A. What is based on?
Q. Isn't the care and treatment of a patient and the acceptableness of the treatment based on whether or not the physician is taking care of the signs and symptoms of a sick patient? Would you agree with that?
A. I --I don't really understand your question. Obviously
Q. Let me ask you this. I'll withdraw it. Do you send sick patients home from the emergency room, Doctor?
A. All the time.
Q. Do you send people that are sick and having symptoms that are indicative of a septic process home without working them up?
A. Well, hopefully not, but I probably have missed a few in my lifetime.
Q. All right. Well, let's go back and let me start with my original question before we get into it. We've got David Lykins. This is a healthy guy, tough guy, smart guy. He gets off work at 7:30, he's fine. Talks to his brother, going to go down, do a little estate planning for his family.
This guy has lifted and worked and built barns and he's never been known to have a problem with vomiting, never had a problem with his shoulder, never had a problem with anything but a back where he's had a herniated disc, and he didn't even take work off in 21 years with that disk.
I want you to assume that in the afternoon of March the 1st, he noticed a pain, a pain like he had never had before, in his left shoulder. I want you to assume that that pain continued to build and that he had fever,
he had chills and, in fact, he did get some ibuprofen.
I want you to assume further that besides that pain, it got to be excruciating, that he could not move his arm, that he did go to an Urgent Care center where he, not the doctor, reported that this is in my muscle twice. It's in the record, if you would like to see it, twice, muscle, muscle, and he was unable to move it.
And he threw up there at the Urgent Care center. They gave him a little Phenergan, twenty-five milligrams, and they noted that he might have some possible swelling, that he appeared to be sick, and he reported he was dehydrated. He, using what he knew, said it's not cardiac-related, it's not my heart.
And the Urgent Care doctor said rule out a septic arthritis process, that he called down to the emergency room and said rule out a septic joint; that Tina Lykins took her form or the Urgent Care form you have talked about down to the emergency room for them to use it, but they didn't use it, nor did they use the health --the phone records, nor could they read the triage nurse's notes, but I want you to take a look and see where the triage nurse, Janice Licht, indicated that he had had excruciating pain, he had a history of fever, that he had had chills, and indicated that -well, anyway, they know that he vomited two or three more times in the emergency room. All right?

And even with his vomiting, they continued to give him Phenergan. Even as he went out the door at 2:25 when he was discharged, they gave him another shot of Phenergan, and that while he was in the emergency room, he was screaming with the pain. When they tried to x-ray him and moved his arm, he screamed.
I want you to assume that the physicians or the physician's assistant who were providing their care indicated that he wouldn't move his arm and, in fact, as you well know, noted in the record that he tends to sometimes overreact to his health-care needs. I want you to assume that that was taken into consideration by the physicians.
I want you to consider that Tina Lykins specifically begged for a lab --set of lab tests. I want you to assume that the physician, Dr. Vaughn, noted right in his record he has had no fever, has had no fever, that they didn't take a temperature when they released him, that he did not feel well, that he, in fact, left and immediately threw up again in the car, that he was still having excruciating pain, pain like --that he described like none other he had ever had.
Now, Doctor, first of all, if you assume all those things are true, and let's go back there, let's not look back, let's go back, you are standing there and you are a reasonable emergency room physician, you are telling the ladies and gentlemen of the jury that you don't believe that an infectious process would be anywhere in your differential diagnosis as that man walked out the door?
MR. FREUND: Objection.
THE COURT: Overruled.
THE WITNESS: That was the longest question.
BY MR. BRANNON:
Q. I'm sorry, I can't do any better, but you understood it, didn't you?
A. I'll try to make my answer to the point.
Q. Yeah.
A. When patients come in with all those things and maybe others or less, we consider a broad range of things, of course, including infection. But just because we consider them at the beginning, that doesn't mean we wind up with that at the end. And so then you engage in your history, your physical, sometimes Some lab tests, you think about the epidemiology of disease, what's common, what's a reasonable explanation, and then you narrow it down to what's reasonably likely, what's a reasonable suspicion, what's a reasonable differential diagnosis. And I understand your case. There are features of this that could be consistent with this eventual diagnosis, but there are many that aren't, and I won't go into them because I did before.
Q. Just get to my question if you would, sir.
A. Yes. I'm addressing what you said in your question, and bear with me because your question was fifteen minutes and my answer still has barely a minute. Okay?
Q. Yours is a yes or no. Would you have considered it or not?
A. Okay. So I'm explaining what it means to consider. I think since that was the basis for your question finally; I'm explaining to the jury how a doctor considers things.
Q. Oh-hum.
A. So, yes, the answer is yes, with those symptoms, you would certainly consider infection among them, but at the end of this process and for the reasons I've gone through, which I won't bore the jury with, I don't think that infection was a reasonable consideration at the end of that process.
Q. Well, an infection, any infection, not this infection, you would have considered an infection, would you not?
A. Yes.
Q. All right. Now, Doctor, and I don't mean to irritate you or bore you or anything else. I'm doing the best I can.
A. You are not irritating or boring me, but I --this takes some concentration to understand what you are getting to sometimes, so if that's the case, I'm sure it's nothing personal. I'll do my best to listen.
Q. Well, I'm just an ordinary guy. I'll do the best I can. I don't know the medicine like you do, but let me ask you this: You indicated that you agreed with the diagnosis of muscle sprain and perhaps a muscle tear; is that correct?
A. Yes. And the isn't it true that a CPK would have confirmed whether or not there was some tissue damage to the muscle or could have, I mean, that's kind of even the point that if there was a muscle tear due to lifting --and I just want to digress a little bit, because it was part of your assumptions that I think weren't portrayed exactly like the record. Every --almost every time, this patient related his pain to this lifting.
In fact, if you look at the --not only during the ER and Urgent Care visits, but if you look at the visit on the 3rd when he was SO sick, Dr. --what is it – [one doctor] says he apparently had been lifting weights and he thinks that he might have pulled a muscle, and he attributed his discomfort to this initially.
I don't think that the doctors cooked this one up, but in any case, I think that, you know, it's --I think that's something that you have to take into consideration when you wind up finally with your list of reasonable considerations.
Q. SO David Lykins was responsible for not giving enough information to make it an appropriate history?

A. I'm not blaming David Lykins. I think he gave the history as he as he honestly would, but, look, life is not always fair. Sometimes you lift something and you think that's what injured you and it turns out maybe that's the case -- that's not the case or there's something on top of that, and unfortunately, how we practice clinical medicine relies a lot on some of these likely associations.
Q. Now, David Lykins was very sick on March 2nd, wasn't he?
A. No, I don't --I mean, in what sense? He had a lot of pain. His vital signs were not unstable.
Q. Wasn't he fighting for his life on March the 2nd?
A. I mean, this is --I don't even understand what you --why you are trying to dramatize this in your question.
Was he fighting for his life on March 2nd? We know in retrospect he had a terrible infection. It was tragic. Please, don't misunderstand me, jury members, that I don't feel for what happened here. But, look, the standard of care as a doctor and P.A. who would see this prospectively, I think this is a very difficult case.
Q. Well, let me just go back, and if you would just answer my questions, maybe I'll make them shorter or easier.
Would a CPK, properly done, have shown destruction of a torn pectoralis muscle if they believed that's what it was?
A. I'm sorry. I didn't fully answer that question. It could have shown a number of
things. It could have --because the process undoubtedly was a lot earlier, it could have been normal. The second thing
THE COURT: That didn't answer the question. We're having this problem, you are not listening to the question.
THE WITNESS: All right, well I think –
THE COURT: Some of his questions are long. The question was would a CPK have shown muscle damage on the 2nd, right? Was that the question?
MR. BRANNON: Yes, if there was a torn muscle.
THE COURT: Had one been conducted.
THE WITNESS: Well, I'm answering that I beg to differ from my medical perspective.
THE COURT: Maybe I missed it. Go ahead and answer that
THE WITNESS: OK
THE COURT: Would it have?
THE WITNESS: Yes or no? It may have, it may not have, and I'm trying to explain why.
The court: Go right ahead.
THE WITNESS: All right. So the process was early so it may have been normal, in which case the answer is no. Or because it's early, it might have been slightly elevated, in which case the answer is yes, or in a muscle tear it could have been elevated, in which case the answer is yes, but you would still be kind of left with dealing with this fellow who relates these symptoms, very, very common association, versus a very, very rare disease with no measured temperature, no external manifestations of infection, no evidence of septic shock. You would still --that's where you would be left. So I don't think most people would do it, nor would it be likely that the test result would be that helpful.
BY MR. BRANNON:
Q. Well, Doctor, assuming a past history of fever, excruciating pain, chills, vomiting, repeated vomiting, don't you think a reasonable physician would go further to rule out something other than the obvious that you say you could see, obviously, a shoulder sprain?
A. Well, if I haven't made it clear, I will make it clear, even clearer. No, I don't think many --or let's do it positively. think reasonable emergency physicians would have done what was done here.
Secondly, even if they had, I can't logically see how the results of a CT scan or this CBC or sed rate or those things would have likely led to this diagnosis or the operation, which was critical, sooner.
Q. Well, Doctor, let me ask you: You've testified previously that the redness and the swelling can sometimes be a very late sign of a deep-seated infection, correct?
A. Well, I think in this case, they tended to correlate.
Q. When you've treated this disease or any deep-seated infection, Doctor, you want to get to it and get it diagnosed as soon as possible, correct?
A. Yes.
Q. And when you suspect any kind of infection, you want to eliminate the most dangerous things for the patient, don't you?
A. Reasonably so.
Q. Sure. And you agree that time is tissue with this type of a disease, correct?
A. Right.
Q. And you've testified that David Lykins appeared to be not that sick on the 2nd. Now, I won't put words in your mouth, but I believe you indicated he wasn't that sick on March the 2nd.

A. Well, again, you see, you know, these are terms that could have all sorts of meanings. He was sick in that he was in tremendous pain. He *did* have vomiting, so, I mean, to any average person, you would say he is sick.
Was he sick in the sense of being unstable like we would view it as an emergency specialist, unstable vital signs, high temperature, altered mental status? No, he wasn't sick in that way.
Q. Is pain one of the signs or symptoms that you take into consideration?
A. Absolutely.
Q. Is it how you perceive his pain or is it how the patient perceives his pain?
A. Well, it's usually patient-driven.
Q. Right. And if I ask you to assume that the physician's assistant just assumed he was exaggerating, just assumed he was being a big crybaby in asking for all these tests, his wife was asking for all those tests, would that color your opinion concerning the care and treatment they gave?
A. Not really. I'm assuming that he did have pain and that the doctors recognized pain as a major part of his symptomatology.
What --what makes it difficult here, fairly speaking, is that these other findings that would lead reasonable care givers to this diagnosis were not present.
Q. How about the vomiting? Did he exaggerate that?
A. I never said he exaggerated anything.
Q. No. I'm asking you. You are assuming that these physicians performed an adequate examination, took an adequate history, correct?
A. Yes
Q. And, of course, whether they did or not *is* up to the *ladies* and gentlemen to decide; would you agree with that?
A. Absolutely. They're going to make the final decision.
Q. And can you explain to me how many times from a shoulder sprain a person has vomited repeatedly in front of you after seventy-five milligrams of Phenergan or at any time? How many times have you seen a person throw up because he sprained his shoulder?
A. Well, do you have to use a patient as an example? I would like to use my six year-old, because he was in pain and he threw up in my new car.
Look, it happens. Does it happen most of the time? No. People can react very strongly to pain, and sometimes they throw up.
Q. And have you seen them throw up repeatedly from pain --did your child continue to throw up repeatedly just from a sprain?
A. Well, it was kind of like one long one with like sort of -
Q. How much Phenergan did you give him? How much Phenergan did you give him?
A. I was driving, so I was trying to get him to contain it in his lap, but, you know, the poor kid couldn't quite comply with that, so
Q. Let's talk about the lab tests here. We're talking about David Lykins. Now, the CPK, the sed rate, the CBC, those are fairly simple tests and inexpensive, aren't they?
A. Yes.
Q. They're very readily available, aren't they?
A. Yes.
Q. And you use them in your everyday practice, don't you?
A. Yes.
Q. And you use them anytime you suspect an infection, don't you?
A. A CPK?
Q. Any of these, any --well, let's leave the CPK out. Okay? Do you use a CBC anytime you suspect an infection?
A. No, not anytime. I think we order tests where we think the results are really going to change our management that we wouldn't already do from our history and physical. Q. Now, I'm confused here, Doctor. Do you presuppose what a test is going to show you or do you wait for it to come back to read it?
A. No. Again, let me explain how medicine is practiced. We don't just order tests, because even inexpensive tests, when you order them like routinely and for no good reason, become very expensive. So we think about whether the test might logically, might possibly have a result that could change what we would do. That's how we order tests.
Q. Now, does your --do you have a contract with the hospital?
A. No. I'm an employee of the hospital.
Q. You are an employee. You don't get anything *in* your contract for what you save on tests to treat a patient?
MR. FREUND: Objection. Relevance.
MR. BRANNON: We have a contract, Your Honor.

THE COURT: Sustained.
BY MR. BRANNON:
Q. So let me understand, if another physician thought that someone had a septic process and his rule-out, not his diagnosis, his rule-out, was septic arthritis and the patient came in and continued to throw up and continued to complain of unbelievable pain and continued to be sick, forget the rest of it, you believe it's in the standard of care to send him home in that condition?
A. I think that what was done here met the standard of care.
Q. An average, reasonable physician would have let David Lykins go home?
A. Yes.
Q. Wouldn't have held him for observation?
A. No. They could have, but I don't think it was required to meet the standard of care.
Q. Okay. Wouldn't be required to call for an orthopedist to check out this arthritic or torn shoulder muscle now?
A. No.
Q. Who treats torn shoulder muscles?
A. Primary care doctors, emergency physicians, orthopedists, family practitioners, sports medicine specialists.
Q. How was it treated here? How was his muscle sprain treated here?
A. He was given pain medicine, he was given a sling, he was told to ice it and to follow up with his physician.
Q. And would it have been reasonable to call a fellow like you, an infectious disease specialist?
A. I don't think it was required to meet the standard of care.
Q. But it wouldn't be unreasonable, would it?
A. Well, I mean, especially in cases like this, looking back on it, it would have been very reasonable, but that's not how we evaluate these things.
I don't think that with this presentation, and for the reasons I've given now many times, that any additional care was required to meet the standard of care.
Now, had they gotten additional care, additional consultations, certainly would have still been within the standard of care.
Q. So you agree with the Defendants in this case that if this happens again in the future, it should be handled exactly the same way; is that what you are saying?
A. Yeah. Well, of course, this is pretty acutely painful for everybody here to think of an upstanding citizen like this getting something that, you know, frankly, the diagnosis was probably there early and was missed, I think reasonably so. I don't think that could have been avoided. I'm sure everyone feels bad about it.
You know what I do when stuff like that happens? It makes me so overreact the other way with the subsequent cases that I probably make mistakes by being too careful. That's not right either.
Q. Doctor
A. I don't I would say, look, based on what happened, at this point in time, not knowing anything else about the outcome, the same thing should be done again. Now, 99.9999 times out of a million or whatever, it's going to be right, and one time out of a million, it might be wrong.
Q. And, Doctor, are you saying that you can never be too careful? As a physician, you can never be too careful?
A. Well, it comes down to what's reasonable. There's an entity, sir, where we know people can have silent heart attacks. Can you imagine? We could all be having silent heart attacks.
You might --I mean, so if someone comes in with a sprained ankle and I ask them is there anything else bothering you? No, I sprained my ankle. Anything else? Do you have pains anywhere else? Shortness of breath? No.
If I did testing of everybody whether they had no symptoms, put them in the hospital just because I could never be too careful, I think we all understand that that would be unreasonable.
The question is what is reasonable, and that's how I'm looking at this case.
Q. Well, let me ask you, we're not
A. Without exaggeration, I think that it has to be confined within what would be medically reasonable.
Q. I'm asking without exaggeration. I'm not asking for us to pretend that we're all having silent heart attacks or anything like that. I'm asking you to put yourself in that room with this responsible citizen, paramedic, with his wife, screaming from pain, can't move his arm, and continually throwing up. Are you telling the ladies and gentlemen of the jury with that and the history that was available, whether they bothered to look at it or not, you don't think it would have been reasonable to at least rule out an infection?
A. I think they reasonably excluded infection based on their history, physical, and the laboratory tests that they did.
Q. Are you aware that they missed what medications he was taking?
MR. FREUND: Objection.
THE COURT: Excuse me just a minute. Basis?

MR. FREUND: That's a conclusion that's not supported by anything.
MR. BRANNON: Medications, none. You saw that in the record, didn't you?
MR. FREUND: Right.
THE COURT: All right. Overruled. You may go ahead.
BY MR. BRANNON:
Q. Yeah. Medications, none. Didn't get the medications, did they?
A. Well, they may have missed it or, alternatively, he may not have mentioned them when they asked him.
Q. Or they may have said it and they didn't care and write it down, right?
A. I don't want to even --anything's possible, I guess.
Q. Well, what if I told you that they wouldn't listen to Mrs. Lykins about what medication he had, that they wouldn't listen to him about what he had been ordered? Would that be possible?
A. I think physicians should listen to ' the patient and to their wife.
Q. And when the doctor --did you see where Dr. Vaughn on the 3rd wrote down he vomited a little?
Was that consistent with your understanding of how he presented himself on the 2nd?
A. I'm not sure where you are referring to.
Q. Have you looked at the March 3rd emergency room record where Dr. Vaughn indicated he was here yesterday, gave a history of pulling on some patients, and had vomited a little?
A. I'll turn to that. Okay. What's -what about that?
Q. Well, I mean, is that consistent with your understanding of the presentation of David Lykins on the 2nd?
A. Well, there are conflicting reports of how much he vomited.
Q. Yeah. The records don't reflect he vomited at all, do they, the medical records?
A. No, I don't think so. I think it does say that he had vomiting.
Q. Take a look in the emergency room record of March 2nd and tell us how many times they wrote down that he vomited so we can be accurate.
A. What it says here, the patient is vomiting, it says, in Dr. Vaughn's note.
Q. Okay. Well, how many times does the nurse note he's vomiting?
A. The nurse doesn't note vomiting.
Q. Okay. And there's nothing in the medical records as far as what's been presented in the record or in the absence of the record that gives you any indication of substandard care?
A. No. I mean, I --I think the totality of this met with the standard of care for the reasons that I've said.
Q. And a physician that would rely upon a family physician or a physician assistant to indicate that you should consider exaggeration here --or, I'm sorry, overreacting here, was within the standard of care?
A. Well, I don't know if he relied on him. That's --it was built into the assumptions in your question, but I think what I saw of the evaluations by Mr. Heller and Dr. Vaughn, I think it was clear that the patient had pain, received medication for pain, and I think the evaluation met with the standard of care.
r don't think this diagnosis could have been made by reasonable emergency physicians.
Q. And you would agree that their evaluation did not consider or rule out any type of infection, would you not?
A. No, I --I wouldn't agree with that, and, again, I will get back to what I said, briefly, previously is that we don't typically rule out things. We reasonably exclude them. This was reasonably excluded because of the history, the mechanism that was related, physical examination findings, the likelihood of this disease versus a very, very common and associated type of reason to cause this gentleman's pain, indeed, the one that he had offered.
And on the basis of that, I think infection as a cause of this was reasonably excluded. Was it ruled out beyond an absolutely infinitesimal shadow of a doubt? No, but that is not how medicine can be practiced.
Q. What laboratory or CAT scan test or any other test was used to even rule it out at all?
A. The --- none of those tests were indicated, as I've said. I'll say it again. Had they been done, it's unlikely they would have led to the diagnosis. The way this infection was reasonably excluded was based on the history and physical examination findings and the tests that were done.
Q. Doctor, how many times in your career and history have you found people getting routine tests having some very abnormal findings that are going on?
A. Very rarely.
Q. Doesn't happen. People going in for their monthly exam or going in for their gynecological exam expect to be fine and it doesn't come out. Does that happen?
A. It doesn't happen often. Generally confine doing my tests to where I have a reason to expect that the result might help me.
Q. Dh-hum. Well, most of us are never going to get prostate cancer even though we're men, so we shouldn't have a prostate exam?

A. No, but you are mixing apples and oranges here. Screening for prostate cancer in men over fifty is different than doing a battery of tests for everybody that comes in with what to all for all intents and purposes looks like a muscle strain with no external manifestation of anything to suggest infection.
Q. So if it looks like a muscle strain, it seems like a muscle strain, a doctor is in the position in the standard of care to say it is a muscle strain; is that what you are telling me?
A. Yes. After --after looking at a broad range of considerations, going through a history and an exam and sometimes some laboratory tests.
Q. Sometimes. Sometimes. What laboratory tests? I'd like to know what sometimes is at least. Which ones and what times?
A. Well, I think I agree with getting an x-ray in this case. I think the pain was obviously severe. It was localized by all the care givers to around the joint. The joint is an orthopedic structure and would be well-demonstrated on x-ray, so the x-ray made sense. It fit with the fact that this was a vigorous man who did heavy lifting and could have had some type of orthopedic finding there, so I would order that. There would be a reasonable Heller I might find something that could do something about.
Q. And-
A. I don't think these other --I don't think the other tests that we mentioned would be indicated.
Q. SO if Dr. Roth said do a CAT scan and do the laboratory blood tests, he was being unreasonable?
A. In my opinion, yes. Now, the one thing he could have suggested or we haven't discussed could be an aspiration of the shoulder if you thought it was a septic joint, but even that would --obviously there was no septic joint, and that wouldn't have led to this diagnosis either.
Q. Was David Lykins sick when he was discharged from the emergency room?
A. Well, his vital signs were stable. His pulse had come down. His pain and his nausea had been treated, and based on the clinical evaluation, it didn't appear that he had anything life-threatening.
So I would say in that sense, he was appropriate for discharge. Was he still having some symptoms? It sounds like he still was, but he was appropriate for discharge.
Q. Necrotizing fasciitis, streptococcus A, that's an emerging disease, isn't it?
A. We consider it an emerging infection. Whether it is more common now than five years ago, no one is quite sure.
Q. Do you keep up on the outbreaks in the areas of the United States where it's occurred?
A. I read the public health reports, so only in that sense.
Q. Are you aware that southern Ohio had an outbreak during this time?
A. Well, I wasn't until being involved in this case.
Q. But you became aware of that, didn't you?
A. I've seen it referenced in your questions in depositions, yes.
Q. Let me ask you, in your hospital, are you the chairman of your infectious disease department?
A. No.
Q. Okay. You are actively involved in it, aren't you?
A. Yes.
Q. Now, do you have a process or means of communicating to others in the emergency room about emerging diseases or biological diseases or these strange things?
A. We do. It's not the type of infections that hospital infection control usually reports to the staff.
Q. Is there an obligation in your hospital for the infectious control department to report to the staff?
A. Yes.
Q. How many cases of necrotizing fasciitis have you treated?
A. I've lost count, but probably well over fifty, seventy-five, something like that.
Q. Do you usually treat them there in Los Angeles or do you go to other areas of the country?
Q. Just in Los Angeles alone?
A. Yes.
MR BRANNON: I have no further questions. Thank you.
THE COURT: Mr. Fruend, redirect.
MR FRUEND: Thank you so much, doctor I have no further questions.
THE COURT: Thank you. You can step down. Watch your step.
THE WITNESS: Thank you. Thank you.
THE COURT: All right. Let's take
our lunch break. Let's see you back at let's see here 1:30. 1:30 we're going to have you back. Don't discuss the case, form or express any opinion, and we'll see you back then. Thanks.

(Lunch recess taken.)

Plaintiff closing arguments:

THE COURT: So we ask for your attention to these closing arguments. And we all thank you for your patience and your long suffering. And you've been here now four weeks. And we're all just very grateful for your participation. Now, Mr. Brannon we're ready for the plaintiff's closing argument.

MR. BRANNON: May it please this honorable Court, defense, Tina Lykins, ladies and gentlemen of the jury.

You've heard me say stop, look, and listen. Perhaps you wondered why I would use a simple phrase: Stop, look, and listen. Those are ordinary words for ordinary people. And I've determined that we're all ordinary people. We have to exercise ordinary care for one another.

It's been said to whom much is given, much is required. To a physician is given the very special status in our community. They're required to stop, look, and listen. A physician cannot go speeding down the street, run a stop sign, then run a red light, then pass in a no-passing zone, particularly when there's two medical policeman on guard.

A doctor cannot come in and tell you, ladies and gentlemen of the jury, that he is allowed to tell a patient who is sick to go home. A hospital can't do that. We expect a lot from our medical healthcare providers.

We pay a huge amount of money for that protection. And we are going to pay more, and we're not going to pay more just to allow doctors to make higher salaries or hospitals to build more buildings or make more money. We're going to do it for ordinary people. People like you and me. People like the doctors.

Because, you know, I've come to the conclusion --again, ordinary people. That's all we all are. And once in a while we get called upon to do extraordinary things. A physician, often; a paramedic. Seldom does an attorney get an opportunity to participate in a case like this. I've waited an entire career, and I'm simply an ordinary person without great gift or intelligence, but simply bringing in the evidence as I understand it and believe necessary for you to understand so that we don't have in a courtroom a gamble. Courtrooms and jury trials are no place to gamble. But then, again, neither is medical care, doctors, doctors' emergency rooms, or phone calls between doctors about health care. All of those things.

Ladies and gentlemen, they gambled with David Lykins' life. They gambled by throwing away or destroying forms. They gambled by refusing to read. They gambled by refusing to provide to you any protocol, procedures, other than, "I don't recall" or "Somebody else would have told me" or whatever. You heard the testimony. And I will depend upon you collectively to remember the testimony. I trust a jury. I don't trust doctors to create the standard of care. I trust a jury. You know what? The law requires a jury to establish standards of care. Because something very special is happening here. Very special. A jury has been called, convened to determine the standard of care. Yes, they gambled that an ordinary jury couldn't figure out the medicine in this case based upon the physical facts, the testimony, the missing evidence, and what is more likely than not. They gambled. But you know what, ladies and gentlemen? My job here is simply to try to provide you with information, not simply to provide *you* with my emotions. I often fear in my advocacy, I convey too much emotion. But that’s me. I’m just an ordinary person to do that. I'm sure there's times you would have liked to have told me to sit down.

I'm not the most articulate person that ever walked the face of the earth, nor do I try to be. I seek out representation of ordinary people. And once in a great while I am blessed with an extraordinary person --an ordinary person doing extraordinary things. I knew David Lykins. I know Tina Lykins, and I've gotten to know the family.

Not meaning to be callous, but I've gotten to know the medicine, and I've gotten to know the doctors. You have too. Who came into this courtroom to reveal, and who came in to conceal? There's like a Plexiglas window between you. My job is to advocate. My job is some education. My job is to assist you on behalf of my client.

And if I have been emotional on behalf of my client, I make no apology. We had some things that have occurred that I simply didn't feel comfortable with and often expressed myself. I believe that a person should say what's on their mind. And I believe I should tell you what's on my mind.

And when a jury comes together with that magic --with that magic --to weigh the evidence and understand it, that is justice. Thomas Jefferson said the jury trial is more important than the vote. I don't know if I agree with that, but it's just as important as the vote. Because it has been juries throughout our entire, I believe, 226-year history now --I'd have to check that out; think about it --that have determined that we would not have trials --laws where children are required to work long hours, they would not have pain and suffering needlessly, that those that are in positions of authority or in the professions shall not dictate to the people. We are a government of the people, by the people and for the people. And you will be acting on behalf of this entire community when you determine if these defendants met the standard of care. Did they use what would be the ordinary, reasonable methods available to diagnose, care and treat for David Lykins.

You've heard the evidence of what they claim the standard is. All the evidence from all the experts, what they claim the standard is. But it is your collective judgment. It is the record that you will write that will determine standard of care.

And if you write a record that speaks loudly, strongly, boldly and truthfully, then you will write a record that will do more to upgrade or establish or at least maintain standard of care than any multimillion, 10-hundred-million-dollar study or surveyor government action.

Because if you write the record, every time someone arrives in that emergency room, every time someone arrives by ambulance, by car, with a condition where they expect to be treated and not ignored, where they expect all the information to be available and not ignored or destroyed or whatever, David Lykins will be there. His life will not be in vain. Not that his life was, but his death was. He will be a reminder of all times. He shall be like a sentinel as he stands there at that emergency room door and for all physicians and all hospitals and all people that are family physicians that have an opportunity to help for their patients.

Ladies and gentlemen, you're about to do something extra, extraordinary, because as you collectively get together, it is very special. And what will you decide in this case? Well, you decide do we send people home, do we send David Lykins, with the bells ringing, whistle blowing, the lights and the guard flashing, into that train of that horrible infection to certain death? Or do we listen. Do we collect a true history? Or do we let physicians and healthcare professionals just simply gamble and believe they can come into the courtroom and fool the ladies and gentlemen of the jury. Oh, it happens. But not very

often. But it depends upon your diligence, and I know that and thank you. I have never seen a jury, for more for 30 years, pay more attention. I wish all of us could go back and deliberate. I know three-quarters of you, six of the eight, must come to a verdict in order to arrive at a final disposition of this case. But I've never seen a more attentive or respectful jury. Your adversary --and for that task, as difficult as it may be, I want you to remember one thing. Thousands and thousands of juries have preceded you. They have done the difficult task. They haven't found it too hard to make justice. They haven't found it too hard to set standards of care.

And they haven't found it so awful that they couldn't stop, look, and listen, and see what's here. Not a drive-by diagnosis. Not a guess. Not a probably --or not a possibly. Not a maybe. But we're looking for probabilities.

Now, what is this case about? It's about responsibility and accountability. It's about what's right with America and what's wrong with America. David Lykins was everything that was right with America. He was responsible. He would take his time. When it was time to unwind Mr. Johnson back there, Curtis Johnson, from that auger, those many hours when he would talk to him and take it slow and easy and figure out how to get him out, he would do it. When *it* was difficult to fix that situation, he took his time. He stopped, looked and listened. When he was asked to fix a police department, he took his time. He talked to the community. He stopped, looked, listened, and he was personally responsible.

Ladies and gentlemen, I think personal responsibility is probably the greatest attribute, protector of our society than anything else. Be it personal responsibility or professional responsibility. What's right with America are David Lykins, that care about how people are treated. They care about how their job is worked. They care about making it better for others. They care about their families, care about their children. That makes the extraordinary effort to do their very best.

Andrew Carnegie said the average person puts only 25 percent of his energy and ability into his work. The world takes its hat off to those who put in more than 50 percent of their capacity and stands on its head to those few and far between souls who devote 75 to a hundred percent.

Ladies and gentlemen, when you run through a stop sign, barrel through the red light, pass in a no-passing zone, it does you no good to say, oh, but for a thousand times I stopped, looked, and listened, and I only did it this time.

That's right. A physician is only as good as his next patient no matter who that is. It doesn't do any good to say, "I don't recall, but I always stopped there, so I must have stopped." It doesn't do any good to bring in casts of thousands to say, "He normally stops." It doesn't do any good to bring in others to say, "Well, if he doesn't stop, he'll usually have someone out there to stop him." It's really no different. It really isn't. It's more common sense than anything.

I think it was probably said best --we celebrate who said it --do unto others as you have others do --as you would have others do unto you. Would we want someone to take their time and listen, look at the signs and symptoms --before I get into the evidence and probably repeat what you've heard again and again and again. Or we would expect someone to say, "I normally do this. And I'm sure, even though it's not in the records or I didn't write it, I did it, and it was right. And I'd do the same thing all over again. And I wouldn't use any other tests. And I wouldn't keep him."

You know, ladies and gentlemen, what they have done, they have come in here and said while the Titanic was sinking, and the plaintiffs did not put the chairs in order on the deck. That's what they've done. But I'm proud to say something to you. And I think you will be happy. His honor has ruled that as a matter of law Tina Lykins, David Lykins, and those four children, who I hoped wouldn't have to face the possibility of maybe someday looking at a record where maybe they caused their father's death. Ridiculous. But his Honor has ruled that they met their duty and they weren't negligent anyway.
So all that stuff you've seen is like ink in the water. I watch Discovery Channel quite often. I'm entertained by different animals, things like that, and enjoy watching those shows. I see an octopus. Gets in trouble. He squirts a bunch of ink in the water, and he buzzes off. Ladies and gentlemen, the defense in this case is like the ink in the water.

What has been the defense in this case? Well, this disease is rare. Everyone up there indicated that they knew that this disease exists and that a board certified, qualified physician, level-I hospital should recognize it. That any deep-seated infection is potentially dangerous. Rare? We heard one of the experts tell you he does 75 --75 a year. Use your recall on that. We heard testimony that they expect to see them. You'll have some evidence on that. And can you make your own minds up from that as to what the valley had, what the hospital had to give to the doctors, what they paid attention to. Jiminy, there may be a lot of diseases out there we never introduced. But somebody as sick as a dog, throwing up, unbearable pain, has a history of fever, we send them home?

How in the world is our medical profession going to be able to diagnose biological and chemical problems if we just --if they don't see redness and heat? Think of all the infections you know about, everything that's in an infection that doesn't have redness and heat. Think of any one of them that doesn't require standard laboratory or CBC.

No, this case is not about greedy lawyers forcing plaintiffs, Tina Lykins and her family, to seek justice. Justice is not always pleasant for those that have justice coming. But this isn't about that. This isn't about going out and creating that. The defense would want to play on the bias against lawsuits and the bias against lawyers. There's about 60,000 lawyers across this country that do what I do. We're not plastered on the bus. We're not the ones out looking. But there's many lawyers that are very necessary to bring evidence in to allow you to establish and maintain the safety of the community and to do justice for those that have been the victims of negligence. And it is part of our system of justice and always has been that that right is inviolate and it is there to be used or our society would cease to exist as it is. That's right. Believe it or not, all damages that we all know from our common sense and experience.
I can only hope, as I want to reserve some time, that I've done this family justice, that I've done David Lykins justice, that I've done this case justice. I hope that when it goes to you, you too will do it justice and you too will write a record for which the community can be proud, a record for which Dave Lykins can stand as sentinel in the emergency room and the doctors' offices reminding them of their awesome responsibilities. To whom much is given, much is required.

With my apologies to --I want to read a little bit to you --may have some photographs. Again, ladies and gentlemen, you're going to be instructed not to decide this case on sympathy. We don't want your sympathy. We had plenty of sympathy at the funeral. We had plenty of sympathy when the baby was born. We had plenty of sympathy. Easter, Thanksgiving, Christmas, every otherwise joyous occasion that would have been that will not be. No, we don't want your sympathy.

But I do want you to understand --if you want to look at the video, fine. You saw it before. There are a lot of --there is a lot involved in this case. There is a lot of hurt. There is a lot of damage. There is a lot of pain. And justice required compensation.

So, as I read this --that's David. Put David up there. There's Tina. You got the kids and David.
I'm going to apologize to Walt Whitman, who I believe I'm going to quote just a little differently because I probably should read this after the jury verdict comes back perhaps not before. Can you all see that? Why don't you hold that for me, would you? One hand.

We've got Tina here. Tina there. I just got to show you that picture of that baby. Not for the sympathy. But because that baby is there. That's a reality. That's a fact.

I address it to David Lykins. My tribute will be: Oh Captain, my captain, our fearful trip is done. The ship has weathered every rack the prize we sought not yet won. The port is near, the bells I hear, the people all exulting, while follow eyes the steady keel, the vessel grim and daring; but oh, heart, heart, oh, the bleeding drops of red, where on the deck my captain lies, fallen cold and dead. 0 Captain, my captain, rise up and hear the bells. Rise up. For you the flag is flung, for you the bugle trills. For you, bouquets and ribboned wreaths, for you the shores are crowded, for you they call, the swaying masses, their eager faces turning. Hear Captain, dear father, this arm beneath your head. It is some dream that on the deck you've fallen cold and dead. My Captain does not answer. His lips are pale and still. My father does not feel my arm. He has no pulse nor will. The ship is coming in to anchor, its voyage is closed and done, from fearful trip to the victor ship comes in with object won. Exult, oh shores, and ring the bells. But I, with mournful tread, walk the deck my Captain lies, fallen cold and dead.

What was the prize here? David Lykins wanted three things in his life. One, he personally wanted to do his very best for his mankind. He wanted to be reasonable, responsible and accountable. He didn't want to be ignored, nor he didn't want to ignore anyone else. He wanted security for his family. Worked hard at it. Triple jobs. I respect that man. And still had all that time for his family. Above all he wanted to be there. He wanted to be there.

Second, professionally, he wanted to advance. He wanted to give, he wanted to serve, he wanted to take that time. And he meant it when he said he wanted to serve. Volunteered on many occasions. And if you look at that, what he got paid for being the chief of police in the troubled village, it was obviously a token of his desire to better his community and serve mankind. And particularly the people that he could help when he could. And volunteer.

Third, his community. This is about the community. Accountability, responsibility. Those aren't hollow terms. Standard of care, medical treatment. This community awaits your decision. This community awaits your determination. It's just the way it's going to be done. The next time, I'll do it the same way. We'll do it the same way. We wouldn't change a thing. If we had the records, we wouldn't have bothered to look at them. If we did look at them, it wouldn't matter. We don't have the records because they may have been destroyed.

Will you look at the ink in the water. When you see your way clear because --Captain Lykins saw his way clear to do the best he could with everything he tried to put in front of his life. He was a good man and a good father. And I ask you, in light of the evidence and in light of the testimony of Jerry Oster, the urgent care doctor, who threw him the lifeline --threw him a lifeline, "David, go to the emergency room." And Tina took him. And they took --went to the emergency room with that lifeline.

And at the emergency room, ladies and gentlemen, the triage nurse didn't meet standard of care. Then Mr. Heller didn't meet standard of care. Then Dr. Vaughn didn't meet standard of care. That's the lifeline. And then they called Dr. Oster to close the loop. They closed the loop all right. Instead of giving him a lifeline, they gave him the noose.

And all they had to do was stop, look and listen and pay attention to their patients. This patient. For Tina Lykins, it's really that simple. And then defiance. I'll do it all over again. I was right. Forget all the testimony. Forget Dr. Roth's careful --he needed to have lab work. CBC means nothing. The hospital itself calls it high. No, we're going to fool a jury of Montgomery County people that somehow you believe that the CBC on March 3rd was normal as he's dying of an infection. You've gotten that clear. But they walk in and they gamble and they make the voyage very difficult.

I will get to speak to you again, and I will for another 20 or 30 minutes, unless you want to just tell me to you don't want to hear from me anymore. But I hope I have brought something to help you out. Something convincing. This case really needs no convincing. I ask the question what is fair, what is justice, what is standard of care. That is not standard of care. Look --no evil, see no evil, hear no evil. And in fact the lesser of two evils is going back and having to determine standard of care, and fair, reasonable verdict, then they will have won.

Ladies and gentlemen, I await your verdict so I can tell the captain that his trip is truly over, his prize is truly won, and that you will post the conscience of this community in the emergency room where these defendants jointly and severally --the hospital, the nurses, the three doctors --so that they stop, look and listen and listen to ordinary people. Because this courtroom is for the victims. This courtroom is for ordinary people. And I --as an ordinary person, I salute you as doing something very special in having the opportunity to do what I can't do. Because a jury has all the power. Not a decision in this world has not been reviewed by a jury. Everything we do is reviewable by a jury. I ask you to realize how important it is and what an important thing that you do here.

I thank you for your time and attention. I hope that what I've said is helpful to you. I believe that with all my heart. Thank you ladies and gentlemen.

THE COURT: Thank you. Let's take a break here. 15 minutes would put us at 2:30. Don't discuss the case, form or express opinions until your deliberations commence.

DEFENSE CLOSING ARGUMENTS, NEIL FRUEND, ESQ.

Good afternoon, ladies and gentlemen. Before I start into what we call argument and what we're supposed to tell you what the evidence was, want to tell you that --especially the alternates here, because those of you who are regular jurors, you'll be with us a little bit longer. But all of you, ladies and gentlemen, I would like to thank you on behalf of Dr. Oster, Ed Heller, Dr. Vaughn, who from what I saw in the courtroom, did a terrific job.

You know your job is as important in our society and our system of government as our men and women in Afghanistan. It really is. You probably feel like you've been through some war in this courtroom on occasion. But you have done a yeoman's job for almost four weeks, which is an unusual length of time. Not only for you folks -- surely for you folks, I get paid for my time. You don't. And whatever your stage in life is, it's still out of the ordinary for you folks. This is, for better or for worse, the ordinary for me. So thank you on behalf of my clients, Shady Valley Hospital.

I want to start from the beginning with you because I think it's important. When we selected you folks as jurors, you'll remember that before we even selected you, I played a portion of the tape to show you the beautiful family of David and Tina Lykins. I did that for a reason. And I'd like to share with you that reason again in case you don't recall.

I did that because in this particular case, especially this kind of a case, it is so difficult, so difficult as a human, as you all are, as I am, and the older we are, the more experience with life we have. The more tragedy --the older we are, the more tragedy we've seen. The older we are, the more we know that bad things can happen to good people. Okay?

I know from my life's experiences how I react to death of loved ones. I know how, if you had it --some of you surely have --how you react to death of loved ones. And yet we expect you yet we expect you to come in here and judge us Dr. Vaughn, Ed Heller, Dr. Oster and Shady Valley Hospital --judge us fairly and impartially. We do that. We ask that of you. And I know how difficult that is because I have --I'm not cold-hearted. I'm not cold-hearted. But I have experienced loss, and I know how it is. And then we bring you in here and we say --and the judge will instruct you later to decide this case on the facts without the normal compassion, and feelings and sympathy that you naturally have for a beautiful family. Naturally. And we expect you then we ask you to do that. And we ask you to decide the case on the facts.

So I want to acknowledge the difficulty and talk about the difficulty with you. And so I was thinking, okay, now, how are we going to go about this? How are we going to approach this? And I thought that we would approach it like the doctors approached this case.

I'm just going to put this up here for a moment. You can look at it. And I'll bring it up this way a little bit.

And in fact, what you are doing in this courtroom is you are making a diagnosis. And how are you going to go about making the diagnosis? You're going to look at the facts. And what are the facts in this case? The facts are the testimony admitted into evidence the exhibits that have been admitted into evidence. Then the judge l when he gives you an instruction is going to give you the law.

And then *you're* going to make --when you go back in the jury room and you're going to talk about what has been presented in this case. And there will be given recollections and things that you all think you remember. Some of you have written some things down. And then you are going to render a verdict l which is your diagnosis. And you are going to go about this the very same way that the doctors did when they made their diagnosis in this case.

While you're making your diagnosis l I put down some things for you to remember. The judge will tell you that the plaintiff has the burden of proof. The judge will tell you that we have no burden in this case. Although I want to touch on that later because I think we have proved to you a lot.

I ask you, when you go back and deliberate this sounds pretty simple. It is simple. Because that's the way I am and that's the way I talk. I have no quotes for you. I have nothing like that. I also want to tell you I'm not going to take two hours.

Common sense and reason. That's how -that's how doctors make their decision based upon their medical training. That's how I ask you to make your decision when you go back and talk to each other and deliberate with each other. Common sense and reason. Without hindsight and retrospect.

Now, why is that so important? Well, there are two things that bothered me about this case. The one I've just covered here, and that was the tragedy, the loss that was suffered here. That bothered me.

I think, how can I overcome that? And the only way is with facts and asking *you* to decide the case not on hindsight or retrospect, because we're all pretty smart. Hindsight is 20/20. If we would know what the markets are going to do and we would be smart like these guys on television think they are and they're really not. They have proved it. They have proved it big time in the last couple years, ·for probably all of us with our pension and is retirement.

But as the doctors made their decisions, when they made their decisions --and put yourselves in the shoes of the caregivers.

MR. BRANNON: Objection, your Honor. That's a golden rule, obviously, and I hate to interrupt. But he can't tell the jury to put themselves in the shoes of one party or the other.

THE COURT: You want to make a record?

Mr. Fruend: No.

THE COURT: All right. Sustained.

Mr. Brannon: I would ask the exhibit be put down as unfair argument.

THE COURT: All right. Let's have a sidebar.

(Sidebar conference as follows):

MR. FREUND: Judge, it is not the golden rule. They judge the case as the facts were presented to the caregivers at the time.

MR. BRANNON: Put yourself in the shoes of the caregiver. That's the golden rule if I've ever seen it in my life.

THE COURT: It's not the golden rule.

MR. FREUND: This is not the golden rule.

THE COURT: You've said you think it was. It is not.

MR. BRANNON: Put yourselves in the shoes of the caregiver. If I had said, "Put yourself in the shoes of the plaintiff" that is unfair.
THE COURT: No, it's not. And the Court will entertain objections during close, but it's one of my pet peeves, and -- a lot of objections during close. I'm going to tell you that. Make whatever record you need.
MR. BRANNON: Didn't intend to object, but that is so clearly a violation of the golden rule for them to ask --that is the golden rule. It's a violation.
THE COURT: Okay.
MR. BRANNON: You can't put yourself in the shoes of the defendant.
THE COURT: It's fair argument. Overruled.
MR. BRANNON: Then I'm going to do the same in rebuttal, your Honor. (Sidebar concluded.)
THE COURT: The objection is overruled. And you may proceed, Mr. Freund.
MR. FREUND: Thank you. And what I mean by put yourselves in the shoes of the caregivers is simply, when you're judging my clients --Dr. Oster, Ed, Dr. Vaughn when you're judging them, judge them from the information they knew or should have known --from the information they knew or should have known --as the caregivers at that time. And I put down below: At the time the care was given. That's what I meant by this. At the time the care was given. Independent of what we've already talked about. Independent of compassion or sympathy.
Now, if we do judge the facts --and I do intend to talk to you about the facts --there are a couple things I want to talk to you about. Now, I don't know --you don't know me. But I'm pretty honest and straightforward, I think. And so I don't like --I'm going to talk to you just very briefly about damages. I don't like to talk about damages. And I don't like to talk about damages because I don't want you to think that we did something wrong. That's why I don't like to talk about damages. I'm going to talk about them very briefly, though, because I don't know what you're going to do. I have no idea. This is all --this is your decision. I can only present the facts and argue the facts.
So I just want to talk to you about a couple things. And it is not --not anything that is complex. I want to talk to you about the disability and fatality with the best of care. Indeed, I did in opening statement tell you about this disease. This is a terrible disease. And I don't think any of you feel otherwise on that. This disease causes --once somebody contracts it, it will cause disability and in some cases it will cause fatality with the best of care. I don't think anybody will disagree with that.
There is nobody, according to what the evidence is in this case, that was presented to you folks, that comes out of this disease who lives without a disability. There's no evidence of that in this case.
Everybody comes out of this disease, at best, with a disability. With the best care. And some people actually die with the best of care, like Mr. Lykins. Die with the best of care.
So when there are figures being presented to you, millions of dollars, when there are figures being presented to you on these issues --for example, they are claiming millions of dollars for the two weeks that Mr. Lykins survived. Think about that. If you start thinking about it, well, with or without claims against my client, would Mr. Lykins have been suffering? Of course. Would he have been in pain? Of course. Would he have been incurring medical expenses? Of course. Would he have incurred any less medical expenses? Just go back, and when you talk about this stuff --if you get that far, when you talk about this stuff, ask yourself: What proof did the plaintiff give us? They have the proof. What proof did the plaintiff give us that one penny less would have been incurred in this case?
Now, the only evidence you heard from that was the surgeon, who said he believes that the medical bills would have been the same on the 2nd if the diagnosis would have been made on the 2nd. But that's what he said. He's the only one --and I asked him. He's the only one who gave you any testimony to that. So when you go back, and if you get this far and you talk about damages, and you talk about how much Mr. Lykins would have made into the future, the millions that they presented to you, talk about whether or not and what proof there is that Mr. Lykins could have continued to work in the same job that he was in. That's what I mean by that.
I put down myositis and multisystem organ failure just to remind me in this case that the death certificate does in fact show that Mr. Lykins died from multisystem organ failure. The surgeon said in his opinion he had multisystem organ failure starting on the 2nd. The surgeon said that people --some people remember the person he was talking about? I think it was a lady --a woman that he almost cut in half that didn't have it and survived because she didn't get multisystem organ failure.
Mr. Lykins did. And according to the surgeon and according to the death certificate, that's what he had. And some people get it and some people don't. The time the diagnosis is made doesn't seem, according to the surgeon, to have anything to do with that condition. That's what he said.
Myositis. We have ranges on myosisis from 80 percent fatality with the best of care – it goes up to 80% and as low as 20%.

But you are being asked in this case to take the quantum leap that in this particular case with this particular individual he would have survived this terrible, deadly disease and not only that, he would have survived it without disability. And you folks, when you are using your common sense, are going to reject that.
And the same with the wages. If you use the common sense that some things are not what they appear --and that is all --that is all part of what I'm talking about. Yeah, it makes sense. Yes, lost wages. Well, if you really examine it and what information was given to you in this courtroom, just analyze it, if you get that far.
Next thing I want to talk to you about. Facts. No quotes. Facts. If you remember, we started this case --we started this case with --I think Dr. Roth was one of the first witnesses. We started this case with the septic joint. And a septic joint, septic joint, septic joint. And septic joint that we should have been thinking about. Sepsis or a septic process or something like that.
Let's analyze what was going on there and what conclusions reasonably can be made. The records are clear, although in the last week or so we've been trying to hit a moving target. Now Mr Lykins didn't injure himself lifting. We made it up.
We didn't make that history up. That history is all over the records. Five or six times. The fact is that he had a history of injuring himself lifting.
Why is that important? When at presentation one of the experts --I think it was Dr. Henry --said in the emergency room, it's a snapshot at a particular moment in time. Everybody agrees --all the experts agreed that history was the most important part of the case. Right? I think everybody goes along with that. History is the most important part of the case.
All right. What history was given to Ed and Dr. Vaughn? What history? History, a most important part of the case. Not anymore, because we're backing away from that. But that's what the testimony is. Hasn't been the last few days. Oh, he didn't hurt himself lifting.
Anyway, he hurt himself lifting. Roth said it. It's in the --Roth's office record. And --it's twice. Severe left shoulder pain started suddenly after started sudden several hours after lifting.
Well, okay. So that's our history. What do we make with that? What use do we make of the lifting? His shoulder began to hurt several hours later. So that is the history that Dr. Roth got. And that's the history that we got at Shady Valley Hospital. And that was the history.
Why did I put this in? None of the classic signs of redness, swelling, high temperature, vitals out of whack. Why did I put that in there when we're trying to make a diagnosis? Let me cover that one and the next one and the other things there.
Well, if we're --when we're making a diagnosis, and now he comes to us, Mr. Lykins comes to us from urgent care -- just picture that in your mind. Coming to us at urgent care with that history. And Dr. Roth's diagnosis was pain, if you remember, and rule out septic joint. Septic arthritis. That's what it says: Rule out septic arthritis.
Now Mr. Lykins is corning to Ed and Dr. Vaughn. All right. When these physicians are trying to figure out what's wrong with Mr. Lykins, we know he's given two people a history of hurting his shoulder lifting. Now, Ed Heller he gives the history. And when incidentally, he put ice on his shoulder. Did you notice that in the --talks about left shoulder muscle, ice? Patient iced and took ibuprofen. Okay?
Left shoulder. But as the --oh, last few uays, we move from the left shoulder and started to --started to go down, didn't we? Started to go down.
Dr. Roth talked about palpation himself. I said to Roth --Roth, they say, is a great doctor. Maybe he is. All that I can tell you is that when I asked him about whether or not he had any pain in his chest, that I asked Dr. Roth, "Did you palpate his chest?" And the answer was "Yeah." I said, "How do you it?" He showed me. "Did he have any pain in his chest?" The answer was "No."
Let's move on. As we're trying to make our diagnosis you know, we're not superhuman. We're not superhuman. That's not how we're judged, and that's not the standard of care. But we accept the standard of care. So now we're trying to figure out. Okay, we got a healthy fellow. A healthy fellow coming to us. A fellow who has no risk factors. Why is that important? That's not bogus. Most of us or some of us as we grow older, we have risk factors. Whether we have hypertension or whether we have bad joints or whether we have injuries, prior injuries, as you would expect from septic arthritis, dislocations or football injuries or whatever it might be to cause septic arthritis. So he has no risk factors for infection, much less --much less the terrible disease of necrotizing fasciitis. He has no risk factors. Is that in their consideration? Of course it is. Does he have risk factors? Then you put that history of lifting, and then he's got the rule out of septic arthritis.
So no risk factors or predisposing factors as we used in this case.
Now, we're supposed to be thinking remember infection, infection, infection. One of the witnesses screamed that out at us. We're-that's what we're supposed to be thinking. But there is no infection, infection, infection in his shoulder, and never was. And finally we debunked that. There never was anything wrong with his shoulder.

Was there attention drawn to the shoulder? Absolutely. Was it from lifting? Absolutely. Did he rule out septic arthritis? Absolutely. But then we have a witness, who says --who says --he was the orthopedic surgeon who has never cared for a patient with necrotizing fasciitis, never treated a patient with necrotizing fasciitis, wouldn't know it if he'd see it, who says --who says --that he would have stuck a needle into the joint, a normal-looking joint, to aspirate after the X-ray showed no joint effusion, nothing.
You see, I can get worked up, too. You know, I sit there and I listen to this stuff --I'm sorry --but, you know, sitting there listening, I started off this case, it sounds like we're criminals.
MR. BRANNON: Object.
MR. FREUND: It sounds like we're criminals.
THE COURT: Overruled.
MR FRUEND: And it's not right. Common sense. OK. So now not only does he have a history of lifting and – and I say classic signs. Here I'm talking about necrotizing fasciitis. But it's infection too. Redness, swelling, high temperature, vitals. out of whack. That's infection, too. Doesn't have to be necrotizing fasciitis.
So he's got a normal-looking shoulder. And, up to this point, no problem with the chest. No pain in the chest after palpation. By both --if you remember, in questioning of Ed, we had this. Do you remember that? In questioning by Dr. Vaughn, we --we had this. And I said --when he's talking about palpating with the stethoscope, if you remember, I asked Dr. Vaughn, "Did you palpate his chest like Ed Heller?" He said yes. And then I asked him then, "Did you use the stethoscope?" And he said yes. And I said, "Did you use it in all places that Ed Heller said?" Yes. But now we're going that Dr. Vaughn only palpated the chest with a stethoscope.
And if you go back and think about that testimony, you will know that what I'm telling you is accurate.
Okay. Now, the testimony here by the plaintiff is that we were supposed to pick up a rare disease. A rare disease. And the testimony is and I think Dr. Miller is probably surely the most learned, has done the most investigation, the most study, the most writing. He basically told us -and I used his number. He basically told us that about 3,000 in a year, of which 50 percent of those have no portal of entry. I think that's what he said. So I put that down.
So does rare disease make a difference? Of course it does. Is it an excuse --is it an excuse on a disease that should be picked up? No. If I have a rare disease and I go in, I would hope that the disease would be picked up. But remember, they get one crack at it. They get one crack at it. A snapshot at a particular moment in time. And-and the disease is dependent upon that moment in time. So what you're going to be doing when you go back and discuss this case, you're going to be trying to decide in your own minds whether or not Ed and Dr. Vaughn should have picked this disease up.
And then I put down: No complaints, no findings, of chest abnormality or pain. So now we've got a history. We have nausea and vomiting and history of fever, history of lifting. Nausea and vomiting and history of fever. And with that, the plaintiff says --the plaintiff says --we're supposed to pick up this infection. Okay? That's how we're supposed to pick up an infection. Where there is 15,000 - 1500 of these in the United States with 300 million people per year. We're supposed to pick that infection up. So I thought what I would do, when you're making your diagnosis and trying to figure out the testimony in this case, I thought I would highlight some of the testimony given in this case.
When I was asked to represent Dr. Vaughn and Dr. Oster and Ed and Shady Valley Hospital, I decided --I decided that I wanted to find the best experts to review this case. So I got the literature and --to see who wrote more than anybody else. That was Dr. Miller. And then I thought --I thought, okay. Dr. Miller is an infectious disease specialist. And if I and he, I think you'd agree --you're going to have the CVs back there if you care to look at them --he's written more, studied it more, knows more than anybody.
Then I thought, okay, but --but Ed Heller and Dr. Vaughn are not infectious disease physicians. They're emergency physicians. Emergency medicine physicians. So I thought I'm taking you through my process. You may think I did wrong. But I'm just taking you through my processes because it makes a difference who comes into this courtroom, I think, and gives you opinions.
Then I thought, okay, I wonder if there's anybody out there who is an infectious disease person and an emergency medicine person. That was Dr. Talan. Dr. Talan is the fellow from UCLA. Did you notice he had sandals on? Couldn't believe it. From California. Figures. I was hoping he would stay in the box and not come out.
But anyway, he is one of two --one of two in the United States who is double boarded in emergency medicine and infectious disease. One of two. And I got him, and I had him review the case. And he said the case was defensible, as did Dr. Miller.
Then I thought, I need somebody local. I need somebody local. So I went to Ohio State and I had Dr. BUCHANAN review the case. Assistant dean, professor, in emergency medicine, the works. And he gave me a favorable review. And I thought --I'm going to do it some more. And I sent the case to Dr. Henry. Now, Dr. Henry is from Ann Arbor. I thought, I wonder what the folks will think about Michigan? And I decided that he had the qualifications. Now, his

qualifications were a little different, though, because he was boarded in emergency medicine. But Dr. Henry happened to be president of the whole United States American College, 22,000 of them. He was president of the American College of Emergency Medicine in '96, I think.
So with Henry, Dr. Miller, Talan, Dr. Buchanan, then I thought, we have got an issue here also with Dr. Oster. And I went to Ohio State. There's a sports medicine doctor to the basketball team and some others. And he reviewed the case and gave the same opinions. So he teaches at Ohio State. All teachers. All teachers. All professors at their universities. All familiar with the disease. From allover the country. And that's how I presented to you the standard-of-care issue and that is how you're going to judge Dr. Oster, Ed Heller, and Dr. Vaughn. That's how you're going to judge them on standard of care. Will these guys --they happen to be all guys --will they do --should they know what the standard of care is for an emergency physician? The answer is unequivocally yes.
On the other hand --on the other hand, if you think back, we had four witnesses coming from the find-an-expert group in Maryland. We had Dr. Belman, we had Dr. Kane, we had Dr. Schmultz, and we had Nurse Remsio? All of them came from the find-an-expert group in Maryland. And that wasn't by chance. All right? That was not by chance.
And the other two experts came from Dayton, Ohio. Dr. Smalley, a friend of Mr. Brannon.
Went on a trip to the Bahamas with him, went on a trip out west with him. Dr. Mavis, a political friend. Dr. Smalley is the one who gave us a whole slew of opinions but has never --orthopedic surgeon, much less --but never saw one, touched one, or treated one.
Dr. Mavis did, according to what he said. One who had an amputation, one who he lost track of, and another who he described as maybe functional. He's lost track of him too.
We've had Dr. Belman who came in and gave you a whole bunch of opinions. And Dr. Belman had one who died and one who survived with an amputation. And the other one --I forgot to ask him. I don't know.
Then we had Dr. Kane. Dr. Kane. Let's talk about Dr. Kane. Julie, if you remember, asked Dr. Kane some questions. I think I'll just hold these because it's easier.
MR. BRANNON: Could I see it, please?
MR. FREUND: Sure. I'll hold it up so everybody can see it.
MR. BRANNON: Go ahead.
MR. FREUND: Dr. Kane was asked -
remember, we got into this huge argument about whether vomiting could be caused by something other than sepsis. Dr. Kane – that's their expert – he said yes. Other than could be – this is Dr. Kane – could be a gastrointestinal virus causing vomiting, in the ER record. Or pain, which he had. Or certain medications like ibuprofen, which he had. Which we didn't know about.
Dr. Kane also said --this probably shouldn't be highlighted because it wouldn't make sense. I'm -more interested in the bottom. Can you folks see it back here so Mr. Brannon can see it? Okay.
In this case, we're aware that Mr. Lykins offered a history of either lifting a patient or lifting oxygen bottles at work, which he mayor may not have attributed to injury. But he did give that history. Answer: Right.
And would you agree that if this history was given to the physicians, that that might give them a reason to attribute the pain in the shoulder to it?
His answer was: Oh, yeah. I think that from trauma, like some kind of strain, had to be one of the considerations, yes. So you would agree with that --that that wasn't a deviation from the standard of care for those physicians to consider that he had a strain.
Correct.
Well, for example --I'm going to stop there just for a second to comment about that. That's what we're talking about in this case. That is what we're talking about in this case. Then we went on: And you told us that the pain in this case, or your understanding from the records, was that the pain actually started several hours after this physical activity.
Yes. That's true. And that is consistent with a muscle strain, isn't it?
Question: So when you do physical activity, you may not feel the effects for several hours.
Right. I mean even the next day.
Right.
Well, their expert didn't think there was anything wrong with our diagnosis. Let's go on:
Did this patient or Mr.. Lykins get worse between the time of his discharge from the hospital until he returned the next day?
Yes.
Actually, his condition changed very rapidly over several hours. Yes. Now why does that make a difference?

Let me just talk about that. There is no question here that Mr. and Mrs. Lykins are not considered to be at fault. Not suggesting that in any way, shape, or form.
But when they were discharged from the hospital at 1:00 o'clock in the early afternoon on the 2nd, they were given the specific instruction to return if the condition got worse. Well, it surely did get worse. And it got worse, according to Mrs. Lykins' own words, about midnight. Okay?
Now, what are we supposed to conclude from all of that? Going from 1:00 o'clock at the time of the discharge to about 10:00 o'clock the next day. All we can tell you is he was out of our care and out of our treatment. And at no time --at no time did a paramedic --don't forget, we spent a lot of time --Mr. Brannon spent a lot of time talking about that he was a paramedic. Think about that. Here's an individual who, from the testimony of the plaintiff, we're supposed to believe his eyes were rolling up when he was in our institution on the 2nd. He had available to him every ambulance in Fairborn if he would have chosen to. He had available to him relatives, brothers who were in the fire department. He had available --
MR. BRANNON: Object to this, your Honor. It's beyond the scope of the Court's instruction. It's not part of the evidence.
THE COURT: Overruled.
MR. FREUND: He had available to him the ability --if we are to --when you're considering whether his condition got worse, and we think it did --the opportunity to seek medical care elsewhere, anywhere. But if we're supposed to believe that his condition was so bad, he didn't want to go to the emergency room on the 2nd. We know that from the record of Dr. Oster, on the record, where he said he injured his shoulder. And when you're going back there and using your common sense and you're discussing what all of this is about, and whether or not Shady Valley Hospital and the doctors are responsible for the care in this case, for our two and a half hours, from 10:30 until 1:00 o'clock, the clock ticks all the way around for almost 24 hours before the patient returns to us. And 19 hours before the patient ever seeks any additional medical care. Okay?
When you're thinking about that, just think about, if the condition was as bad in the hospital as it was suggested to you, which we reject. We've got --we've got somebody here who has some medical training. I would suggest to you that his condition did worsen significantly at midnight on March 3rd. It did. That's when it significantly turned. And by 4:00 o'clock he had swelling, and by 6:30 he had discoloration and swelling and heat.
Is it your opinion in this case --this is Dr. Kane. Is it your opinion in this case that he did not have necrotizing fasciitis on the 2nd? Right.
Let me show that to you. Again, this is Kane. This is their expert. It's your opinion that he did not have necrotizing fasciitis on the 2nd.
Right. Yeah, I don't think – I don't know for sure. But I would say more likely than not he didn't.
So would you agree with me that surgery wasn't indicated on the 2nd?
Answer: If he didn't have necrotizing fasciitis, yes. That's their expert.
Dr. Jones. Their expert. Now if it's OK for Dr. Jones to not diagnose necrotizing fasciitis for 24 to 48 hours, I respectively ask you folks, why is it not standard of care to diagnose it for 19 hours? The only reason is that he didn't come back until 19 hours went by.
Let me ask --let me read this for you:
As a matter of fact, you can think of patients you saw who ended up having necrotizing fasciitis who took you 24 to 48 hours to diagnose?
Yes.
And you're not even sure in this case you would have made the diagnosis of Mr. Lykins within 24 hours.
You remember the claim here is the delay was 19 hours. And her answer was: I think diagnosis would have been made within 24 hours.
Well, it was.
I think a diagnosis would have been --I think the --I don't know I ever said I wouldn't have made a diagnosis. I said --I think I said that a diagnosis, had his symptoms been paid attention to, it might not have been a direct route to a diagnosis, it might have been circuitous, but I think a diagnosis would have been made within that first 24 hours.
Folks, we did that. And when you go back and you talk about it again among yourselves, we had no opportunity to make a diagnosis after 1:00 o'clock.
And the snapshot of time when you're judging my doctors and Ed Heller in that snapshot of time, did he have sufficient signs and symptoms to make the diagnosis when he was at the hospital?
Dr. Krispo, a treater. So when he asked me if the patient's illness had been diagnosed 19 hours earlier -this is Dr. Krispo's answer - would not have survived. I cannot answer that specifically for Mr. Lykins.

Dr. Krispo is telling you there -you can read it --Dr. Krispo is telling you there if the diagnosis would have been made on the 2nd, he does not know if this patient would have survived. Does a white blood count make a diagnosis of infection? No, it doesn't. You have to include this information with all the other information to make a diagnosis.
Krispo again. This is where Dr. Krispo told us about how he thinks the infection started.
And he says here: Certainly, if there is no bacteria in the muscles, you don't get an infection. But if you have an injured muscle and you happen to have bacteria that somehow gets into your bloodstream, which is not a very uncommon event, it can localize in the tissue.
The question is, are you going to believe Dr. Krispo and Dr. Miller about whether or not he had a strain? Because they both say that he had a strain which allowed --I'm almost done. It's okay. That's okay. It's okay.
I understand, so don't worry about it. I have that ability sometimes. But I do --I'll get through this.
I've only been about an hour. Right?
THE COURT: 45 minutes.
MR. FREUND: I'm going to get through it in just a little over an hour. Okay? About 15 more minutes. Okay?
The point I want to make here is very simple. That is, he did have a muscle strain, at least according to what Dr. Krispo says and what the real expert says, and that's Dr. Miller.
And let me move on. The other things this is Dr. Miller. The only reason I did this was just to show you that that ibuprofen can mask the symptoms and it can mask a fever, and it can also mask redness and swelling. And it also causes nausea and vomiting.
This is Dr. Miller again, where Dr. Miller in fact gives the opinion that he believes that Mr. Lykins strained his shoulder, that it was referred pain from the pectoral muscles and that the strep A seeded --that the strep A seeded in the area because of the muscle strain.
By the way, I know it's not easy. This is not easy for you. And I want to get through this as quickly as possible.
This is again Miller. And this is about the CBC. And Dr. Miller testified that the CBC on the 3rd --that the WBC on the 3rd was normal. He further testified that the CBC on the 2nd would have been normal. Now we have talked about this CBC business at length.
And here's where he says. Just take you to the conclusion: I think the number of neutrophils in the blood is normal. When you go through the white count, which was normal, and then you multiply the white count by the neutrophils --that's what he says here. That's why I blew it up for you.
This is bunk. This is Dr. Miller again talking about the left shift:
You cannot say the left shift means infection or is supposed to mean infection. You can't say this is Dr. Miller: You can't say somebody is in a left shift when you have no bands.
We've talked about that at length. I blew this up. I'm going to keep going.
Let me just give you the bottom line on Miller. Now, this is a fellow who knows more about this disease than anyone.
I asked him his opinion --after I go through his training, education, and experience, right here --whether or not the healthcare providers at Shady Valley Hospital could have made the diagnosis of necrotizing fasciitis or necrotizing myositis on March 2.
First, do you have an opinion?
Answer some objections.
I have an opinion. And I think --don't think they could have made a diagnosis. And I blew this up for you because it's the key to the case, where Dr. Miller --I think you probably remember where he said this:
I had a very good medical professor, rheumatologist, told me --and it's true --that there are diseases where at one point in time *you* cannot make the diagnosis and, therefore, you need to see the patient repetitively in order to establish that. That's common, very common.
I would suggest to you whether -whether you accept the idea that he suffered a strain and that's why the strep A seeded or whether you believe that the strep A seeded for some other reason, when *you* go back and talk among yourselves and discuss this among yourselves about signs and symptoms --what was there for these doctors and Ed Heller to diagnose? And you will decide that the signs and symptoms were not sufficient to even suspect infection, much less that deadly disease.
And then if *you* take The surgeon and plug in The surgeon's testimony, who actually did the work on Mr. Lykins, that he would not have done would not have done surgery on the 2nd. That he would not have cut on what looked to be perfectly viable tissue.
You would agree that the earliest time a diagnosis could be made was probably at about 6:30 in the morning when he actually had the discoloration, the swelling, the puffiness in his pectoral area.
That's how I ask you to go back to make your diagnosis.

Couple other things. We should have done a CT. We covered the CBC. We would have done a CBC --if anybody here believes that when a patient comes to us --in today's society, patient comes to us and says to us, "We want a CBC." If anybody believes that we won't do it, then you -then maybe we're in a different world. In today's society -- or a CAT scan, who really asks for it. Somebody who is alert and oriented, with Dr. Roth, who's alert and oriented with yourself, who is described many times, seen by three different nurses, who is discharged in improved condition --five medical care providers at Shady Valley Hospital --who is being suggested to you that we blew him off. Five. Not one. Five. Who it is suggested didn't care. Who it is suggested didn't care.

Probably in hindsight and retrospect, if I had something to do over again in this case, with my client, you know what it is? And that is I would tell Ed Heller, "Ed, don't use the word overreact." I would. Because that was an unfortunate use of the word. And I want to cover that very briefly. By the time --by the time --by the way, what that means is that Ed believed that the symptoms did not coincide with his medical findings.

And that's where Dr. Oster fits in. Dr. Oster --when you're making your diagnosis in this case --Dr. Oster had a great relationship with them. I think you can all agree with that. They even wanted to go see Dr. Oster the morning of the 3rd after they saw the swelling and discoloration, the whole works. Refused to go to the emergency room at 4:00 o'clock and wanted to see their family physician.

Now is this is this a family who believes --who believes that there is really something serious going on here? Just ask yourself when you talk about that. Is this a family who really thinks there's something serious going on?

Why did I bring up the strep? The conversation between Dr. Oster and Mrs. Lykins on March 7th. Why did I bring it up? I brought it up not to show that --somebody was somehow responsible within the household that he contracted this terrible disease. Not for that reason. But for the only reason, to show you that when you're thinking about this and using your common sense, when you're trying to decide whether Dr. Vaughn and Ed Heller did the right thing here and tried to make a diagnosis, that they weren't thinking infection. Nobody was thinking infection on the 2nd, because if anybody would have been thinking of infection on the 2nd, they would have discussed the fact that they had strep at home. Diagnosed strep. That's why brought it up. Think about it. If they were thinking infection, there would have been discussion at home with Dr. Roth, and with Ed Heller and Dr. Vaughn about that. Without a doubt. And I would suggest to you that the evidence in thts case from the medical records, from the logical testimony, is infection was not a consideration other than the noninfection in the left shoulder joint.

A cou0ple more things then I’m done.

You’re going to be given interrogatories. Lots of instructions.

The first interrogatory says: Have the plaintiffs met their burden --remember I told you they have the burden by proving by a greater weight of evidence that Todd Oster negligently departed from accepted standards of care in his care and treatment of David Lykins?

Now, what did Dr. Oster do? First of all, he saw, on the morning of the 3rd --let's go back to the morning of the 2nd. What Dr. Oster's involvement was, in a nutshell, is he saw --he got the call --his staff got call on the 2nd. He wanted to send him to the emergency room. He didn't want to go to the emergency room. Not because he was mad. Talk about that when you go back there. No, he wasn't mad at Shady Valley then, if we're supposed to believe that's true. He hadn't been there. He doesn't want to go to the emergency room.

Then he sends him to urgent care. That's his involvement. The next involvement is the call that Ed Heller made to Dr. Oster where Dr. Oster said, "Well, I've had a couple occasions when the symptoms cannot be clinically related to my medical findings." That's his involvement on the 2nd.

And then on the 3rd, in the morning, 8:30, sees --thinks he's really sick and sends him to Shady Valley Hospital. And that's why he got sued. That's the extent of his involvement. That's why he got sued.

So I respectfully ask you, when we're talking about whether Dr. Oster met standards of care, you can answer the question one of two ways.

Did he meet tstandard of care? Yes or no. Yes, you sign it and go to the next question. The next question is: Did Dr. Oster cause harm? The answer to that is no. Then you go to Dr. Vaughn and Ed Heller. When you're judging Dr. Vaughn and Ed Heller, I only ask you to judge them from the snapshot in time they had with the disease. If you believe --I don't know whether he had the disease on the 2nd. I don't know. I do think he had a strain. But I don't know whether he had the disease. I can tell you respectfully if he --if he did have the disease, he didn't have the signs and symptoms sufficient to diagnose it. And I don't think I would suggest to you --I just don't know. But I can ask you and would suggest to you that when you get to interrogatory number 4, dealing with Dr. Vaughn and Ed Heller, that they met standards of care. And I would suggest to you that the nurses met standards of care. I believe that we have demonstrated --although we don't have the burden of proof, I think we have demonstrated to you clearly, with the facts, as they existed for these doctors at the time that they met standards of care.

Now, I could go on and try to convince you with more facts. I could talk about sed rates. I could talk about CPKs. I could talk about all these things they've brought up.

But I ask you, when you go back there, to use your collective judgment and discuss with each other the things that I missed. When I sit down, I'm finished. And I don't get to see you again until you have a verdict. That's pretty hard. Going to be hard for you too. But that's hard. And I'd like to go on, but you folks have listened to me long enough. On behalf of Dr. Oster --hopefully this is some help. Because I know you've taken good notes. Hopefully this is good help.
When you go back there and you are deciding about whether --the doctors and Ed Heller -
and Shady Valley met standards of care, judge these folks --judge these folks as the facts existed and as the signs and symptoms existed at that time. And if you do, I am convinced that you'll make a decision that's favorable to them.
This is not --this is not send a message to the world. This is not a "send a message to the world" case. I expect that you'll treat Tina Lykins and her family fairly, and we simply ask the same.
So, ladies and gentlemen, it's been a long four weeks. I thank you kindly for your attention. I hope I haven't bored you too much. And I look forward to your verdict. Thank you very much.

157 Ohio App.3d 291 (2004)
2004-Ohio-2732

LYKINS, Admr. of the Estate of Lykins, Deceased, et al., Appellants,
v.
SHADY VALLEY HOSPITAL et al., Appellees.

No. 1974.

Court of Appeals of Ohio, Second District,

Decided May 28, 2004.

Dwight D. Brannon, Dayton, for appellants.

Neil F. Freund, Dayton, for appellees.

301*301 Bain, Presiding Judge.

{¶ 1} Plaintiffs-appellants, Tina M. Lykins and her minor children, appeal from a judgment rendered against them on their claims for medical malpractice, following a jury verdict adverse to them on their claims. For ease of reference, the plaintiffs-appellants will be referred to collectively as "Lykins" throughout this opinion. Lykins alleges that the trial court committed numerous errors during the trial of this case. She also claims that the defense acted improperly in numerous respects.

{¶ 2} From our review of the record, we conclude that any errors committed by the trial court were harmless. We further conclude that the record does not support the claim of improper conduct on the part of the defendants, defense counsel, or the defense witnesses.

{¶ 3} Accordingly, the judgment of the trial court is affirmed.

{¶ 4} On March 1, 2000, David Lykins began experiencing pain in his shoulder. The next morning, David's wife Tina called the office of their family doctor, regarding David's complaints. Upon being informed that he could not see David until 11:00, Tina and David asked for, and received, a referral to an urgent care center.

{¶ 5} That same day, David was examined by Dr. Roth at the urgent care center. He complained of shoulder pain, nausea, tiredness, headache, and stated that he felt "dry." He also related that he "had fever." David also told the urgent care staff that he worked for the fire department, that he had lifted patients, and that the pain began hours later. David vomited while at the urgent care center. David's temperature was normal when taken at the urgent care center. David had no redness, heat, or wound to the skin.

{¶ 6} Dr. Roth gave David an injection of Phenergan to alleviate the nausea, and sent him to the emergency room at Shady Valley Hospital ("MVH") for blood work. Dr. Roth gave Lykins a referral form that stated: "severe left shoulder pain, need septic arthritis ruled out." Dr. Roth also called the the emergency department and left a message regarding his findings and the reason for referring David to the hospital.

{¶ 7} At MVH, David was first seen by a triage nurse. She took the Lykinses to a triage room, where she saw the urgent care form, and she noted David's information and history and checked his vital signs. David's vital signs, including his temperature, were normal. David complained of pain, chills, and fever, and he appeared pale. She categorized David as non-urgent.

302*302 {¶ 8} Physician's Assistant Edward Heller saw David and obtained a history. David indicated that he had been lifting patients and thought that he may have hurt his shoulder. David also indicated that he was not taking any medications. Heller conducted an examination of David, including his shoulder, chest, and back. David's skin showed no signs of trauma, scratches, or infection. David had no chest pain. Heller ordered an x-ray of the shoulder and clavicle, which was normal. David's vital signs were stable. Heller was aware that Dr. Roth had requested that septic arthritis be ruled out. Heller found no signs or symptoms of infection.

{¶ 9} Dr. Timothy Vaughn also examined David and performed a physical examination, which included palpating the shoulder and chest and having David perform range-of-motion exercises. David indicated that he had hurt his left shoulder. Vaughn noticed no swelling, discoloration, redness, heat, or skin breaks in the chest area. David had no pain in his chest area. David's vital signs were normal except that his heart rate was slightly elevated — a finding common with pain. Vaughn associated the vomiting with the pain David was experiencing in his shoulder. Vaughn's dictated notes indicated that nothing in David's examination or history indicated a septic joint.

{¶ 10} David was given Demerol and Phenergan. Phenergan is used to control nausea and vomiting but also helps make Demerol work better and helps alleviate any nausea caused by the Demerol. David did vomit — a common side-effect of Demerol — while at the hospital.

{¶ 11} David was discharged, in stable condition with a diagnosis of left shoulder strain/sprain. His arm was placed in a sling, and he was given a prescription for pain medication. David was told to return if the condition worsened and to follow up with Dr. Oster.

{¶ 12} Heller telephoned Dr. Oster regarding the diagnosis and to inform Oster that David needed to be seen within a few days. Heller made a notation in the chart that Oster indicated that David "tends to sometimes overreact to his health care needs."

{¶ 13} Neither the urgent care form nor the telephone form noting Dr. Roth's call to the hospital was retained in the hospital record.

{¶ 14} During the course of the night, David's condition worsened. Tina telephoned Dr. Oster's office and spoke to Oster's partner, who told the Lykinses that they could return to the emergency room or they could see Dr. Oster in the morning. The Lykinses elected to wait to see Oster. Upon arrival at Oster's office at 8:00 a.m., it was noted that David appeared septic. Oster immediately told the Lykinses to return to the ED.

303*303 {¶ 15} When he returned, it was immediately noted that David had skin discoloration on his left chest. Vaughn started David on fluids and ran some tests. Other physicians were consulted, and David was admitted to the hospital with "acute soft tissue infection in the left side of the chest with septic shock and multiple organ failure with acute renal failure and acute hepatic failure." He was immediately placed on antibiotics.

{¶ 16} David had contracted Necrotizing Fasciitis and Necrotizing Myositis, which are popularly referred to as "flesh-eating bacteria." They are caused by bacteria known as Group A Streptococcus. The disease does not actually eat the flesh. Instead, it causes the blood supply to muscles to be cut off, resulting in the death of the muscle.[1] The disease may enter the system in two ways. First, and more commonly, a person has a "portal of entry" — for example, a cut, surgical incision or other wound to the skin — which permits the bacteria to enter the body. Second, and more rarely, is the type in which there is no portal of entry, and the person comes into contact with the bacteria, which then passes through the blood stream and settles in an area of trauma.

{¶ 17} Gary Anderson is a board-certified general surgeon. He was called into the MVH emergency room on March 3 to examine David. He was able to make a diagnosis just from observing David's chest. When he initially saw David, he observed a discolored, darkened spot about the size of "a fifty-cent piece" above David's left nipple. In the short amount of time between Anderson's initially seeing David and obtaining a CAT scan, the lesion had grown to the size of a softball, so that Anderson was "impressed" with how "rapidly progressing" the infection was.

{¶ 18} Anderson immediately took David into surgery to remove the affected tissue. Some skin, fascia, and muscle were removed from the chest wall. Following that surgery, according to Anderson, "there was nothing at that point that would say [David] would not survive." Anderson was "a little encouraged" at that point because the infection was not more extensive.

{¶ 19} David underwent a second, "re-look" operation approximately 12 hours later. This followup procedure is common with this type of infection. The infection had not extended beyond the margins of the first operation, no more necrotic tissue was discovered, and it appeared that the surgery had controlled the infection.

{¶ 20} David was placed on medications to keep his blood pressure from dropping too low. However, these medications caused a lack of blood flow to other portions of David's system. Therefore, David had two more operations to 304*304 remove areas of his body that were suffering from necrosis due to a lack of blood flow caused by the medications. This included removal of David's gall bladder and a portion of his right colon.

{¶ 21} Subsequently, David underwent another procedure to determine whether his small intestine was functioning. At that point, it was discovered that his entire small intestine had shut down. David subsequently died as a result of the multi-system organ failure that was caused by the initial infection.

{¶ 22} Dr. Anderson indicated that some patients develop multi-system organ failure during the course of this disease and that it cannot currently be determined who will develop multi-system organ failure. He further indicated that whether a patient develops organ failure is not related to the timing of the diagnosis.

In other words, some people may develop multiple organ failure at the onset of the infection while some may not develop it until a week later. Anderson also stated that some people never develop organ failure and that he had treated a patient with much more extensive infection who did not develop organ failure and who survived the infection.

{¶ 23} Tina Lykins initiated suit against MVH, Vaughn, Heller, and Oster. Extensive discovery was conducted, and the case was tried before a jury during a four-week trial. Following trial, the jury rendered a verdict in favor of all the defendants, and judgment was rendered accordingly. From this judgment, Lykins appeals.

II

{¶ 24} Lykins' first assignment of error states as follows:

{¶ 25} "The defense committed reversible error in closing argument."

{¶ 26} In this assignment of error, Lykins focuses on the alleged misconduct of defense counsel during closing argument. Specifically, she contends that defense counsel acted improperly because he (1) suggested that Tina and David Lykins were negligent; (2) violated "the Golden Rule"; and (3) "breached the permissible bounds of law" because he "appealed to bias and prejudice * * * by repeating a call to fate and abandonment of the civil justice process." Also, Lykins argues that the trial judge erred by classifying objections made during closing arguments as a "pet peeve."

{¶ 27} It is well settled that trial counsel is afforded wide latitude during the presentation of closing arguments. *Pang v. Minch* (1990), 53 Ohio St.3d 186, 559 N.E.2d 1313, paragraph two of the syllabus. Whether counsel has exceeded the proper bounds of closing argument is a discretionary determination to be made by the trial court. Id. at paragraph three of the syllabus. Absent an abuse of discretion, the trial court's decision will not be reversed on appeal. Id.

305*305 {¶ 28} We begin with the claim that even though the trial court granted a directed verdict in favor of Lykins on the issue of comparative negligence, defense counsel continually attempted to show that the Lykinses were negligent for failing to return to the emergency room in a more timely manner. Lykins refers to numerous passages from the transcript of the defense's closing. The essence of the argument in these cited passages relied upon the fact that, after his initial discharge from MVH, David Lykins did not return to the hospital for approximately 19 hours.

{¶ 29} From our review of the entire closing argument, we conclude that counsel's argument was not intended to, and did not, imply that David or Tina Lykins were at fault for failing to return to the hospital until the next day. Indeed, defense counsel specifically informed the jury that "Mr. and Mrs. Lykins are not considered to be at fault[,]" and that he was "[n]ot suggesting that in any way, shape or form."

{¶ 30} Instead, it appears to us that the argument was meant to emphasize the testimony of defense experts. Specifically, the defense experts indicated that the doctors were not unreasonable in their failure to diagnose Necrotizing Fasciitis/Myositis during Lykins's initial emergency room visit because he did not present with classic symptoms. The defense experts testified that the diagnosis reached at the time of the first visit was reasonable, given the clinical findings present at that time. Their testimony suggested that by the time Lykins did return, the doctors were able to make the diagnosis, due to the worsening of his condition and the additional symptoms presented. Defense counsel's argument appears to have been calculated to impress upon the jury that there was ample time for the disease to progress to a level sufficient for diagnosis during the time between the initial discharge and Lykins's return to the hospital and that it could have progressed so far as to be fatal. Based upon our review of the record, we find no merit to Lykins's claim that this argument was improper or unfairly prejudicial.

{¶ 31} We next address the allegation that defense counsel violated the "Golden Rule." Lykins contends that defense counsel committed prejudicial error when he asked the jurors to "put yourselves in the shoes of the caregivers." This type of argument, commonly referred to as the "golden-rule" argument, exists where counsel appeals to the jury to abandon their position of impartiality by imagining themselves in the position of one of the parties. *Boop v. Baltimore & Ohio RR.* (1963), 118 Ohio App. 171, 174, 25 O.O.2d 37, 193 N.E.2d 714. While the golden rule argument is no longer deemed prejudicial per se, this type of argument would be better avoided. *Dillon v. Bundy* (1991), 72 Ohio App.3d 767, 775, 596 N.E.2d 500.

306*306 {¶ 32} In reviewing the opening statement by counsel, we are not persuaded that the cited passage resulted in any prejudice to Lykins. Counsel for Lykins made an objection to the statement, which was overruled. Defense counsel then continued on and stated: "And what I mean by put yourselves in the shoes of the caregivers is simply, when you're judging my clients * * *, judge them from the information they knew or should have known — from the information they knew or should have known — as the caregivers at that time. * * * At the time the care was given."

{¶ 33} Counsel stressed that he was not urging the jurors to judge the case based upon sympathy or compassion, but merely to base their judgment upon whether the doctors responded appropriately given the information available at the time they first examined David Lykins. At the oral argument of this appeal, counsel for MVH, who was also trial counsel, acknowledged that he wished that he had used different words to have expressed the point he was making, so as to avoid any implication of a golden-rule argument. We agree that the point could have been made differently, in a way that would not have implicated the golden rule at all. Nevertheless, we understand the essential point defense counsel was making to have been aimed at persuading the jury to consider those matters that were known to the doctors at the time of the initial treatment and diagnosis, rather than a request to empathize with the doctors. The record does not demonstrate that the comments were so heinous or reprehensible that the jurors would be likely to abandon their position of impartiality or that Lykins would have been prejudiced by the statements. Therefore, we cannot say that the trial court abused its discretion by overruling Lykins's objection to this argument.

{¶ 34} Next, Lykins claims that defense counsel exceeded the bounds of permissible argument by making comments such as "bad things happen to good people" and "everyone dies," and by referring to "hindsight" and to death as "unavoidable." She contends that by making these comments, the defense was asking the jury to hold fate, rather than his clients, accountable. Along with this argument, Lykins complains that defense counsel "brutally and unfairly attacked" her experts. We find no merit to this contention.

{¶ 35} We have read the entire transcript and cannot say that these few references are prejudicial. Defense counsel was merely attempting to acknowledge that David Lykins was a good person, while denying that his clients were responsible for David's death. This is defense counsel's duty as an attorney — to defend his clients. Additionally, as noted in Part VII, below, we find that defense counsel's argument regarding Lykins's experts was merely an appropriate attempt to show bias and was therefore within the bounds of permissible argument.

307*307 {¶ 36} Finally, Lykins raises an argument with regard to the following statement made by the trial judge:

{¶ 37} "And the Court will entertain objections during close, but it's one of my pet peeves, and — a lot of objections during close. I'm going to tell you that. Make whatever record you need."

{¶ 38} Lykins contends that this "comment clearly put a chilling effect upon the absolute duty of [her] counsel to timely object."[2]

{¶ 39} The comment by the trial judge was made at a sidebar, and, therefore, was not heard by the jury. It is clear from the record that counsel for Lykins continued to make objections during the defense's closing

argument. Moreover, Lykins fails to refer to any specific instance during closing argument where counsel wanted to object but was intimidated from doing so by the trial judge's "pet peeves" remark. Indeed, we note no obvious error on trial counsel's part with regard to raising objections during the defense's argument. Therefore, while we might conclude that the trial court would have been better advised not to have made the "pet peeve" remark, we do not find any prejudicial error arising therefrom.

{¶ 40} We have remarked previously, "It is the tradition in this legal community to avoid interrupting opposing counsel's closing argument if at all possible * * *." *State v. Luoma* (Dec. 7, 1990), Montgomery App. No. 10719, 1990 WL 197944. Thus, Lykins's attorney was already under some influence, by that tradition, to minimize objections during closing argument. We doubt that the trial judge's "pet peeve" remark added any significant pressure to keep objections to a minimum, or, for that matter, constituted much more than a judicial recognition of the tradition we alluded to in *State v. Luoma.*

{¶ 41} Lykins's first assignment of error is overruled.

III

{¶ 42} The second assignment of error provides as follows:

{¶ 43} "The trial court committed prejudicial error when it prohibited the plaintiffs from introducing expert and fact witnesses at trial."

{¶ 44} Lykins contends that the trial court improperly excluded her from presenting certain witnesses at trial.

308*308 {¶ 45} First, Lykins contends that the trial court abused its discretion by excluding the testimony of Matthew E. Levinson, M.D., who was named by the defense as an expert witness. According to Lykins, when Levinson's deposition was conducted, he provided testimony favorable to her case. Specifically, she claims that while answering a question posed by her counsel, Levinson stated: "well, then this would have to be an outright lie." Lykins argues that by this statement, Levinson intended to indicate that the defendants and defense counsel were being untruthful. Therefore, she contends that "she had a legal right and duty to present this damaging evidence of `the lie'" to the jury.

{¶ 46} Lykins claims that during trial she "made it known that [she] would utilize the testimony of Dr. Levinson in [her] case in chief." However, she claims that the defense objected and stated that Levinson would be produced live at trial. She further argues that she "proffered the videotaped deposition as part of [her] case in chief" but that the trial court did not permit its introduction, based upon its finding that Levinson was not unavailable to testify. When the defense did not present Levinson in its case, Lykins again attempted to introduce the deposition as rebuttal. The trial court again ruled that the deposition could not be used.

{¶ 47} Lykins fails to cite, and we cannot find, any portion of the record supporting her claim that defense counsel stated that Levinson would be produced live at trial. Likewise, there is no citation to the record, and we did not find evidence that Lykins attempted to introduce the deposition of Levinson during her case in chief. Instead, it appears that she attempted to introduce it merely as an exhibit following her announcement that she had rested her case in chief. Additionally, we note that defense counsel did not make any reference to Levinson's testimony during opening statement or any other portion of the defense case. While the issue of whether the deposition could be used during the rebuttal portion of Lykins's case was raised, the record is devoid of any ruling on the matter.[3]

{¶ 48} It appears that the trial court simply did not issue any ruling on the matter and that Lykins did not make any attempt to introduce the deposition during her rebuttal.

{¶ 49} Furthermore, upon reading the portions of the deposition surrounding the cited answer, we do not come to the same conclusion as Lykins regarding this testimony. The following exchange took place during testimony regarding 309*309 whether David Lykins had a fever, and whether this was indicated on the patient history taken by Heller and Vaughn during the March 2 visit:

{¶ 50} "Levinson: The physician is the one responsible. So no matter what other people say, if they document that this is not part of the patient's illness, I have to assume that's correct.

{¶ 51} "Q: Okay. Why would you assume that he's correct, and everyone else, who reported or written [sic] their paperwork that you have read or testified, is wrong?

{¶ 52} "A: Well, then this would have to be an outright lie."

{¶ 53} After reading the above passage, as well as several pages surrounding it, we conclude that Levinson did not accuse any of the defendants of lying. Instead, his testimony indicated his reasons for his belief that the findings of Vaughn and Heller were correct.

{¶ 54} Based upon the record before us, we cannot say that the trial court abused its discretion by excluding the deposition of Levinson. Furthermore, even if the trial court had abused its discretion, we would find that any error was not prejudicial.

{¶ 55} Lykins next contends that the trial court erred by excluding the testimony of her expert witness, Arthur Shorr. Upon proffer, Shorr testified that he is a "graduate-prepared hospital administrator." He testified that MVH was derelict in its duty to comply with the standards set forth by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) with regard to the retention of medical records. Specifically, in this case, Shorr's testimony centered on the hospital's failure to retain the urgent-care form and the hospital telephone-record form. He testified that it is necessary to get all of these records with information regarding a patient to the treating doctors and that the failure to keep these type of records would result in the issuance of a violation from JCAHO.

{¶ 56} The admission of expert testimony is a matter vested within the sound discretion of the trial court. *Scott v. Yates* (1994), 71 Ohio St.3d 219, 221, 643 N.E.2d 105.

{¶ 57} Lykins contends that Shorr's testimony, which was relevant to the issue of MVH's failure to abide by JCAHO policies, shows that the failure of the defendants to establish, maintain, and enforce those policies was the proximate cause of David Lykins's death. However, upon review of the proffered testimony, we note that Shorr stated that he would not give testimony regarding medical standards or the deviation from medical standards of care. Indeed, when 310*310 specifically asked whether the deviation from JCAHO standards had an adverse affect upon David Lykins, Shorr declined to provide an opinion.

{¶ 58} While Shorr's testimony does establish that MVH failed to maintain records, it does not establish that its failure was related to the inability to diagnose Necrotizing Fasciitis/Myositis on March 2, or to David Lykins's course of treatment. Therefore, the testimony had no relevance to the issue of duty and breach. Accordingly, we cannot say that the trial court abused its discretion by excluding this testimony.

{¶ 59} We now turn to Lykins's claim that the trial court erred by excluding the testimony of Donna Batdorff. On proffer, Batdorff testified that she is the co-founder and director of the National Necrotizing Fasciitis Foundation, which operates an Internet website that provides information about the disease, as well as access to a support group. Batdorff testified that she is a survivor of the disease. She testified about how she contracted the disease and her course of treatment. She testified that she had a portal of entry — a cut on her finger — and that when she presented to an emergency room, she exhibited a red, swollen arm, flu symptoms, vomiting, diarrhea, and extreme pain. She further testified that many people survive the disease.

{¶ 60} Lykins contends that Batdorff's testimony "about the statistics and number of survivors in the nation was essential to the case to rebut the defendants' unfair and untrue arguments that [the disease] is so rare (as to be unavoidably fatal), everyone dies, everyone has the same symptoms, there is always redness, there are always portals of entry, no effective treatment, patient attribution, norm bias, etc." She further contends that the testimony was relevant to rebut the claim that "everyone who doesn't die is permanent [sic] and substantially disabled."

{¶ 61} First, we find that Lykins's characterization of the defense arguments is misleading. From our review of the record, we conclude that the defense did not make the claims cited above. Indeed, the defense presented competent expert testimony regarding the treatment of the disease and the fact that people can survive.

{¶ 62} Second, we fail to see how Batdorff's testimony is relevant. David Lykins had no portal of entry; Batdorff did. Batdorff contracted the disease in a limb, while David had it in his chest. Batdorff presented to the emergency with redness and swelling, which was not initially present in David. Batdorff survived; David did not.

{¶ 63} We further note that Batdorff was unable to provide any statistics regarding survival rates. Additionally, she testified that as a result of the disease process her finger was amputated and her arm was badly scarred. Therefore, 311*311 her testimony was incompetent to rebut the defense claim that many people who survive have a disability.

{¶ 64} We agree with the trial court that the testimony proffered from Batdorff was not relevant to this case. Therefore, we conclude that the trial court did not abuse its discretion by excluding her testimony.

{¶ 65} Lykins also contends that the trial court erred by preventing her from presenting evidence regarding three other cases of Necrotizing Fasciitis at MVH. This argument is not clear. However, it appears that she contends that evidence that there have been three other cases of this disease that have been presented to MVH is relevant to the issue of the defendants' credibility, because it undermines their argument that the disease is so "rare as to be virtually unknown."

{¶ 66} Again, Lykins's claim that the defense incorrectly argued that the disease is so rare as to be "virtually unknown" is disingenuous. From our review of expert testimony contained in the record, it is evident that the disease is rare — with only approximately 3,000 cases occurring per year in the United States — and that it is a disease that many, if not most, doctors never see or treat. Therefore, we fail to see how this evidence would undermine the credibility of the defendants.

{¶ 67} "Prior occurrences are sometimes relevant `to show that a party knew or had notice of a dangerous condition.' `[I]n order for such occurrences to have been admissible to show prior knowledge on the part of [the defendant], these incidents must have occurred under circumstances substantially similar to those in [the plaintiff's case].' The trial court has the discretion to determine whether the prior occurrences were substantially similar to the accident in question. Furthermore, the proponent of prior occurrence evidence has the burden of showing the substantial similarity of the circumstances." *Lumpkin v. Wayne Hosp.,* Darke App. No. 1615, 2004-Ohio-264, 2004 WL 102860, ¶ 13.

{¶ 68} We note that Lykins has failed to set forth any details regarding the three other cases of the disease. Indeed, it appears from her argument that at least one of the three was not the same disease that David contracted, and we cannot tell whether the other two patients had portals of entry. It further appears that none of the same doctors or nursing staff who attended David attended the other patients. We find no basis for the introduction of this evidence and agree with the trial court that this evidence would be more prejudicial than probative of any issue in this case.

{¶ 69} Finally, Lykins contends that the trial court improperly excluded the testimony of the CEO and other employees of MVH. She contends that their 312*312 testimony was necessary to "establish the

substandard care given to David Lykins, as well as the failure to maintain" standards and records, "all of which are relevant to the issue of medical negligence."

{¶ 70} Other than to state that many of the employees have been deposed, Lykins fails to set forth the names of these proposed witnesses. Therefore, we will address this issue with regard to the CEO and the deposed employees.

{¶ 71} The record reveals that Lykins deposed more then 25 MVH employees during the course of discovery. A review of those depositions shows that these employees did not have any contact with David or Tina Lykins and did not have knowledge about the case. Furthermore, there is no support for the claim that these employees or the CEO presented any testimony regarding the standard of conduct or deviation therefrom. Additionally, we have not found any evidence in the record to indicate that the failure of the defendants to maintain the records, specifically the urgent-care referral form or the telephone-message form, impacted David's care or outcome. Therefore, we find no abuse of discretion in the trial court's decision to exclude this evidence.

{¶ 72} The second assignment of error is overruled.

IV

{¶ 73} Lykins' third assignment of error states as follows:

{¶ 74} "The rulings of the trial court during the pre-trial motions and at trial which prohibited the use of JCAHO standards, Miami Valley Hospital rules, regulations, protocols and other matters in establishing the standards of care of defendants, substantively or for credibility upon cross-examination, especially as to MVH, was prejudicially erroneous."

{¶ 75} Lykins contends that the trial court abused its discretion by failing to admit the following evidence: (1) JCAHO guidelines; (2) MVH policies and procedures; and (3) records kept by the Montgomery County Health Department, the Ohio Department of Health, and the Centers for Disease Control, regarding Streptococcus A.

{¶ 76} A trial court has broad discretion in determining whether to admit or exclude evidence. *Lumpkin,* supra. Absent an abuse of that discretion, rulings on the admissibility of evidence will not be reversed. Id. The term "abuse of discretion" implies that the decision of the trial court is arbitrary, unreasonable, or unconscionable. Id.

{¶ 77} We begin with the issue of whether the trial court erred by denying Lykins's request to introduce the JCAHO guidelines and the MVH policies and procedures. Lykins argues that these documents are relevant to the 313*313 issue of standard of care because the failure to properly maintain records and to follow standard procedures resulted in the failure to diagnose David's disease. She contends that had the defendants kept the urgent care and telephone forms, and complied with the instructions of the urgent-care physician, they would have performed the appropriate test and found the infection.

{¶ 78} The physician at urgent care sent David to MVH with a referral form stating that David had severe left shoulder pain and requesting the MVH doctors to rule out septic arthritis. The followup telephone call from the urgent-care physician to the emergency room of MVH, recorded on the telephone form, merely repeated the request to rule out septic arthritis. These forms were subsequently lost or destroyed.

{¶ 79} Again, while there is evidence and testimony to indicate that the hospital failed to properly maintain the urgent-care form and the telephone form, there is no evidence relating that failure to the fact that David was not diagnosed with Necrotizing Fasciitis/Myositis during his first visit to the emergency room. Indeed, from the record, there can be no doubt that the defendant doctors did act in accord with the

wishes of the urgent-care physician. Specifically, they examined David and determined that he did not have septic arthritis in his shoulder. More important, it is clear from the record that David did not have septic arthritis. There is no connection between the loss of these forms and the care rendered; therefore, the trial court did not abuse its discretion by refusing to admit the requested exhibits.

{¶ 80} Lykins also contends that the trial court abused its discretion by denying her request to introduce records regarding an "outbreak" of Necrotizing Fasciitis, which she claims occurred in southwest Ohio around the time of David's case. Lykins claims that the evidence of this outbreak is contained in records from the Centers for Disease Control, as well as records from the Ohio and Montgomery County Departments of Health. While Lykins fails to set forth any argument in her appellate brief to support this claim, our review of the transcript reveals that her argument is based upon the contention that the MVH physicians should have been aware of the possibility that David had Necrotizing Fasciitis/Myositis, because they should have been aware of the records from the various health organizations.

{¶ 81} There are five exhibits relevant to this argument — exhibit numbers 47 through 50.[4] A portion of exhibit 47 was excluded because it involved information regarding a different type of disease process. Exhibits 48 and 50 were both admitted by the trial court. The only exhibit rejected, number 49, was a report 314*314 from the Centers of Disease Control. This report was made in regard to Group A Streptococcus, which causes Necrotizing Fasciitis/Myositis; however, the report covered a mix of diseases caused by this bacteria. Furthermore, the report involved only Butler, Clermont, and Hamilton Counties in southwestern Ohio and did not purport to include any other counties. We find no error in the trial court's decision regarding these exhibits.

{¶ 82} The third assignment of error is overruled.

V

{¶ 83} Lykins's fourth assignment of error is as follows:

{¶ 84} "It was prejudicial error for the court to allow defense counsel to play portions of the videotape on David Lykins' life to the jury prior to their voir dire."

{¶ 85} In this assignment of error, Lykins complains of prejudice resulting from the defense's use, during voir dire, of a videotape she had prepared that "attempted, in some small way, to ethically, professionally, and tastefully show, without undue sympathy, David Lykins as a husband, father, brother, son, fire captain, police chief, and generally an industrious family man." According to the trial court, which reviewed the tape prior to trial, the tape was one-hour long. It also contained an additional three minutes of photographs, put into videotape format, with a sound track of a song called "In the Arms of the Angels." During voir dire, counsel for the defense indicated his intent to play a portion of the tape for the jury before continuing his examination of the jurors. Lykins raised an objection to the playing of the tape based upon her claim that the defense should play the entire tape rather than just portions of it. The objection was overruled by the trial court, and the defense played approximately 15 minutes of the tape for the jury.

{¶ 86} Lykins contends that permitting the defense to play only a portion of the tape was prejudicial. First, she complains that the defense fast-forwarded the videotape "in a cartoon-like Gumby fashion," thereby distorting the evidence. Second, she claims that the defense was able to "mark for removal" the jurors who did disclose a tendency toward sympathy, and thus caused the loss of "valuable objective, fair, prospective jurors." Finally, she claims that the use of the film did not merely erase all juror sympathy, but also made the case "somewhat surreal" and "dehumanized" the decedent.

{¶ 87} The conduct of voir dire is left to the broad discretion of the trial court, and decisions related thereto will not be reversed absent an abuse of discretion by the trial court. *Gwen v. Regional Transit Auth.,* Cuyahoga App. No. 82920, 2004-Ohio-628, 2004 WL 253484, ¶ 38. In this case, we have reviewed

315*315 the entire voir dire and note that the most we can determine from this record is that defense counsel did not play the entire tape to the jury. There is no way for us to assess whether it was played in fast-forward or slow-motion mode. Indeed, there is no indication that Lykins raised any objections with regard to the speed at which the tape was played. Furthermore, the mere fact that defense counsel was able to "take the sting out" of the presentation of the tape or to identify potential jurors who might display undue sympathy toward Lykins does not equate to a finding that the trial court abused its discretion with regard to this matter. In fact, weeding out jurors who might be unduly sympathetic to one side is a permitted purpose for voir dire. Upon the record before us, we find no abuse of discretion in the trial court's decision to permit the tape to be played by defense counsel during voir dire.

{¶ 88} Accordingly, the fourth assignment of error is overruled.

VI

{¶ 89} The fifth assignment of error states as follows:

{¶ 90} "The court erred when it failed to enter judgment of default against the defendants jointly and severally, due to their reprehensible answer, not filed in good faith, or at least award some appropriate and meaningful sanctions."

{¶ 91} Lykins contends that the trial court should have entered a default judgment against the doctors and the hospital because the answer filed on their behalf was not filed in good faith and because it consisted of only a general denial. Thus, in her argument, Lykins contends that she is entitled to summary judgment and requests that this court enter judgment in her favor and remand the issue to the trial court for a hearing on damages.

{¶ 92} Civ.R. 55(A) provides that default judgment may be awarded when a defendant fails to make an appearance by filing an answer or otherwise defending an action. *Davis v. Immediate Med. Serv., Inc.* (1997), 80 Ohio St.3d 10, 14, 684 N.E.2d 292, citing Civ.R. 55(A). However, it is "a basic tenet of Ohio jurisprudence that cases should be decided on their merits." *Perotti v. Ferguson* (1983), 7 Ohio St.3d 1, 3, 7 OBR 256, 454 N.E.2d 951. Furthermore, Civ.R. 8(F) requires a court to liberally construe all pleadings "as to do substantial justice."

{¶ 93} In this case, an answer was filed. However, the trial court made the following finding with regard to the answer: "Defendant's Answer, while reprehensible and precariously close to failing to plead as provided by the Civil Rules, does not warrant default judgment. Defendants' general denial of paragraphs one through fourteen in the Complaint is evidence of little diligence on Defendants' part and this Court advises Defendants to exercise professional discretion when submitting such documents."

316*316 {¶ 94} The trial court denied the motion for default judgment on the basis that voluminous discovery had been conducted and that default judgment is best reserved for disposing of uncontested cases.

{¶ 95} We find no abuse of discretion in the trial court's decision to deny default judgment.

{¶ 96} The fifth assignment of error is overruled.

VII

{¶ 97} The sixth assignment of error states:

{¶ 98} "The trial of the case was prejudicially flawed and against the manifest weight of the evidence because of the misconduct of the defense and their counsel."

{¶ 99} In this assignment of error, Lykins claims that the case was prejudicially flawed because of numerous instances of misconduct on the part of the defendants and their counsel.

{¶ 100} We deal first with Lykins's claim that Heller and Vaughn testified dishonestly during trial. As background for this claim, we note that Lykins deposed both Heller and Vaughn. During their depositions, Lykins provided copies of the notes made by the triage nurse and asked Heller and Vaughn to read the notes. Neither was able to do so. When questioned at trial, Heller and Vaughn testified that they could read the notes. Lykins states that the testimony by Heller and Vaughn was an "obvious fabrication." We disagree.

{¶ 101} A reading of the depositions reveals that Heller and Vaughn did indicate that they could not read the copy of the nursing notes provided by Lykins. No other copies of the notes were on hand. A review of the trial transcript reveals that when requestioned regarding the notes, both doctors indicated that they had subsequently reviewed different copies of the notes, that the different copies were more legible, and that they both could read the notations. From our review of the record, the claims of Heller and Vaughn that they were able to read the triage nurse's notes at trial, despite having been unable to read the copies shown them at their depositions, appear plausible. While the plaintiffs may have enjoyed an opportunity to argue to the jury that Heller and Vaughn were less credible witnesses because of this circumstance, we do not find it to be a basis for reversal.

{¶ 102} Lykins next complains that "the nature and appearance and testimony of Dr. Quazi Roth at trial was a complete surprise" to her and that counsel for the defense "feigned no knowledge of the same." During trial, 317*317 Lykins called Dr. Quazi Roth as a witness. Roth appeared with his counsel and requested a conference with the trial judge. During the conference, Roth's counsel informed the court that Roth would not render any expert testimony. While Roth did testify at trial, the trial court refused to require Roth to provide expert testimony.

{¶ 103} It is not clear from her argument whether Lykins contends that defense counsel was responsible for Roth's failure to testify as an expert, or whether she contends that the trial court erred by not requiring him to testify at trial as an expert.

{¶ 104} We have not found, and Lykins has failed to cite, any authority to indicate that a trial court can force a witness to provide expert opinions. Roth indicated that he was not qualified to testify as an expert in this matter. Thus, we see no basis for compelling such testimony. Also, we have found no evidence that defense counsel was involved with Roth's decision not to provide expert opinions. Roth was represented by separate counsel who clearly acted as his advisor with regard to this matter. There is no indication that defense counsel had any involvement with Roth other than to depose him, at which time he provided no expert opinions. The record indicates that Lykins was made aware by counsel for Roth, as much as a year prior to trial, that Roth did not intend to provide expert testimony during trial. We cannot say that the trial court erred by failing to compel Roth to testify as an expert, and we cannot say that defense counsel acted improperly with regard to this witness.

{¶ 105} Lykins's next claim centers on two of David's treating physicians, Dr. Jose Crespo and Dr. Gary Anderson. She seems to be implying that because these physicians refused to speak privately with her attorney, they were somehow influenced by defense counsel. She also implies that these doctors did not testify truthfully. Finally, she claims that defense counsel improperly obtained a copy of confidential correspondence from her counsel to Drs. Crespo and Anderson.

{¶ 106} First, we find nothing in this record to support the claim that the doctors were improperly influenced by defense counsel or that they provided dishonest testimony. Second, there is nothing to support the claim that the correspondence to which Lykins refers was confidential, or that it was

improperly obtained by counsel. The letter contains what appears to be a veiled threat by Lykins's counsel that these doctors would be included in the suit if they did not talk to plaintiffs' counsel. This fact alone explains their unwillingness to discuss the case without their counsel present — something to which they are entitled. We find no merit to any of the issues raised with regard to these physicians.

318*318 {¶ 107} We next turn to the claim that the trial court inappropriately "shut down" discovery and note that once again, counsel has failed to make appropriate citations to the record. From our review of the record, we find that the trial court did enter an order limiting the number of requests for admissions and interrogatories that Lykins could serve upon the defense. Initially, Lykins made 293 requests for admissions and the same number of interrogatories. The trial court found this to be unduly burdensome. We agree. Furthermore, we note that Lykins conducted approximately 60 depositions and that discovery lasted approximately two years. We cannot reach the conclusion that discovery was shut down.

{¶ 108} Lykins also argues that the trial court permitted defense counsel to conduct improper cross-examination of her experts. Specifically, she objects to the fact that defense counsel elicited information from two of her expert witnesses concerning their "personal relationship with plaintiffs' counsel." Lykins further complains that defense counsel attempted to demonstrate that the remainder of her experts were "hired guns."

{¶ 109} From our review, it appears that defense counsel acted properly with regard to the cross-examination of Lykins's experts. The evidence indicates that one of the experts was a close friend of plaintiffs' counsel and had accompanied him on several trips. The second expert testified that plaintiffs' counsel had made contributions to the witness's political campaign. As for the remainder of the experts, defense counsel elicited information regarding the fact that they were all associated with an expert-witness service.

{¶ 110} This cross-examination is proper. Pursuant to Evid.R. 607, the defense was entitled to impeach the credibility of Lykins's witnesses. Furthermore, Evid.R. 616(A) permits a witness to be impeached by showing "[b]ias, prejudice, interest, or any motive to misrepresent * * *." We find no error with regard to this issue.

{¶ 111} Finally, Lykins asserts that the judgment is against the manifest weight of the evidence. In support, she claims that the facts were uncontested and that "testimony which contradicts such facts, even if contested by the defense, is still sufficient to support a verdict in [her] favor."

{¶ 112} In reviewing a claim that the evidence does not support a verdict, we are guided by the holding that "[j]udgments supported by some competent, credible evidence going to all the essential elements of the case will not be reversed by a reviewing court as being against the manifest weight of the evidence." *C.E. Morris Co. v. Foley Constr. Co.* (1978), 54 Ohio St.2d 279, 8 O.O.3d 261, 376 N.E.2d 578, syllabus. Furthermore, we must presume that the findings of the trier of fact are correct because the trier of fact is best able to 319*319 observe the witnesses and use those observations in weighing the credibility of the testimony. *Seasons Coal Co. v. Cleveland* (1984), 10 Ohio St.3d 77, 81, 10 OBR 408, 461 N.E.2d 1273.

{¶ 113} We begin with the observation that, despite Lykins's assertion to the contrary, this case was anything but uncontested. There are some facts that are uncontradicted: David contracted a disease, he went to the MVH emergency room, he was sent home with a diagnosis of shoulder sprain, his condition worsened, he returned to MVH the next day, he was diagnosed and treated, and he subsequently died. However, the transcript is more than 4,100 pages in length and is filled with contested matters. Both sides presented numerous expert and fact witnesses. Thus, we are required to determine whether, after reviewing the entire record, the judgment is not supported by competent, credible evidence.

{¶ 114} The defense produced numerous experts, including Dennis Stevens, M.D., and David Talan, M.D. Dr. Stevens is board certified in infectious diseases and internal medicine and has conducted extensive research and writing on Necrotizing Fasciitis and Necrotizing Myositis. Dr. Talan is board certified in

emergency medicine, infectious diseases, and internal medicine. He has also conducted research on these diseases.

{¶ 115} It is undisputed that David did not have septic arthritis of his shoulder. The defense witnesses testified that when David presented to the emergency room on March 2, he did not have the clinical signs of Necrotizing Fasciitis or Necrotizing Myositis; specifically, he did not have swelling, redness, discoloration, or heat on his skin, and he had no fever.[5] Additionally, David's vital signs were essentially normal on that date. The experts further opined that the tests that Lykins claims were required were, in actuality, not indicated by David's presentation or history. Furthermore, the experts agreed that the diagnosis of strain/sprain of the left shoulder was reasonable given David's symptoms.

{¶ 116} The proper standard of care in a medical malpractice case was laid out by the Ohio Supreme Court in *Bruni v. Tatsumi* (1976), 46 Ohio St.2d 127, 75 O.O.2d 184, 346 N.E.2d 673. In that case, the court stated:

{¶ 117} "Under Ohio law, as it has developed, in order to establish medical malpractice, it must be shown by a preponderance of the evidence that the injury complained of was caused by the doing of some particular thing or things that a physician or surgeon of ordinary skill, care and diligence would not have done under like or similar conditions or circumstances, or by the failure or omission to do some particular thing or things that such a physician or surgeon would have done 320*320 under like or similar conditions and circumstances, and that the injury complained of was the direct result of such doing or failing to do some one or more of such particular things." Id., 46 Ohio St.2d at 131, 75 O.O.2d 184, 346 N.E.2d 673.

{¶ 118} The defense experts testified that none of the defendants breached the standard of conduct. Given the evidence introduced by the defense, we conclude that a reasonable juror could find that Lykins had not demonstrated that the defendants had breached the standard of conduct by failing to diagnose Necrotizing Fasciitis/Myositis during David's first visit to MVH. There is competent, credible evidence to suggest that David's diagnosis of strain/sprain on March 2 was reasonable and that the proper diagnosis could not be made until the following day, when the signs of discoloration and swelling appeared. There also is evidence that Dr. Oster was not involved in the care or treatment of David, and that his conduct was not improper and had no effect on David's outcome.

{¶ 119} Based upon the record, we conclude that the judgment is not against the weight of the evidence. Therefore, the sixth assignment of error is overruled.

VIII

{¶ 120} The seventh assignment of error provides as follows:

{¶ 121} "The trial court committed prejudicial error on pleadings, motions and instructions concerning the medical records and loss, spoliation and destruction of same."

{¶ 122} Lykins contends that she should have been permitted to maintain a separate cause of action for the loss or destruction of the urgent-care referral form and the telephone-message form. She also claims that the jury should have been instructed to presume negligence based upon the failure of MVH to retain those records.

{¶ 123} The elements of a claim for interference with or destruction of evidence are "(1) pending or probable litigation involving the plaintiff, (2) knowledge on the part of defendant that litigation exists or is probable, (3) willful destruction of evidence by defendant designed to disrupt the plaintiff's case, (4) disruption of the plaintiff's case, and (5) damages proximately caused by the defendant's acts." *Bae v. Dragoo & Assoc., Inc.,* 156 Ohio App.3d 103, 2004-Ohio-544, 804 N.E.2d 1007, ¶ 26.

{¶ 124} The record is devoid of any evidence that MVH or any of its physicians or employees willfully destroyed these forms. Furthermore, it cannot be said 321*321 that the lack of these forms disrupted the presentation of Lykins's case. The jury was made aware of the existence and the subsequent loss or destruction of these forms and the content thereof and was free to consider or to disregard the matter in reaching its verdict.

{¶ 125} We conclude that Lykins has failed to present evidence to establish a claim for spoliation of evidence.

{¶ 126} We have found no evidence in the record to demonstrate any relationship between the failure to retain these records and the treatment of David Lykins; in other words, the timing of the diagnosis and David's death were not caused by the hospital's failure to keep those forms. It is clear from the record that Heller and Vaughn ruled out septic arthritis in David's shoulder, as requested by the urgent-care physician. It is further undisputed that David did not have septic arthritis of the shoulder.

{¶ 127} Last, Lykins has failed to cite any competent authority for her assertion that the jury should have been instructed to presume the negligence of, or shift the burden of proof to, the defendants based upon the loss of these records. Therefore, we conclude that the trial court did not err by failing to give such an instruction.

{¶ 128} The seventh assignment of error is overruled.

IX

{¶ 129} The eighth assignment of error provides:

{¶ 130} "The trial court granted prejudicially erroneous rulings on plaintiffs' pretrial (summary judgment) (in limine) and directed verdict motions that denied the plaintiffs' right to remedy and prejudiced their case for trial."

{¶ 131} Lykins contends that the trial court improperly rendered summary judgment in favor of the defense. She also contends that the trial court erroneously sustained motions in limine and requests for directed verdicts made by the defense. Lykins further claims that the trial court erred by denying her motion for directed verdict on the issues of loss of Heller and joint and several liability. Counsel for Lykins has completely failed to comply with the requirements of App.R. 16(A)(3) and (D) by neglecting to include any references to the portion of the record demonstrating these alleged errors. This has been an ongoing and consistent problem throughout Lykins's appellate brief. Counsel should note that compliance with the Rules of Appellate Procedure is mandatory and that the failure to adhere to these rules may result in sanctions or adverse rulings.

322*322 {¶ 132} We begin with the claim that the trial court erred by rendering summary judgment in favor of the defense. This claim is directed to the fact that the trial court dismissed counts four, five, six, seven, eight, nine and ten of Lykins' complaint pursuant to a motion for summary judgment filed by the defense.

{¶ 133} On appeal, a reviewing court conducts a de novo review of a trial court's summary judgment entry. *Grafton v. Ohio Edison Co.* (1996), 77 Ohio St.3d 102, 105, 671 N.E.2d 241. Civ.R. 56(C) provides that summary judgment is proper when (1) no genuine issue as to any material fact remains to be litigated, (2) the moving party is entitled to judgment as a matter of law, and (3) it appears from the evidence, viewing the evidence most strongly in favor of the nonmoving party, that reasonable minds can come to but one conclusion, which is adverse to the nonmoving party. *Zivich v. Mentor Soccer Club, Inc.* (1998), 82 Ohio St.3d 367, 369-370, 696 N.E.2d 201.

{¶ 134} In counts four and five of her complaint, Lykins raised a claim for the intentional infliction of emotional distress. These allegations appear to center on Lykins's argument that Heller and Vaughn's failure to properly investigate the diagnosis made by the doctor at urgent care resulted in emotional distress to her and her children.

{¶ 135} To prevail on a claim for intentional infliction of emotional distress, a plaintiff must show the following: (1) that the defendant intended to cause the plaintiff serious emotional distress; (2) that the defendant's conduct was extreme and outrageous; and (3) that the defendant's conduct was the proximate cause of plaintiff's serious emotional distress. *Phung v. Waste Mgt., Inc.* (1994), 71 Ohio St.3d 408, 410, 644 N.E.2d 286. Extreme and outrageous conduct is conduct that goes beyond all possible bounds of decency and is so atrocious that it is "utterly intolerable in a civilized community." *Yeager v. Local Union 20* (1983), 6 Ohio St.3d 369, 375, 453 N.E.2d 666.

{¶ 136} The trial court found that Lykins failed to present any evidence to demonstrate that the defendants, by failing to diagnose Necrotizing Fasciitis/Myositis on March 2, intended to cause serious emotional distress. Furthermore, the trial court found that while the issue of the professional competence of the defendants is a matter for the jury, there is nothing in the record to demonstrate conduct so extreme or outrageous as to go beyond all human decency. We must agree and conclude that the trial court did not err in rendering summary judgment in favor of the defendants on this issue.

{¶ 137} In count six of her complaint, Lykins alleged a cause of action for loss of consortium. The trial court rendered summary judgment in favor of the defendants upon this issue, based upon its finding that Lykins's cause of 323*323 action for loss of consortium was included in her claim for wrongful death set forth in count two of her complaint, and thus could not be maintained as a separate action. See R.C. 2125.02(B). We disagree.

{¶ 138} Lykins was entitled to maintain a loss-of-consortium action for two separate periods of time. First, she suffered a loss of consortium for the two weeks that David survived after diagnosis, during which time he was hospitalized and completely disabled. Second, she suffered a loss of consortium following David's death.

{¶ 139} While we find no error in the trial court's decision insofar as it regards the time period following David's death, we do find that it was error to dismiss the loss-of-consortium claim for the two-week period he was in the hospital as that time period is not covered by the claim for wrongful death but rather is for damages resulting from the alleged malpractice. However, since the loss-of-consortium claim for that two-week period is derivative of the claim for medical malpractice, and since the jury determined that such claim was without merit, we find that any error was harmless.

{¶ 140} For her seventh count, Lykins claimed that the defendants breached their fiduciary duty to David. It is clear from reviewing this count that it is based upon her claim for malpractice.

{¶ 141} The Ohio Supreme Court of Ohio has held that a patient's action for breach of contract arising out of his physician's negligence is one based in malpractice and not contract. Cf. *Ratcliffe v. University Hosp. of Cleveland* (Mar. 11, 1993), Cuyahoga App. No. 61791, 1993 WL 69553. Lykins raised a claim for malpractice in count one of her complaint. "[T]herefore, [Lykins's] claim for breach of fiduciary duty by a physician is a medical claim under R.C. 2305.11(D)(3)." Id. Thus, the trial court did not err in rendering summary judgment on this claim.[6]

{¶ 142} The eighth count of the claim raises an allegation that MVH was negligent and/or reckless in its hiring, policies, and standards based upon the contention that MVH failed to implement policies with regard to hiring and training.

{¶ 143} Lykins did not oppose the motion for summary judgment on this issue, and the trial court found that she failed to establish the required element that MVH had actual or constructive knowledge of the

incompetence of any of the persons involved with this case. See *Evans v. Ohio State Univ.* (1996), 112 Ohio App.3d 724, 680 N.E.2d 161. We find no error in the trial court's decision.

324*324 {¶ 144} The ninth count of the complaint contained a claim for the refusal to timely provide medical records pursuant to R.C. 3701.74. The trial court found that the records were provided in a timely manner and that this claim was thus rendered moot. We conclude that this decision was correct.

{¶ 145} Finally, in her tenth count set forth in her complaint, Lykins made a civil claim for reckless homicide. Lykins, again, did not oppose summary judgment on this claim. The trial court found that there was no basis for this claim. We agree. Indeed, we are somewhat dumbfounded by counsel's attempt to bring a claim for which there is no basis in law and for which there is no showing of a good-faith attempt to change the law.

{¶ 146} We next turn to Lykins's claim that the trial court improperly granted the defendants a directed verdict on "several causes of action" and note that we find only one instance in which the trial court granted a directed verdict in favor of the defense. This was made with regard to the issue of whether MVH could be held liable for any negligence of Dr. Oster.

{¶ 147} Civ.R. 50 controls motions for directed verdicts and states:

{¶ 148} "When a motion for a directed verdict has been properly made, and the trial court, after construing the evidence most strongly in favor of the party against whom the motion is directed, finds that upon any determinative issue reasonable minds could come to but one conclusion upon the evidence submitted and that conclusion is adverse to such party, the court shall sustain the motion and direct a verdict for the moving party as to that issue."

{¶ 149} When deciding such a motion, the trial court does not weigh the evidence but "assumes the truth of the evidence supporting the facts essential to the claim of the party against whom the motion is directed, and gives to that party the benefit of all reasonable inferences from that evidence." *Ruta v. Breckenridge-Remy Co.* (1982), 69 Ohio St.2d 66, 68-69, 23 O.O.3d 115, 430 N.E.2d 935.

{¶ 150} We have examined the record and, like the trial court, find no legal theory under which "any negligence of Dr. Oster could implicate the liability of the hospital." Oster was not employed by the hospital; he was not present when David was examined, and he played no part in the examination and treatment of David. Additionally any comments made by Oster to the MVH physicians in connection with the first trip to the emergency room was clearly made after David had already been examined and a diagnosis had already been reached.

{¶ 151} The eight assignment of error is overruled.

325*325 X

{¶ 152} The ninth assignment of error raised by Lykins is as follows:

{¶ 153} "The court failed to properly apply or instruct the jury on the presumption of negligence in the case at bar and require the defendants to produce evidence solely within their possession."

{¶ 154} In this assignment of error, Lykins contends that the trial court should have shifted the burden of proof to the defense because of its failure to retain the urgent-care and telephone-message forms.

{¶ 155} Given our disposition of the eighth assignment of error above, we conclude that this argument is rendered moot. Accordingly, the ninth assignment of error is overruled.

XI

{¶ 156} All of Lykins's assignments of error having been overruled, we affirm the judgment of the trial court.

Judgment affirmed.

GRADY AND FREDERICK N. YOUNG, JJ., concur.

[1] Necrotizing Fasciitis involves the fascia covering the muscle, while Necrotizing Myositis involves muscle.

[2] We note that Lykins also states that the objections she did make after the statement were "met with non-verbal disapproval by the Court" and that the trial court had received notice of a "serious medical condition" and was "obviously preoccupied causing the remark to probably not be meant." We have found nothing in the record to support these assertions; therefore, we ignore them.

[3] In her appellate brief, Lykins notes that the ruling regarding this issue was not made on the record, and she states that the record will be supplemented with the ruling pursuant to App.R. 9(A). Lykins has failed to supplement the record regarding this matter.

[4] Again, counsel for Lykins fails to cite the record with regard to this claim or to identify the specific exhibits.

[5] Although Lykins argues that David informed the emergency room staff that he had a fever and had taken medicine to reduce the fever, there is competent evidence in the record to indicate that his temperature was normal when checked and that David did not inform the defendants that he had taken medicine.

[6] We note that Lykins did not oppose summary judgment on this count