IN THE SUPERIOR COURT FOR THE COUNTY OF FULTON

STATE OF GEORGIA

[redacted]

Plaintiff,

vs.

PATIENCE AJUZIE,

Defendant.

CIVIL ACTION FILE

NO. [redacted]

VIDEOTAPED DEPOSITION OF

ANNA CHOO ELMERS, M.D.

March 25, 2014

2:24 p.m.

Shepherd Center

2020 Peachtree Road, N.W.

Atlanta, Georgia

Carolyn J. Smith, CCR, RPR, RMR, CCR-A-1361

INDEX OF EXHIBITS

| EXHIBITS | DESCRIPTION | PAGE |
|---|---|---|
| #1 | Curriculum Vitae, Dr. Elmers | 4, 7 |
| #2 | Photocopy of X-ray, [redacted] 000130 | 14 |
| #3 | Photocopy of X-ray, [redacted] 000131 | 14 |
| #4 | Rehabilitation and Life Care Plan of [redacted] by Kathy Willard | 32 |

INDEX TO EXAMINATION





(Plaintiff's Exhibit 1 marked)

MR. BUTLER: Just before we started this deposition, Mr. Hiestand and I conferred about some medical records. It appears that the last medical records that Plaintiff had from Shepherd, we -- we, meaning Plaintiff, acquired in late 2013 and produced to Defendant then.

Plaintiff had requested, but had not yet received, updated medical records from Shepherd. Immediately before this deposition, we -- Plaintiff requested and received updated medical records from Shepherd. And I've just offered them to Defense. Defense and Plaintiff have just reviewed them.

I've just learned that Defense also had some medical records from Shepherd that Defense acquired via third-party subpoena that I had not seen until today, despite previous correspondence on the subject. However, I've now reviewed what I understand to be all of the medical records from Shepherd that Defendant received via third-party subpoena.

Anything to add?

MR. HIESTAND: That is all accurate. The only exception I would note is I understand that there may have been a visit which occurred last



Friday, that neither one of us has yet because I don't think it's been transcribed.

MR. BUTLER: Okay.

MR. HIESTAND: So with the exception of that record, I think that's all accurate.

MR. BUTLER: All right. Let's go.

(Off-the-record discussion)

(On video)

THE VIDEOGRAPHER: We are on the record, and the time is approximately 2:25. This is the beginning of disk one for the video deposition of Dr. Anna Choo Elmers. Would counsel present please identify themselves and who they represent for the record.

MR. BUTLER: Jeb Butler on behalf of the Plaintiff, [redacted]

MR. HIESTAND: Trevor Hiestand for the Defendant.

THE VIDEOGRAPHER: Thank you, Counsel. Would the court reporter please swear in the witness?

ANNA CHOO ELMERS, M.D.,

having been first duly sworn, was examined and testified as follows:



MR. BUTLER: This will be the videotaped deposition of Dr. Anna Elmers, taken pursuant to notice in the case of [redacted] against Ajuzie. The deposition is taken pursuant to the Civil Practice Act and for all purposes allowable under the Act, including use in evidence at trial.

EXAMINATION

BY MR. BUTLER:

Q Dr. Elmers, as you know, my name is Jeb Butler. I represent the Plaintiff, [redacted] Would you state your full name for the record, please?

**A My full name is Anna Choo Elmers.**

Q And today is March 25th, 2014; is that right?

**A That's right.**

Q Would you tell the jury where we are today?

**A We're at the Shepherd Center on 2020 Peachtree Road in Atlanta, Georgia.**

Q And what do you do here at the Shepherd Center?

**A I'm one of the spinal cord and brain injury physicians here, so I'm what you would call an attending physician. I manage both spinal cord**

**and brain injury patients. I have four teams here, two spinal cord teams, one brain injury team, and one medical-surgical team.**

Q Are you one of [redacted] doctors?

**A I am.**

Q I'll ask you about your diagnoses and treatment of [redacted], but first I wanted to learn a little bit about your educational background. Could you tell us about that, please?

**A I can. I went to medical school at St. George's University initially, and transferred to George Washington University, graduating from there in 2005 in Washington, D.C. Then I moved down here to Emory University, where I did my residency in physical medicine and rehabilitation, the last year of which I was chief resident, finishing in 2009.**

Q Are you board certified in physical medicine and rehabilitation?

**A I am.**

Q I've got here something that I've already marked as Plaintiff's Exhibit 1. I'll show you that and show a copy to opposing counsel. What is that?

**A This is my CV.**

Q Is it true and accurate insofar as it's



been updated?

**A It hasn't been updated for a while, so I haven't put any of my talks in here but it is -- the meat of it is very accurate.**

Q Dr. Elmers, do you practice spinal cord medicine?

**A I do.**

MR. BUTLER: At this time, we'd like to tender Dr. Elmers as -- as an expert in spinal cord injuries, physical medicine and rehabilitation.

BY MR. BUTLER:

Q I'll ask you, as I said earlier, some questions about your diagnoses and treatment of [redacted]. And I'll ask that you respond to those questions to a reasonable degree of medical certainty.

Can you do that, and, if you can't do that, let me know?

**A Yes, sir.**

Q What is [redacted]'s injury?

**A [redacted] suffered a spinal cord injury to the lower part of his spine. And that occurred in the accident that was in 2011, I believe, '10 or '11.**

Q Does December 2010 sound right?



**A Yes, it does.**

Q Is there a more specific way that you classify spinal cord injuries?

**A There is. And the best way to go about this, may be -- may be an explanation --**

Q Sure.

**A -- of how spinal cord injuries are classified.**

Q Please.

**A So, normally, we'll bring a model of the spine, because it's very difficult as a layperson to understand exactly what's happened within the body without actually visualizing it. So what we'll briefly chat about, if it's okay with you guys, is what I sit down and talk to my patients about. And this is just so they understand their level of injury.**

**As you're sitting now -- or as I'm sitting now, this is kind of how I'm sitting. This is a model of the spine. And your bottom is here, your head is up here, front, and your back. The spine is broken down into four different sections, as far as the bones. You've got your cervical spine up here. That's just a fancy name for the neck bones. There's seven bones up here.**



**Then you've got your chest bones, your thoracic spine. There's 12 bones here. That's the area that the ribs attach to. Then you've got your lower spine, your low back. There's five bones here called the lumbar spine. And down here, this area that's fused is called the sacrum.**

**The bones fit together like shingles on a roof. And they form this tunnel in the middle that houses the spinal cord, which is an extension of the brain. You can think of the spinal cord like an information superhighway. So messages travel up and down the spinal cord from the brain to the arms to the legs to the feet, your bowel, your bladder. And then information travels up.**

**So if a patient were to step on a pine cone, for example, before their injury, their foot would send the message up to their brain, on these tracks that I look at as freeways, highways, you know, roads. And their brain would send a message back down to your foot saying, that hurts, move.**

**And in essence, that happens instantaneously. And they move. When there's an injury to the spinal cord, because the brain -- the bones have been broken, then those messages don't get through like they otherwise would.**

**In [redacted]'s case, I believe his injuries were at the lower level, L -- lumbar -- I think 2, 3, and 4. And, initially, I think the worst injury, if I remember correctly, was further down. The spinal cord itself ends at between L1 and L2.**

**So if you look here, it says 5, 4, 3, 2, 1. And so the spinal cord itself ends right around here. And then you've got a cone at the very bottom, and then something that they call conus medullaris, horse's tail, that goes out. And you can think of like that electrical wiring to a house. So if you think about it, if the lights in your house are out, that problem can be either the lightbulb, the switch, or it could be the central fusebox. It depends on where the issue is and that, kind of, will tell you how to -- you know, go about managing it.**

**In -- when -- when we look at a spinal cord injury, the issue is at the main fusebox. You know, the -- very central. The other thing you want to look at is, you know, the horses's tail. Think of those like a bunch of roads that come out of this main information highway. And all of those roads travel in different directions. And so when there's an injury at that level, then certain roads are**



**going to be out, but other roads are not.**

**Hopefully, that kind of explains anatomically what happened, but his injury was -- is classified as an L2. So current -- my most recent classification was L2, incomplete. Incomplete referring to the fact that he has got sensation and some movement below that level.**

Q Was there ever a time when [redacted]'s injury was classified at another level?

**A Prior -- I think when he initially left Shepherd, it was a higher level, at L1.**

Q Does that sometimes happen in the normal course of treating patients, that the level changes somewhat?

**A It does. And we expect it to change in the first year to 18 months, and patients may gain an additional level. What I didn't explain when I talked about the spinal cord itself is, you know, each of these roads, so to say, that come out of the spinal cord area, they go to innervate a set of muscles. And so depending on where your injury is, that determines what you're able to move, what you're able to feel.**

**So even though this doesn't apply to [redacted], if you think about someone that gets injured**



**at the neck level, if it's a complete injury, it would take out all motor movement and sensation below that level of injury. Depending on how far up it is, it determines whether they have shoulder shrug, biceps, wrist extensors -- you know, being able to move back on your wrist -- and triceps and fine hand movement.**

**When we get down here at the lower back lumbar level, depending on the level of injury, you may have hip flexors, so you're able to bring -- bring your knees up to your chest. You may be able to kick out your knees -- I'm sorry, your legs at the knees, move your foot back and forth, and move your toe up. Those are all, quote, the different roads and the different wires that go to these different muscles.**

**And so at [redacted]'s current function, he's able to move his knees to his chest, but not with full strength, so not the strength that he had before or the strength that you and I have. And he's able to kick out his leg at the knee a little bit, more on the left than on the right. So, again, very incomplete.**

Q Is it important for purposes of [redacted]'s rehabilitation that the injury is complete -- or,



excuse me, is incomplete as distinct from complete?

**A A complete injury refers to, you know, no motor movement or sensation below that level. So, prognostically, someone with an incomplete level would have a better chance of walking. And I say that, but -- knowing that in [redacted]'s case, even if -- even though he wants to walk, the chances of him walking are slim to none, walking on a regular basis.**

(Plaintiff's Exhibit 2 and Plaintiff's Exhibit 3 marked)

BY MR. BUTLER:

Q I'd like to show you now what I've marked as Exhibits 2 and 3. That's 2, and that's 3.

**A Whoops.**

Q What are those?

**A These are films that we took when [redacted] was here in the hospital. And so what we do -- so when a patient is initially injured, they may be treated as a facility like Grady or Atlanta Medical Center. So 911 may take them there initially, and they're stabilized.**

**And after their surgeries are done, their breathing is stabilized, their hearts are stabilized, and they're ready for rehab, then they**

**come here to a place like Shepherd where someone like me, quote, quarterbacks their team.**

**And so I'm kind of the person that is in charge of the therapists, the nurses, I'm the go-to of the team, so to say. And so what we do here is just make sure that everything gets looked at. So these are films from when he was here that were repeated. And we do these because we want to make sure that that stabilization stays intact.**

**So because of the fractures that occurred to [redacted]'s spine -- so his fractures occurred, kind of in this level, in this area -- the worst of which was around here, the L4 area. That broken bone -- those broken bones rendered that segment unstable. And so the instability caused compression on that spinal cord, or horse's tail, area. So all the way from that horse's tail up towards a little bit of the spinal cord.**

**You can look at that like an accident on the information highway, and so the messages that were going back and forth before are no longer going back and forth. And so I like to tell my patients it's like there was an 18-car pileup on your highway, where important information was going back and forth. And because of that, they can't feel and**



**you can't move your legs, and you can't pee and you can't poop like you did before.**

**The doctors that saw him initially -- and I believe it was at Grady -- that saw him initially, imaged the bones and then, to stabilize that area so that the injuries wouldn't be worse, they put rods and screws in like this.**

**So if you look at this, this is kind of over -- over-imposed on the actual diagram. You've got two rods that come up through the back, and then the screws that go in this way into this main part called the vertebral body. And what that does is just stabilize that segment.**

**So one way to look at it is, if you broke a big piece of board in half and you needed to put it back together so that there wasn't more damage, then what you would do is straighten it up again, and then you would put screws above and below it to hold it in place. And in essence, that's what was done.**

**And so these are his films from that stabilization to make sure the area remained intact. And that, you know, if he was having low back pain for example, it's to look at the screws to make sure nothing is coming out.**



Q Do Plaintiff's Exhibits 2 and 3 fairly depict the hardware that's been installed in [redacted]s back?

**A Yes.**

Q You mentioned walking just a minute ago, and I wanted to return to that really quickly. Just so the record is clear, although the jury will probably have figured it out by this point, can [redacted] walk on his own?

**A No, he can't.**

Q Now, I know that [redacted] can move his legs some. Why can't he walk since he can -- even though he can move his legs?

**A There's a couple things. He was last in rehab here at Shepherd several years ago. And at the time that he was in rehab, he didn't have quite the strength that he has now. So he's gotten a lot back, or he's gotten a significant amount more back since he was last here in actual inpatient therapy rehab.**

**So one of the reasons is he doesn't have access to more rehabilitation. So a therapist has not worked with him since he's -- he was last here. The second thing is, even if you have some movement, for example, you have a spinal cord injury, but you**



**can wiggle your toes, I tell my patients, you know, that's great, you know, I'm glad that you can wiggle your toes. But it's a far way from wiggling your toes to walking, because there's a lot to coordinate.**

**In [redacted]'s case, he probably can walk a little bit, maybe at home, if he had the right braces, the right therapy, and the right equipment. But because the energy that would be required for him to walk, what we call ambulate, on a day-to-day basis in the community would be so great, most people simply can't do it and, you know, don't want to do it because it's a lot of work.**

Q Okay.

**A And they -- they don't move very fast from place to place.**

Q To a reasonable degree of medical certainty, Dr. Elmers, will [redacted] ever be able to walk like you can, for example?

**A No.**

Q When did you first examine [redacted]?

**A I first examined him in 2011.**

Q And when was the last time that you saw him?

**A I last saw him on Friday.**

Q It's my understanding that although you generally understand [redacted]'s treatment before you saw him, and treatment that he has received outside of Shepherd's, you haven't necessarily reviewed every single medical record that's been generated about [redacted]; is that fair?

**A That's fair.**

Q Is it important for you or do you feel like you need to review every single medical record that's ever been generated about [redacted]?

**A No, I get a good sense of what he's doing and where he's at by seeing him.**

Q We've talked a lot about [redacted]'s injuries to his, sort of, lower half and how they affect his legs. Do you expect over the long term for [redacted]'s spinal injury to affect his upper body?

**A Well, definitely. The legs, as made by God, were going to be what you use to walk around. And, you know, walking is kind of what we were designed to do. And so people who don't walk, their arms become their legs. And so all of the tension from rolling and whatnot will develop into overuse injuries in their upper extremities.**

Q What kind of changes would you expect over time to [redacted]s upper extremities?



**A Long term, you know, you expect overuse because shoulders just were not meant to be used like that. So just like baseball players that are -- pitchers, for example, that are constantly pitching, and they don't get that break in between, their shoulders wear down. And so as a result, they need surgery, you know, whether it's rotator cuff or whatever it might be.**

**But it's the same for a spinal cord patient. They are now using their arms and legs as their primary mode of transport. And because of that, the wear and tear is a lot greater. And so long term, likely some pain in his shoulders and possibly surgery to, you know, repair injuries like rotator cuff injuries.**

Q Would injuries like rotator cuff injuries and other problems we've talked about affect the type of equipment that [redacted] will need to remain independent as he grows older?

**A Yes, it does. So the time for recovery in between surgery and getting back into independence, during that time, he would most likely need a power chair, and so he -- so he could still get around. I've had several patients who, during the time that they have undergone surgery, they're not able to be**



**as active as they were before.**

**And so a lot more needs to be monitored in that time, namely mood, because, you know, you've taken someone who possibly is very active to someone that is not able to do anything at all because of the -- being laid up by their shoulders.**

Q What about skin care, Dr. Elmers? Is that something that's important for [redacted]?

**A Skin care is probably one of the most important things that I emphasize with my spinal cord patients. And so as we are all sitting here, you know, we do shifting. You know, you'll notice that you'll sit in one spot for a long time, and then you'll want to shift around because that spot is not getting the oxygen that it needs.**

**And so in a spinal cord injured patient, that feedback is not there. And so [redacted] has to do weight shifts. Currently, it's every 15 to 30 minutes. But normally, it's every 30 minutes. And it may look something like this, where he comes up and then -- or it may look like this, where you're just wondering what he is doing, why is he just leaning to one side or the other side. And that's to offload pressure to that area of his skin.**

**If that's not done, then you get skin**



**breakdown. And [redacted] actually has some skin breakdown on his sitting bones, where -- you know, where he sits up on his chair.**

Q If skin breakdown occurred and went untreated, could that be a serious problem, or is that just a minor discomfort?

**A It actually can be a very serious issue. And one of the examples that I use with my patients is, you know, skin is something you have to be hypervigilant about. If you remember Christopher Reeves, Superman, suffered a spinal cord injury. And when he passed away, some speculated that it was because of a pressure wound, which was unheard of, because he had all this money and 24/7 care. But he was a much higher level, so he couldn't do anything on his own.**

**But skin problems, you know, if it's the one thing I want my patients to take away, it's that you need to monitor that skin very closely. Because once it breaks down, you know, when it heals or even after surgery, it's not as strong as it was the first time. And, unfortunately, even in the best cases, best-case scenarios, there may be breakdown.**

**And I -- you know, we just had some someone here, who after 20 or 30 years, did not --**

Page 23

of not having any issues actually had skin breakdown because his cushion ruptured and he didn't know it. And so even in the best-case scenario, you can have cushions that rupture, you could have, you know, over-inflated cushions that can impair healing and whatnot. So long answer to your very short question is, yes, skin is very important.

Q Thank you, Doctor. I wanted to ask you about some things that we don't normally discuss in -- in polite company that I might feel a little uncomfortable asking about, actually, but it involves what I think you-all call [redacted]'s bladder program.

**A Right.**

Q How does [redacted] urinate?

**A So after someone suffers a spinal cord injury, the bowel and bladder are normally affected as well, depending on the, you know, severity of the spinal cord injury. The name of the bladder is neurogenic bladder after it's been affected from a spinal cord injury. Neurogenic, just meaning coming from the nerves, neurogenic.**

**In man, there are four different ways that that bladder can be managed after a spinal cord injury. What we take for granted every day, being**

Page 24

**able to get up, go to the bathroom in very little time, is something that spinal cord injured patients have to deal with for the rest of their lives because they can't urinate like they did before.**

**And so the four ways of managing that are, first, there's the Foley catheter, which is the tube that goes through the urethra in the penis and goes into the bladder. You can think of the bladder like a balloon. And so here's your balloon, and then there's a little hole here, and it comes out through the penis.**

**You put a tube in through the penis. It seems like it's through the penis, but it's through the urethra. And that tube comes up, and it's like a straw, and it sits kind of up here, and it drains the bladder all the time.**

**That tube called the Foley stays in there all the time. And it's not something I recommend because it can cause skin breakdown in patients. So initially a spinal cord patient, say, at the acute hospital like Grady or Atlanta Medical, may have that. But that gets removed pretty quickly. And they may need it again if they're hospitalized or something comes up.**

**But the ideal way for someone like [redacted]**

Page 25

**is something called intermittent catheterization, or, abbreviated, IC. In that case, every four to six hours, a catheter is inserted through the penis, drains the bladder and then discarded. And that happens every four to six hours. In [redacted]'s case, he does it every four hours.**

**It's still introduction of a foreign body four to six times a day. So if you do it every four hours, it's six times a day. Every six hours, it's four times a day. So four times a day, he's introducing a foreign object into his bladder to drain that area and keep his bladder from overfilling.**

**Before catheters were developed in spinal cord injured patients, kidney failure was actually the most common cause of death. And so we have to make sure that his bladder is well managed and that his bladder doesn't overfill. Because when it overfills, you can have backing up, so to say, if you look at it like a plumbing system, backing up into the -- into the kidneys.**

**And so he has to watch what he's drinking. He has to watch to make sure that he's cathing, maybe getting up in the middle of the night to cath. And we have our patients here set alarms so that**

Page 26

**they get up in the middle of the night and do this procedure.**

**The other two ways of managing it are condom catheters. And so that's where you have a condom that you put over the penis and it -- with reflex voiding. So that's just a fancy word for the bladder will actually go on its own, when it contracts and will go into the -- the catheter, the condom catheter. And then the last way is something called a suprapubic tube.**

**And so if [redacted] were not able to catheterize on his own, then I would recommend one of these other methods, most likely a suprapubic tube.**

Q Does [redacted] insert his own catheter --

**A He does.**

Q -- multiple times a day?

**A He does.**

Q What about urinary tract infections? Is [redacted] at an increased risk of those?

**A He is. And anyone that would introduce a foreign object to their sterile -- the sterile parts of their body are at risk for urinary tract infections. And that's something that spinal cord injured patients have to be very aware of. He**

**actually has gotten a handful of them.**

**When I saw him on Friday, he had just gotten treatment for a urinary tract infection. It's something that manifests a little bit differently in spinal cord patients because they can get so sick from a urinary tract infection. And so I always tell my patients, you know, if you feel like you're starting to get one, then we need to be aware so we can treat you for it.**

Q How would [redacted] know if he had a urinary tract infection?

**A He'll start to feel badly, or he'll get a fever. But he will feel it. It's just like if you were coming down with a cold or the flu, he -- you know, that's kind of how he would feel.**

Q When --

**A But different people feel different things.**

Q When -- when [redacted] gets a urinary tract infection, is it just sort of a moderate unpleasantness, or does he actually feel bad while he has it?

**A He -- he actually feels bad. So in -- in the spinal cord patient, urinary tract infections are always considered complex or complicated,**



**because of the bladder and the complexity, you know, of the injury itself. So spinal cord injured patients do not respond to -- you know, if you had a urinary tract infection, you would probably take a couple antibiotics over -- or take antibiotics over a couple of days, and you'd be better.**

**But it probably wouldn't keep you out of work. It probably wouldn't really make any -- wouldn't slow down your life, so to say. In spinal cord patients, it definitely could make a huge difference. So in my inpatients, the patients that I see in the hospital, when someone has a urinary tract infection, it could take them out of therapy because they just don't feel good.**

Q Are -- are urinary tract infections common among spinal patients?

**A They are.**

Q The next two subjects I'll just -- I'll just address very briefly. Does [redacted] defecate or -- or poop in the same way that someone who doesn't have a spinal cord injury does?

**A He doesn't. He actually has voluntary bowel movement. So he can sense when he needs to poop, and he can poop on his own. But, you know, there has been injury to those roots. And so when**



**he was first injured, he definitely could not. And my sense is, even what he's doing now, is not normal compared to what he was doing before.**

Q What about -- just briefly, what about [redacted]'s sexual abilities? Have they been affected by his injury?

**A They have. So most of my spinal cord patients will need something like Viagra or Cialis, or sometimes even a penile pump or injections to get an erection and then to, you know, have intercourse. Most of my spinal cord patients don't actually ejaculate. And so when it comes to fertility, they would need to go to a fertility specialist and have their sperm harvested.**

Q I wanted to ask you something about special consequences for ordinary events. And what I mean is, given [redacted]'s injury, are there things that might be common for someone who doesn't have a spinal cord injury that have special consequences for [redacted], given that he does have a spinal cord injury?

**A So, you know, spinal cord injury will affect your bones. And so in someone with a spinal cord injury, they become what we call osteopenic. That's just a fancy name for loss of bone. And**



**so -- you know, the brittle bones or the very fragile bones. And so he's at higher risk for breaking his bones than you and I are because of all the calcium that seeps out and whatnot.**

**He's -- so if during a transfer, for example, he --**

Q What do you mean by transfer?

**A Oh, I'm sorry. So, you know, [redacted] can't walk, and he can't stand -- stand up and move from place to place. So he's confined to his chair. So when he needs to get from his chair to his bed, he has to lift up and kind of, you know, transfer himself over a surface to the next surface that he wants to be on.**

**Because of the quality of his bones -- and, you know, I have not checked an X-ray on him lately because there's been no reason to -- but long term, his bones would be more brittle. And so he could break bones a lot easier, whether they be his long bone in his femur, or his ankles, anything like that.**

**And he wouldn't necessarily know it immediately if he were to break it because of his incomplete sensation.**

Q Okay. So if [redacted], say, were to fall

during a transfer from his chair to his bed, would he have to take special action that someone like me might not have to take if I were to fall out of my bed?

**A Well, if [redacted] were to fall out of his chair or bed -- and he has more sensation than someone, say, with an -- a complete injury, he may actually feel pain. But what he would need to do is just get checked out. And so -- one example I could think of is one of my patients in the hospital now, he went home this weekend to see how the modifications were going on in his house, and he rammed into a door, the side of a door.**

**He can't feel it. So, you know, he didn't think anything of it. But by the time he came back to us, it was all bruised up. And, you know, we took X-rays. We needed to make sure that it wasn't a broken bone or anything. The same is true for [redacted]. He'll need to make sure that he is a little more vigilant about things like his skin, his bones, his -- you know, caring for his bladder, his bowels. Everything is a little more effort.**

Q I wanted to ask you now about [redacted]'s life care plan. Tell the jury in the abstract, what is a life care plan?



**A A life care plan is a way to kind of estimate what the cost of someone's injury is going to be, so lifelong needs.**

Q Did you work with Kathy Willard in this case to develop a life care plan?

**A I did.**

Q Tell the jury how that goes, how you and Ms. Willard worked together on that.

**A So I -- I know [redacted] from clinic, and so I have an understanding of what his injury level is. She knows [redacted] from, you know, interviews with him, visiting him. And so she has an idea of what his injury and his needs are. And so, together, we come up with what we foresee him needing for the rest of his life.**

Q Did you and Ms. Willard meet to discuss this kind of thing?

**A We did.**

(Plaintiff's Exhibit 4 marked )

BY MR. BUTLER:

Q I want to show you now what's been marked as Plaintiff's Exhibit Number 4. Tell the jury what that is, please.

**A This is [redacted]'s life care plan.**

Q Is that the life care plan that you and



Ms. Willard developed and that you approved?

**A It is.**

Q Do you approve Plaintiff's Exhibit 4 as medically necessary to provide [redacted] with the future medical care that he needs?

**A Yes, I do.**

Q Will that life care plan, Dr. Elmers, improve [redacted]'s quality of life?

**A Absolutely.**

Q I wanted to ask you some about future complications which I think are mentioned, but not gone into in great detail in the life care plan. Is there a possibility that you could think of now that [redacted] might need future treatment or future surgeries related to his injury?

**A We talked about this a little bit. He may need, you know, shoulder surgery in the future. He may need skin surgery. You know, there are so many things that can come up with a spinal cord injured patient in the future that is -- you know, that you may see in another patient farther along down the line. So, meaning years out, you know, these are the things that we worry about that our patients will need.**

Q What about if [redacted] were to get sick in



the same way that -- that I might get sick? If he got the flu or something, would his care needs escalate, or go up, as a result of that illness?

**A If he were to get the flu or something, given his level of injury, he would respond similar to you and I would. You know, his lungs are not as affected by the injury as someone with, say, for example, a higher level of injury.**

**But if he were to get a urinary tract infection, his urinary tract infection could progress to what we call sepsis, which is an overwhelming infection of the body, more likely than yours and mine may.**

Q I wanted to ask you this -- and we're almost finished -- but how is [redacted] doing? How is he adjusting to his injury?

**A So the appointment that I had with him on Friday was actually a great appointment. The last time I had seen him before that was the fall -- last fall. And I kind of felt like there were things that he just had not accepted yet with his injury. His overall just mood and affect were different back in the fall.**

**And in fact, Friday's appointment happened on Friday because -- I don't know if it was a**

**transportation issue or what happened. He was actually scheduled for earlier. As a 3-4 month followup to the fall appointment. I am thrilled to report that his mood -- I mean, he was a different person when I saw him on Friday, and just so much more optimistic, very glass half-full, and really starting to adjust and take life back.**

**And so one of the things I say to my patients like [redacted] or any paraplegic patient is that, you know, this injury has changed your life. It's kind of made everything like your bowel and bladder, sexual function different. It's made it so much more of an effort. But I anticipate and expect that my spinal cord patients at the paraplegic level or lower, where they have full function of their arms, will lead full, complete, independent lives, provided they have good resources and are able to get to -- you know, get the things that they need.**

Q Is [redacted] trying to get better?

**A Yes, he is.**

MR. BUTLER: Thank you. That's all I have.

EXAMINATION

BY MR. HIESTAND:

Q Doctor, thank you so much. I'd just like



to ask you a few additional questions about your treatment. First of all, do you know how many times you've seen [redacted], Mr. Smith?

**A I think it's four or five times.**

Q Okay. And I'm showing the first time that you saw him would have been on March 16th of 2011.

**A That's right.**

Q All right. And at that time, he indicated that he had returned to school, and he was living on campus at Clark Atlanta University?

**A Right.**

Q Okay.

**A I think so.**

Q You --

**A I'm trying to remember if --**

Q You do know that he is a college student?

**A Yes.**

Q Okay.

**A I knew at the time of the accident, he was a college student.**

Q And as -- after the accident, he had actually returned to school as a computer arts major?

**A Okay.**

Q Did you know that?



**A I didn't -- I didn't know that.**

Q When you spoke to him on Friday, did you speak with him about how he's doing in college right now?

**A When I spoke to him on Friday, I asked if he was in school, and I don't think he is in school right now.**

Q Okay. Was he taking the quarter off?

**A I don't recall. But I think he was pursuing -- and, actually, I know he was pursuing more auditions, Open Mic opportunities. And he's actually performed at [redacted] since I last saw him, which I thought was great.**

Q I think that was a notation dated February 5th of 2014. He had come in, and he had reported that, at that time, he was sitting out a quarter, but he was returning to college.

**A Okay.**

Q Do you remember that?

**A I don't think I saw him in --**

Q Okay.

**A -- February, but --**

Q Did you review his notes before today's deposition from maybe some of the other folks at Shepherd that had seen him?



**A I did, but I don't think I reviewed all of them.**

Q Okay. But it appears as though he's trying to pursue a career; is that fair to say?

**A Yes, it is.**

Q And certainly there's nothing about his injury that would prevent him from getting a college education. Would you agree with that?

**A I agree.**

Q And there is nothing about his injury that would prevent him from seeking a career that he would love and could make a living from after he finishes school. Would you agree?

**A I'm --**

MR. BUTLER: I object --

**A -- sorry, repeat that one more time.**

BY MR. HIESTAND:

Q Is there anything about his injury that would prevent [redacted] from pursuing a career after graduating from college?

**A Depends on what that career is.**

Q Sure.

**A And that's another thing I tell my patients. If your career was to be a star baseball player, then it's probably not going to happen. If**

**it was -- and I think in his case he wanted to be a dancer. And so that is probably not going to happen.**

Q There are certainly other ways to make money, though, other than as a dancer. Would you agree?

MR. BUTLER: I object, beyond the scope.

**A Absolutely.**

BY MR. HIESTAND:

Q I'm sorry, Doctor, what was that?

**A Yes, he can.**

Q Okay.

**A Yes.**

Q Let me ask you this, do you encourage all of your spinal injury patients, especially paraplegics, that they should pursue a career that would be adapted to their individual disability?

**A Yes.**

Q And is there anything about [redacted] that you think would prevent him from pursuing a career?

**A No.**

Q Is there anything about [redacted] injury that would prevent him from pursuing a family?



**A No. He -- you know, we are going to refer him to the fertility specialist, so -- family as in have children?**

Q Sure.

**A Yes, we are going to refer him to a fertility specialist and see if that's doable.**

Q There's nothing to prevent him from getting married, certainly?

**A No.**

Q Nothing to prevent him from having children, either adopting children or having children of his own, is there?

**A No -- no.**

Q There is really -- and -- and I think you did a good job of summarizing what it means to be a spinal injury patient and somebody who adapts to a new life. And would you agree with me that your life is always going to be different after that injury, but there is really nothing that's preventing you from having a fulfilling life? Is that fair to say?

**A Absolutely.**

Q And a lot of that is also going to depend on [redacted]'s motivation?

**A Yes. And, actually, what I will say there**



**is -- so [redacted] suffered an injury kind of at the worst time of his life.**

Q Age 18?

**A Yes.**

Q Uh-huh (affirmative.)

**A It's a really tough time to suffer an injury because he has not gotten into a career yet. And so, you know, if I look at my patients, my patients who get into accidents or suffer injuries after they've established their careers actually are a little bit better off because they've already established themselves.**

**And so, for example, I have a patient that's a C4 quad, meaning all he can do is shrug his shoulders. But he's dependent on everyone else for everything, draining his bladder, changing his colostomy bag, getting around. But he was an electrical engineer. So his career path was already established before his injury. And he was able to go back to work, as far -- as long as he was able to bring an attendant with him so that they could change out his catheter bag and they could turn pages, you know, the little things that he couldn't do -- or the big things he couldn't do on his own.**

**We actually have an adolescent team here**



**at Shepherd. And so that team of patients are kind of in that age group, you know, as young as 12 and up to 18, 19, 20, sometimes up to 20. That's a special team here because we recognize that it's a very difficult time to suffer an injury. You're kind of at a time in your life where you're trying to find yourself still and figure out what you want to do.**

**And so those, I would say, are my patients that have the most difficult time adjusting because if they don't have direction already before, then this is not going to help them have direction.**

Q There's nothing about [redacted]'s situation, though, that would tell you that he would not be able to self-direct himself in this respect, is there?

**A No. But once we are -- and that's why I was so -- actually, I was so happy to see that his mood was better on Friday, because he's finally, after all these years, accepting that this is probably going to be permanent.**

Q Which would --

**A And --**

Q Which would, in theory, allow [redacted] to make appropriate decisions and to make appropriate

goals for the changes that have occurred in his life so he can build a career, so he can build a family, and he can build a fulfilling life?

**A Absolutely.**

MR. BUTLER: I object to cutting off the witness.

BY MR. HIESTAND:

Q Were you able to finish your responses?

**A Yes.**

Q Thank you. You have discussed some potential complications that [redacted] may have. For example, because he is more dependent on the use of his upper extremities, that there is a possibility that he could, for example, need surgery. But certainly you're aware of spinal cord injury patients, paraplegics, who don't require shoulder surgery?

**A Yes.**

Q And so when you talked about future complications, those are things that may happen or may not happen?

**A Right.**

Q And you had also talked about the increased occasions of urinary tract infections. You're certainly aware that persons can treat



urinary tract infections themselves, they can get medications, and they can treat it. It's not going to be something that's going to require hospitalization or a visit to a doctor every time you have a urinary tract infection. Would you agree?

**A I actually disagree with you there, respectfully, because --**

Q Before you answer -- just let me make sure that you answer, are you saying that patients will need hospitalization --

**A No.**

Q -- every time? Okay.

**A I'm not.**

Q Okay.

**A But I will disagree with you because when patients start to treat their own urinary tract infections, i.e., bum antibiotics off of friends or whatever, that's where we end up with -- because you had mentioned that they could self-treat. They can't self-treat unless they were in Mexico, because they can't get the antibiotics without a prescription.**

**So I always tell my patients, if you have a urinary tract infection, we need to culture it,**



**because if you're going to continue having these, we need to find out what's causing them. I don't want you to just blindly treat it every time without culturing.**

Q I guess what I meant is not so much self-medicate where you would get illegal drugs or --

**A Thank you.**

Q -- or medications, but, for example, somebody may have an ongoing prescription or relationship with their doctor, where their doctor may give them a prescription for say, Bactrim.

**A Yes.**

Q A broad -- you know what Bactrim is?

**A I do.**

Q A broad spectrum medication. And their doctor may say, listen, if you're beginning to experience some symptoms, go ahead and take some of your Bactrim, take a ten-day program of it. And if it clears up, you're going to know, and you don't need to come in to see me?

**A Yes.**

Q Would you agree that that may be the situation?

**A I do.**



Q Okay. So maybe my use of the term self-medicate was probably not accurate.

**A We're very sensitive about that here, self-medication.**

Q And I understand that, and that's very important. But I guess what I'm saying is persons who have spinal cord injuries, in time, they're going to adjust to their condition, and they're going to understand their condition. And it may be a situation where it's not going to -- for example, every fall is not going to require a trip to the doctor. Every --

**A Absolutely.**

MR. HIESTAND: Okay. All right. Doctor, thank you.

MR. BUTLER: Nothing further.

THE VIDEOGRAPHER: This concludes the videotape deposition of Dr. Anna Elmers. The time is 3:13 p m., and we are off the record.

(Signature reserved)

(Deposition concluded at 3:13 p m.)