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IN THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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SC Court of Appeals

APPEAL FROM DARLINGTON COUNTY
HONORABLE J. MICHAEL BAXLEY, CIRCUIT COURT JUDGE
C/A NO. 2004-CP-16-322

Ruth J. Person,

Appellant,

vs.

Carolina Pines Regional Medical Center,

Respondent.

RECORD ON APPEAL
(VOLUME V OF V)

Daryl J. Corbin, Esquire
Corbin Law Firm
227 West Evans Street
Post Office Box 447
Florence, SC 29503
(843)667-6119
Attorney for Appellant

Martin S. Driggers, Jr., Esquire
Sweeny, Wingate & Barrow
115 Cargill Way, Suite B
Hartsville, SC 29551
(843)878-0930
Attorney for Respondent

1 Q. Hello, Dr. Bannister.

2 A. Hello.

3 Q. You do not have Laparoscopic Nissen Fundoplication
4 privileges, correct?

5 A. I do not.

6 Q. You have not been trained to do that particular
7 procedure, correct?

8 A. I attended a course, but I elected not to pursue that.

9 Q. You believe SAGES Guidelines are an authority, don't
10 you?

11 A. I believe SAGES are Guidelines. I have heard a lot of
12 testimony during the course of this trial. And I
13 think there are other guidelines out there, but I also
14 think there are some other things to do with
15 experience in general, which may alter the exact
16 numbers to some degree.

17 Q. Which other guidelines are you talking about?

18 A. I'm talking about as far as doing Gastroesophageal
19 work. There's been mention of other guidelines from
20 other agencies. I'm not familiar with those because I
21 do not do that procedure.

22 Q. Do you recall when you gave your Deposition testimony
23 in this case?

24 A. Yes, sir.

25 Q. And I asked the question:

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1 Do you know whether or
2 not SAGES actually publishes
3 guidelines involving
4 Laparoscopic Nissen
5 Procedure, and you told me, I
6 feel they probably do.

7 **Question:** Would you
8 consider those to be
9 authoritative? And you told me
10 yes. Yes, sir, in fact.

11 Are they authoritative?

12 A. There has been other testimony since I made that
13 statement. I do not dispute that I made that
14 statement at the time. But I have heard testimony
15 throughout this trial which shows that maybe there are
16 some alterations to this theory, not theory, this line
17 of thought.

18 Q. And under the SAGES Guidelines that you thought were
19 authoritative when I deposed you, now you know that
20 Dr. Mincheff was not qualified because he had never
21 been preceptored, fair?

22 A. When I worked with Dr. Mincheff he was already
23 credentialed. I had no reason, and he had not had any
24 adverse occurrences, and I did not question him at
25 that time.

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1 Q. Under the SAGES Guidelines --

2 A. -- Under the Guidelines which you have said, and it
3 has been re-hatched over and over again, you would be
4 correct in those statements.

5 Q. Dr. Mincheff, would not be qualified, fair?

6 A. In the strictest adherence to those guidelines you are
7 correct.

8 Q. In fact, Carolina Pines has no policies or procedures
9 that require Dr. Mincheff doing that procedure to have
10 a more seasoned person assisting him, fair?

11 A. That is correct.

12 Q. No proctor requirement at Carolina Pines, fair?

13 A. I'm not aware of anything, and the issue has never
14 arisen before.

15 Q. No preceptor requirement of Carolina Pines, correct?

16 A. Well, I don't think there is that I am aware of.

17 Q. How would a proctorship or preceptorship harm a
18 patient?

19 A. There is no way he could harm a patient.

20 Q. Would you agree it would be safer at Carolina Pines if
21 it was, in fact, a policy for proctorship and
22 preceptorships?

23 A. I can't answer that question.

24 Q. Now the spleen --- The spleen is an organ filled with
25 blood, fair?

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1 A. That is correct.

2 Q. You slice it up. You would have 1300 ccs fair?

3 A. Can we get something straight to begin with?

4 Q. Yes, sir.

5 A. You keep talking about slicing the spleen. I can
6 unequivocally tell you that the spleen was not sliced
7 during the course of this procedure. Now, I know you
8 have CT Scan reports that say there are areas that are
9 compatible with lacerations, or consistent with
10 lacerations. There are a number of things that can
11 make this appearance, splenic infarcts, which means
12 there is a lack of blood supply in that area. A
13 splenic contusion, a tear in the capsule. But I can
14 unequivocally say, with a clear conscience, that there
15 was no slicing of the spleen at all during this
16 procedure.

17 Q. The tail of the pancreas, that is the closest organ to
18 the spleen, right?

19 A. It lies right in the middle of the spleen.

20 Q. You have the tail of the pancreas laying right on that
21 spleen, fair?

22 A. No, sir, that is not correct.

23 Q. Where is the tail of the spleen?

24 A. The --

25 Q. -- Let me finish, please. Where is the tail of the

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1 pancreas?

2 A. The tail of the pancreas is actually under the spleen,
3 not on top of it.

4 Q. The tail of the pancreas is the closest part to the
5 spleen, fair?

6 A. The closest part to the pancreas, that is correct.

7 Q. Now, if there were some lacerations to the spleen it
8 is pretty close to the tail of the pancreas, fair?

9 A. I don't know how many times I can say it, Mr. Corbin.
10 And with all due respect, there were no lacerations to
11 the spleen that were documented at the time of
12 surgery. There were no documented lacerations or
13 injuries to the spleen from the Operative Reports from
14 Richland Memorial to my knowledge. And what we are
15 seeing is inferred information on CT Scan, which is
16 not looking directly at the spleen.

17 Q. The tail of the pancreas near the spleen --- In fact,
18 when Ms. Person got to Columbia they did confirm that
19 she needed debridement of the tail of her pancreas,
20 correct?

21 A. Not initially.

22 Q. That was part of her pancreas injury, correct, the
23 tail?

24 A. I am not sure exactly what part of the end tail what
25 it was, was the debrided to the tail that would be the

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1 area that was injured. But she did not initially go
2 to surgery when she got to Columbia to my
3 understanding.

4 Q. Is it just a coincidence that in Dr. Mincheff's
5 transfer summary he was concerned about an injury to
6 the tail of the pancreas, and he was right?

7 A. I am not sure. That would have to be addressed by Dr.
8 Mincheff. I did not see an injury to the spleen. I
9 did not see an injury to the pancreas when I was
10 there.

11 Mr. Corbin: Thank you, Dr. Bannister.

12 The Court: Is there redirect?

13 Mr. Sweeney: Just a couple more.

14 Redirect examination by Mr. Sweeney

15 Q. In terms of SAGES, SAGES doesn't apply to the type of
16 surgery you do; is that correct?

17 A. That is correct.

18 Q. You were not trying to tell --- You are not trying to
19 be an expert in SAGES. You're not an expert in SAGES.

20 A. By no means.

21 Q. All right. You have talked about the testimony that
22 you have heard that deals with how the injury have
23 occurred. And that testimony was from Dr. DeMaria,
24 their own expert, was it not?

25 A. That is correct.

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1 **Mr. Sweeney:** Thank you. Nothing further.

2 **Mr. Corbin:** No questions.

3 **The Court:** All right, sir. Any objection to
4 the release of the witness?

5 **Mr. Corbin:** None, Your Honor.

6 **The Court:** Sir, you are free to go. Please
7 watch your step coming down from the witness box.

8 **Dr. Bannister:** Thank You.

9 **The Court:** All right, ladies and gentlemen,
10 that brings us to the end of our business day.

11 Let me discuss with you, while I was talking with
12 counsel here about at the Bench a few moments ago the
13 Defense tells me that they may have two or as many as three
14 witnesses remaining for direct and cross examination.

15 It appears to me that this case will go to you
16 sometime tomorrow. Again, that is what appears to me,
17 sometime perhaps after lunch. I can't tell you that with
18 absolute certainty because there may be many things that
19 occur. But that is just what the goal is.

20 We are going to ask you to be back at 9:00
21 tomorrow morning. We will start at 9:00. In fact, the
22 Court and lawyers will come a little bit earlier to work on
23 some other things that will prepare the case for you. At
24 least, the arguments of the case the testimony closes.

25 Now, tomorrow morning at 10:00, because it is my

1 privilege to serve on an Advisory Committee to the Chief
2 Justice on certain issues, I have what I perceive to be a
3 mandatory telephone conference. I will have to stand down
4 at 10:00 for just fifteen minutes or so to participate in a
5 telephone conference. Then will come back at 10:15. I
6 expect we will take a break after our first hour so I can
7 participate in that. I just give you that as information.
8 All right, then please if you will be in the jury room
9 tomorrow morning at 9:00. We will all be on time, please.
10 Please if you will be on time. Have a nice evening, and we
11 will see you tomorrow.

12 Everyone else, remain where they are while our
13 jury departs the courtroom.

14 (Whereupon, the jury exits the courtroom at
15 5:15 p.m.)

16 **The Court:** Are there any other issues we need
17 to discuss? Otherwise, we will close the record. We will
18 close our record now and we will see what response there is
19 from Dr. Henniford, and then react accordingly.

20 **Mr. Corbin:** Without Dr. Henniford tomorrow,
21 Your Honor, I think it will be pretty short.

22 **The Court:** As I understand, Dr. Cooler will
23 testify if Dr. Henniford does not. But if Dr. Henniford
24 does, then Dr. Cooler will not. Am I correct in that, Mr.
25 Sweeney?

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1 **Mr. Sweeney:** We will have to decide that
2 truthfully, Your Honor. We will be prepared for either Dr.
3 Henniford, Dr. Cooler, or both. But beyond that, that
4 probably will be it.

5 **The Court:** I am not trying to pen you down.
6 Just trying to make sure that I understand what remains
7 before us.

8 **Mr. Sweeney:** Thank you, Your Honor.

9 **The Court:** Yes, sir.

10 (Whereupon, the fifth day of trial ends at
11 5:20 p.m. on Monday, November 13, 2006.)
12

(Whereupon, The Court comes to order at
10:13 a.m. on Tuesday, November 14, 2006.)

DAY SIX OF TRIAL**Motions**

The Court: Counsel, I know there will be some
Motions at the end of all the evidence. I am advised that
we are at the end of the evidence, and that the Defense
will not call any further witnesses. I am further advised
that there is no reply testimony. Am I correct, Mr.
Driggers?

Mr. Driggers: Yes, sir, Your Honor.

The Court: And, Mr. Corbin?

Mr. Corbin: Yes, sir.

The Court: All right. Now, what I will ask the
Defendant to do at this point is to note your Motion and
the basis or bases for the Motion, and then rather than
argue it, we will give you a later time to do that.

Mr. Driggers: Thank you, Your Honor. Because
this is the close of our evidence, close of the case, under
Rule 50 renew our Motion for a Directed Verdict based on
largely the same arguments that were recited earlier for
The Court at the close of the Plaintiff's evidence. And I
would think there is nothing to strengthen those arguments,
but we would renew for each one of those bases that we made
earlier at the close of the Plaintiff's case, again, to

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1 reserve the record, a Motion for Directed Verdict at this
2 point at the close of the Defendant's case.

3 **The Court:** All right, that Motion noted for the
4 record. Anything further?

5 **Mr. Driggers:** Yes, sir, Your Honor. We would
6 move to strike Plaintiff's prayer for punitive damages. We
7 believe that The Court and the jury have heard evidence,
8 all of the evidence in the case. And there was no evidence
9 that that would rise to the level of reckless, willful, or
10 wanton conduct which is the standard under South Carolina
11 Law. And going above that, there would not be any
12 evidence, clear convincing evidence to support that. For
13 those reasons we would ask The Court to strike the prayer
14 for punitive damages in addition to strike or give some
15 instruction for the testimony of Doctor Oliver Wood, that
16 the other information that was presented to the jury just
17 for that purpose.

18 **The Court:** The Court is going to go ahead and
19 rule on that because that is necessary for final arguments.
20 I am going to deny your Motion.

21 The question at this point is not whether there
22 is absolute proof of it, but whether there is evidence
23 sufficient to submit the issue of punitive damages to the
24 jury. I find there is sufficient evidence to allow that
25 issue to go forward to the jury. And I deny your Motion.

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1 **Mr. Driggers:** Thank you, Your Honor.

2 **The Court:** All right. Now anything from the
3 Plaintiff at the close of all the evidence?

4 **Mr. Corbin:** Nothing involving that. But I do
5 want to raise one quick issue.

6 **The Court:** Yes, sir.

7 **Mr. Corbin:** With respect to the Adverse
8 Inference, the film of Carolina Pines involving the damage
9 to the spleen consistent with lacerations. I asked Dr.
10 Mincheff about that. He said, no, there is no proof of
11 lacerations. If Your Honor recalls that whole line of
12 testimony.

13 When Dr. DeMaria testified, if you recall, Mr.
14 Sweeney made a point, Dr. DeMaria you never actually have
15 seen the film, have you? He said, well I really wouldn't -
16 -- I would like to read it. You have not really seen it,
17 have you, you have not seen that film?

18 Mr. Sweeney was aware that I had subpoenaed that
19 particular document. This Court ordered the hospital to
20 produce that particular document, and they did not produce
21 it.

22 I would think at the very least, Your Honor,
23 would give me an adverse inference ruling on that.

24 **The Court:** Response?

25 **Mr. Driggers:** Yes, sir, Your Honor. This was

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1 discussed prior to the beginning of the case. As The Court
2 is well aware Ms. Person was transferred from Carolina
3 Pines Hospital to Richland Memorial. Those films went with
4 her. The originals went with her at the time that she
5 went. And that's where they were --- We even called and
6 contacted Richland. And that is what we were told that
7 they are the ones that received them, but they were not
8 able to give them to us. I instructed Mr. Corbin of that
9 before the trial that that was where the location of those
10 films were.

11 **Mr. Corbin:** Your Honor, we subpoenaed those
12 films from Palmetto Richland. They don't have them.

13 **The Court:** All right, just one moment. I have
14 an issue I want to discuss.

15 All right. Let's go back to another issue where
16 we had requested an adverse inference. The Court is not
17 going to --- Well, before I rule, let me explain to our
18 students who are here with us this morning.

19 Again, good morning, and welcome, ladies and
20 gentlemen to the courtroom. There is a Rule in the law
21 that says that if a party is unable to produce certain
22 evidence that is within their custody and control, and the
23 evidence becomes pivotal, and there may be a question as to
24 whether or not that evidence is damaging, and that is the
25 reason the other party producing it, then the side

1 requesting that may receive what is called an adverse
2 inference charge, which is basically where the jury is told
3 the party can't produce it. And you may infer from the
4 facts that the information would be damaging if they did
5 produce it, simply because they didn't produce it when they
6 were ordered to do so. This is what this discussion is
7 about.

8 We have had adverse questions on several issues
9 that have arisen in this case. I am going to allow you in
10 your closing argument, Mr. Corbin --

11 **Mr. Corbin:** Yes, sir.

12 **The Court:** -- To broach the issue with the jury
13 about the finances at Carolina Pines, that they were not
14 produced pursuant to your request. They were not produced
15 pursuant to Court Order. I believe it is only appropriate
16 that that be allowed, based on the fact that the evidence
17 was not produced as requested.

18 Now, the Plaintiff has already had, one benefit
19 here in that The Court has allowed the medical information
20 of a parent-company, the financial information of the
21 parent-company, HMA, to come into evidence. But I will
22 also allow you to go into the issue that Carolina Pines
23 information was not produced. And the reason, the specific
24 reason I will allow is because Mr. Sweeney inquired of Dr.
25 Wood on cross examination about the fact that he had not

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1 seen, Dr. Wood had not seen the specific Carolina Pines
2 financial information.

3 For that reason, I believe your argument would be
4 appropriate on that point. The Court is not going to raise
5 this to the level of a charge or comment by The Court. I
6 am going to allow you to do it. All right.

7 **Mr. Corbin:** Your Honor, would that also equally
8 apply to the other instances about not producing records?

9 **The Court:** The Court does not believe that ---
10 We have had a substantial discussion about this in
11 Chambers, that the records have become an issue to the
12 extent that the finances have. The records, although, and
13 specifically what Mr. Corbin is speaking about are records
14 of past Nissen Funduplications performed by Dr. Mincheff at
15 Carolina Pines. I am advised that there have been some
16 records that have been transmitted from Carolina Pines. I
17 don't believe that this has become an issue, because
18 Carolina Pines did not produce records favorable to them
19 into the evidence in this case, which then would not beg
20 the question, well, what about the ones that aren't
21 produce, perhaps they were negative. I just don't find
22 that that is an issue as presented in the evidence. And I
23 will not allow you to go into that argument in your final
24 argument to the jury.

25 **Mr. Corbin:** Your Honor, the last point was that

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1 particular CT Scan, which I think was a major point against
2 my sole medical expert witness.

3 **The Court:** What do you have, evidence do you
4 have about where it went? I know Carolina Pines says,
5 well, we had it, but we sent to Richland, and it is gone.
6 What information do you have about that?

7 **Mr. Corbin:** We subpoenaed Carolina Pines'
8 records. They sent us information that they say they don't
9 it. They said they sent it to Richland Memorial Hospital.
10 I believe under the law they had to keep a copy of it. We
11 then subpoenaed the records from Palmetto Richland, and got
12 an answer that they don't have it, they don't have that
13 document. Under the law, for ten years they are required
14 to keep that record. It just can't disappear.

15 **The Court:** All right. Tell me why you believe
16 that to be of such pivotal nature that you are entitled to
17 an adverse inference.

18 **Mr. Corbin:** Dr. DeMaria indicated that he felt
19 like Dr. Mincheff had injured Ms. Person's spleen during
20 the operation. The CT Scan at Palmetto Richland the day
21 after she got there indicated, she had injuries consistent
22 with lacerations. The CT Scan at Carolina Pines, before
23 she was transferred, indicated she had injuries consistent
24 with surgical trauma, or infarction.

25 Mr. Sweeney made a point, Dr. DeMaria, you have

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1 not actually seen that film have you, you don't know what
2 the film says, you didn't read that film. Made a big point
3 about it, knowing that they did not produce it.

4 **The Court:** Any specific reply to that, Mr.
5 Driggers or Mr. Sweeney?

6 **Mr. Sweeney:** Let me just state there is nothing
7 that has been withheld, there is no evidence withheld. It
8 was sent onto Richland Memorial Hospital. Dr. DeMaria's
9 testimony was more specific than what has been recited
10 here. He said it wouldn't help to have it anyway. He said
11 that if he had even looked at it, it doesn't show the kind
12 of things that a surgeon sees. It doesn't show the kind of
13 lacerations that we're talking about. That was his
14 testimony.

15 **The Court:** Just a moment, please.

16 **(Pause)**

17 **The Court:** Mr. Corbin, I have discussed this
18 further with my clerk, who also has a recollection of the
19 evidence. And of course there is a substantial amount of
20 evidence that has been placed into the record. I simply
21 don't find that this issue arises to the level of being
22 able to grant you an adverse inference.

23 I will tell you that The Court will reconsider
24 this if there are arguments from Defense during their
25 closing arguments that would somehow depict that in an

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1 unfair or inappropriate light, The Court will reconsider
2 before you have your final say to the jury. But at this
3 juncture, I just don't find evidence that Carolina Pines
4 who tells me in due course they sent this onto Richland.
5 Where it has gone, I don't know. But I just don't believe
6 it is appropriate to grant an adverse inference ruling at
7 this juncture.

8 **Mr. Corbin:** I understand. Thank you, Judge.

9 **The Court:** All right, very good. The last
10 thing I want to discuss with you-all is I'm told that today
11 in the Florence Morning News, there is an article in the
12 health and fitness portion about this surgery, not this
13 particular surgery in this case, but about the
14 Gastroesophageal Reflux Disease Surgery in general.

15 I thought I would inquire of the jury, if parties
16 wish me to, if you wish nothing then we will leave it just
17 as it is, but if you wish me to take up with them whether
18 any of them have read this, and then have some response to
19 it, I will be more than happy to do so. What says the
20 Plaintiff?

21 **Mr. Corbin:** Your Honor, I would say leave it
22 alone.

23 **The Court:** What says the Defense?

24 **Mr. Sweeney:** I would agree, with that, Your
25 Honor.

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1 **The Court:** Leave it alone?

2 **Mr. Sweeney:** Yes, sir.

3 **The Court:** Very good. I will tell you that one
4 of our jurors, and I don't know which one mentioned this to
5 Mr. Suggs. This is how it came to my attention. I got
6 here so early this morning that I have not seen the
7 newspaper. But the juror who mentioned this said they did
8 not read the article, they merely had seen the headlines,
9 and in the course of what I had told the jury did not read
10 the article. So I don't have any evidence of any juror
11 reading it. Is your position still the same, Mr. Corbin?

12 **Mr. Corbin:** Exactly the same.

13 **The Court:** Mr. Sweeney.

14 **Mr. Sweeney:** It is, Your Honor. May I seek
15 clarification on something you said earlier? You talked
16 about an inference upon letting him arguing in terms of the
17 financial information?

18 **The Court:** Yes.

19 **Mr. Sweeney:** Are you going to give a charge on
20 that in that regard or leave that alone?

21 **The Court:** No, sir, I'm not going to charge.
22 I'm simply going to let him comment that the information
23 was not produced by the Defendant.

24 **Mr. Sweeney:** I presume I have the right to say
25 something along those lines myself?

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1 **The Court:** Yes, sir, you may respond to it.

2 The Court is not going to get involved in that issue. I
3 will tell you, of course, the Plaintiff will have last
4 response on that, because of the way the arguments will be.
5 I am going to let the lawyers discuss it, but I am not
6 going to charge an inference, and not going to engage in
7 the discussion myself.

8 All right. Now, Plaintiff, how long do you
9 believe, your first argument will be?

10 **Mr. Corbin:** About an hour, Your Honor.

11 **The Court:** And how long do you believe your
12 sole argument will be, Mr. Sweeney?

13 **Mr. Sweeney:** No more than that, Your Honor.

14 **The Court:** Okay. Anything else for our record
15 before we bring in the jury?

16 **Mr. Corbin:** No, sir.

17 **The Court:** From the Defense?

18 **Mr. Sweeney:** No, sir, Your Honor.

19 **The Court:** Please bring in the jury.

20 (Whereupon, the jury comes into the
21 courtroom at 10:26 a.m.)

22 **The Court:** Good morning, ladies and gentlemen.
23 We last left the courtroom and there was more evidence.
24 You were advised there would be further witnesses.

25 Before we talk with the lawyers about that let me

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1 ask you, ladies and gentlemen, since we were last together,
2 has any member of this jury panel who has had a discussion
3 of the facts concerning this case, or who has been
4 contacted by anyone concerning this case? If that applies
5 to you, please raise your hand.

6 Let the record reflect that no one has raised
7 their hand. Thank you again for complying with The Court's
8 request. You have been here this morning as early as 9:00.
9 We gave you an hour break where you were able to leave the
10 courthouse. I apologize for those changes in schedule, but
11 that was unforeseen. And I didn't want you to sit in the
12 jury room and just sit there and twiddle your thumbs while
13 we had the charge conference and discussed some other
14 things about closing arguments.

15 Let me ask, in the presence of the jury, any
16 further witnesses from the Defense?

17 **Mr. Sweeney:** No, sir, Your Honor.

18 **The Court:** Any further witnesses in reply from
19 the Plaintiff?

20 **Mr. Corbin:** All right, then. Ladies and
21 gentlemen, testimony is closed. We are now at the point
22 where we will have closing arguments.

23 I will tell you, you will note that we have some
24 individuals who are not here in the courtroom this morning
25 observing. The Court did have a class from Hartsville High

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1 School, which was Ms. Kathy Hines' Law Class, Business Law
2 Class that she has brought here to the courtroom, who comes
3 annually to visit us. We welcome the students who are
4 interested in a legal career to the courtroom.

5 Now, it is now the time for the lawyers to come
6 before you in closing statements. I want to go back to
7 something I said when we first began, and that is this.
8 What the lawyers tell you in opening and closing is not ---
9 And let me stop here in the middle of this, you need your
10 pads, do you not?

11 Ms. Ruby, please give the pads to the jurors.
12 Thank you.

13 (Pause)

14 The Court: Very good. Let's go back to where
15 we began. What the lawyers tell you in closing, just as
16 what they tell you in opening, is not evidence. What the
17 lawyer says is not evidence. What the lawyers tell you is
18 their position on what they believe the evidence has shown.

19 They may argue to you any inference which is
20 deducible therefrom. But ladies and gentlemen, it is up to
21 you to determine what the evidence is again from what the
22 witnesses say, not from what the lawyer says. So, please
23 understand that.

24 The Plaintiff has the burden of proof, as we have
25 discussed throughout these proceedings. And for that

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1 reason, the Plaintiff is allowed to open and close final
2 arguments. Both sides have the same amount of time, but
3 the Plaintiff goes first in full. Then the Defendant goes,
4 the one argument the Defendant has in full. And then the
5 Plaintiff is allowed to close in rebuttal. Again, this is
6 because the Plaintiff has the burden of proof.

7 All right, with that understanding, The Court
8 recognizes Mr. Corbin for initial closing argument.

9 **Mr. Corbin:** Thank you, Judge.

10 **Closing Statement by Mr. Corbin**

11 **10:30 a.m.**

12 **Mr. Corbin:** The Defense told you, during
13 opening statements if you recall, that Dr. Mincheff could
14 get privileges to do Ruthie's surgery at any other hospital
15 in the country. Do you believe so?

16 The Defense, in opening statements, also told you
17 that Dr. Mincheff was just as qualified as the guy at Duke
18 to do Ruthie's surgery. Do you believe so?

19 Carolina Pines says that the most important goal
20 at the hospital involving credentialing, number one is
21 patient safety. Do you believe that is true at Carolina
22 Pines?

23 I want you to go with me to Carolina Pines.
24 Pretty building, walking down the hallway, we are headed
25 towards the Operating Room right ahead. On our way we see

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1 a poster, patient safety is number one.

2 As we approach the Operating Room, I am standing
3 in front of the doorway. On the left we have Dr. DeMaria,
4 and Ms. Voigt. On the right of the doorway we have Dr.
5 Barker and Ms. Enoch.

6 Dr. Mincheff is walking towards the Operating
7 Room. Ruthie is on the Operating Room table. Dr. Mincheff
8 stops in the doorway and asks permission for privileges to
9 operate on Ms. Ruthie. Who do you believe ought to be
10 making that decision, Dr. DeMaria and Ms. Voigt or Dr.
11 Barker and Ms. Enoch That is the question in this case.

12 Carolina Pines absolutely, under the law, owed
13 Ms. Person a duty to carefully evaluate and assist Dr.
14 Mincheff on education, training, and experience to insure
15 he could reasonably and safely do his surgery. That was
16 Carolina Pines' duty, it owes Ms. Ruthie.

17 Carolina Pines failed Ms. Ruthie. Dr. Mincheff
18 owed Ms. Person a duty, under his standard of care. His
19 duty was to avoid injury to her pancreas during the
20 surgery. Dr. Mincheff failed Ms. Person too.

21 If Carolina Pines has a duty to abide by its own
22 by laws involving credentialing and privileges. Ms. Voigt,
23 the Certified Credentialing Specialist, found thirty-eight
24 violations of Carolina Pines own by laws involving Dr.
25 Mincheff privileging.

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1 Carolina Pines by laws do contain the right words
2 to satisfy the Joint Commission. But Carolina Pines does
3 not apply the correct definition to those words.

4 Do you recall me asking Ms. Enoch, who I believe
5 is more than a clerk, can you define for me in the by laws
6 what these terms mean involving credentialing? Ms. Enoch,
7 what does it mean when it says, Carolina Pines must have a
8 physician prove, that he has performed a sufficient number
9 of these surgeries to obtain privileges?

10 The natural definition of those words, would you
11 not agree, involving a hospital setting would be operations
12 on a human being?

13 Ms. Enoch and Dr. Barker both stated, well, it is
14 kind of broad at Carolina Pines that means also operations
15 on pigs.

16 Under Carolina Pines' definition of what those
17 terms mean, Dr. Mincheff was qualified to do Ms. Person's
18 surgery, because he had gone to Duke for a couple of short
19 courses. He had heard of the professor and instructor talk
20 about this surgery. He had read some materials at Duke
21 about it. And he operated on two pigs..

22 After that experience, Dr. Mincheff goes to
23 Carolina Pines, and asks for permission to do this surgery
24 on a human being without any supervision.

25 Carolina Pines' standards are so low Dr. Mincheff

1 was given the privilege to do his very first operation
2 involving this Laparoscopic Nissen Fundoplication on a
3 human being at Carolina Pines. Does that standard impress
4 you? Are you going to demand a higher standard from this
5 community?

6 What sources can a jury consider to determine
7 what the standard of care was that Carolina Pines should
8 have obeyed?

9 Carolina Pines' own by laws would be a good
10 source. The Joint Commission Regulations, that the people
11 at Carolina Pines, has not even read would be a good
12 source. The literature that Ms. Voigt gathered analyzed,
13 and produced for you to read, every bit of it supports, Ms.
14 Ruthie's condition.

15 A physician, that wants to do this new type of
16 laparoscopic surgery, for the first time on a human being
17 has a learning curve of, at least, twenty operations.
18 During those first twenty operations the surgeon is more
19 likely to hurt a patient like Ruthie was hurt.

20 SAGES, a prominent group of physicians, who are
21 experts in doing this type of surgery, indicate you must
22 have a preceptor actually in the Operating Room with you
23 when his hands in her belly, so if you make a mistake he
24 can fix it.

25 Carolina Pines did not believe in the

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1 preceptorship process. It does not happen there. Does
2 that impress you? How in the world does policy, how in the
3 world does policies and procedures at Carolina Pines not
4 require any preceptor, or an expert physician helping the
5 novice promote patient safety. It is obvious. It does
6 not.

7 I believe that medical literature, text book
8 chapters, documents from the Department of Human and Health
9 Services in Washington, D.C. and Carolina Pines own
10 consulting documents are reliable, and are authoritative.

11 Ms. Voigt gathered the documents for you. She
12 laid them out, took her position, did not hide anything
13 from you. The Defense has said if you have something else,
14 anywhere else in the world written at anytime to support
15 Carolina Pines' position, please produce it.

16 It is mighty odd why in a case like this every
17 bit of literature in the world supports our position. Dr.
18 Mincheff, Dr. Barker, Ms. Enoch, and anybody from Carolina
19 Pines, I want you to believe nothing in the world is
20 reliable. Are you going to fall for that trick?

21 Remember the Greeley Guidelines. And you will
22 have all this evidence, once you go to deliberate you will
23 have this. I would ask you to take the time to look at the
24 Greeley Clinical Privilege White Paper. It is seven or
25 eight pages, but go to the next to the last page. That is

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1 a document that Carolina Pines own outside credentialing
2 consultant provides to its hospitals that it consults as to
3 the minimum requirements. Dr. Mincheff should have to do
4 Ms. Ruthie's surgery. We are not talking about the worst
5 standards in the world. It is the minimum.

6 The Greeley Company hired by Carolina Pines did
7 research, and incorporated in its research the SAGES
8 Guidelines published in 1992, 1994, 1998, long before Ms.
9 Person's surgery. The Greeley Company told Carolina Pines
10 Dr. Mincheff, or doctors like him, must do a minimum of
11 twenty-five Laparoscopic Nissen Procedures with a preceptor
12 to prove you can do it before you even qualify to do the
13 application. It says nothing about doing two pigs and that
14 is good enough.

15 Dr. Mincheff fails under the Greeley proposal.
16 Dr. Mincheff had done zero on a human being when he got his
17 first privileges in 1996. Do you recall every two years
18 the hospital has another chance, and a duty to carefully
19 reevaluate Dr. Mincheff? Each time Carolina Pines in 1998,
20 2000, 2002, and 2004, came to the conclusion that he had
21 enough experience to safely do it.

22 The Greeley Company's proposal in this case ---
23 and you got to maintain your competence doing this complex
24 surgery. You maintain your competence doing by actually
25 performing the surgery. Do you recall Ms. Enoch, her

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1 competence really has nothing to do with doing the surgery?
2 It was just --- we went to a class somewhere. Do you
3 believe that?

4 Greeley indicates when you reapply every two
5 years, unless you have done, at least, ten more during the
6 previous year, automatically from the get-go your
7 application is rejected, not even considered.

8 Under Carolina Pines' own consultant, even today,
9 Dr. Mincheff would not be going in the Operating Room doing
10 Ms. Ruthie's surgery on anyone. Does that information
11 bother Carolina Pines? Apparently not.

12 What standard of care applies to Dr. Mincheff?
13 In this case, it is commonly called negligent
14 credentialing. Or in some states it is called a corporate
15 negligence type of claim against a hospital. We are
16 dealing with a corporate hospital.

17 Under the negligent credentialing cause of
18 action, Ms. Person must show that Carolina Pines was
19 negligent, or careless in granting Dr. Mincheff, privileges
20 to do her surgery, step one.

21 Step two, to prove her damages, she must indicate
22 or produce evidence what Dr. Mincheff did wrong to her.

23 Dr. DeMaria, who is the Department Head at Duke
24 University Medical Center, involving its Minimal Invasive
25 Surgical Center, indicated to you Dr. Mincheff was grossly

1 inexperienced. He did not have a preceptor helping him.
2 He started doing Ms. Person's surgical procedure, Dr.
3 Mincheff encountered difficulties. The operation should
4 taken fifty minutes or an hour or so, and it took Dr.
5 Mincheff almost five.

6 Dr. Mincheff started as he was required to do
7 under the informed consent to do the laparoscopic
8 procedure. After about an hour and a half into this
9 process, Dr. Mincheff is calling out for the nurse
10 immediately, get a scalpel, we need to open the patient, we
11 need to do the traditional open procedure.

12 The records indicate that during this chaos when
13 Ms. Ruthie was laying on the table, for whatever reason she
14 had a sudden blood loss during this procedure of about 1300
15 ccs of blood. Dr. Mincheff does not want you to believe
16 that he lacerated or injured the spleen.

17 Dr. DeMaria said the pancreas is not a bloody
18 organ. It has lots of bile in it. If you break that
19 tissue, the bile will eat up your insides, and cause lots
20 of problems. But the spleen is a different type of organ.
21 It is filled with blood. If you clamp off a spleen, punch
22 a hole in it, if you take a scalpel and slice it on three
23 sides you are going to get some blood.

24 What was a normal estimated blood loss from a
25 competent surgeon doing Ms. Person's surgery? Dr. DeMaria

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1 said 50 ccs, maybe as much as 100 cc's of blood. Ms.
2 Person lost about twenty to forty times that much. She
3 lost about 40% of the blood in her body.

4 Dr. Mincheff's assistant, Dr. Bannister did not
5 know how to do the laparoscopic procedure. Dr. Mincheff,
6 according to Dr. DeMaria panicked. He was inexperienced.
7 From what he did, he caused lots of blood loss. He was
8 clamping and suturing. He injured her spleen. And he
9 injured the tail of her pancreas.

10 The horrible part is, that Dr. Mincheff instead
11 of carefully inspecting the sources of all these blood
12 losses, or inspecting the critical organs, that if they are
13 injured you can die and sew her back up.

14 Dr. DeMaria indicated that an experienced surgeon
15 at that point and time, in about ten minutes if he is
16 competent, could have fixed Ms. Ruthie, and we would not be
17 here.

18 Dr. Mincheff failed to satisfy the standard of
19 care required of him to do the surgery, and avoid injury to
20 Ms. Ruthie's pancreas and spleen. In addition, he failed
21 to meet what was required of him under the standard of
22 care, by not recognizing these complications when he should
23 have. He easily could have corrected it if he knew how.
24 He failed to meet the standard of care.

25 Ruthie, under the law, is required to prove that

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1 Dr. Mincheff proximately caused her injuries. In other
2 words, the Judge will tell you that means, was Ms. Ruthie's
3 type of injury foreseeable. Rather odd word.

4 Do you remember I asked Dr. Barker, if you don't
5 do credentialing properly, would you agree that it is
6 foreseeable that a patient could be hurt from it? And his
7 answer was, yes. We have proven foreseeability.

8 Was it unforeseeable when Dr. Mincheff did Ms.
9 Ruthie's surgery, that if you injure the tail of her
10 pancreas and her spleen, you are going to cause her
11 damages? We have prove foreseeability in this case.

12 Another test, that the Judge will tell you about,
13 involving proximate cause is commonly called the but for
14 analysis. In other words, we contend but for Carolina
15 Pines giving Dr. Mincheff privilege, Ms. Ruthie would have
16 never been hurt.

17 But for Dr. Mincheff hurting Ms. Ruthie's
18 pancreas and spleen, she would have never been hurt. Ms.
19 Ruthie has proved proximate cause of damages.

20 I take my job very seriously. I hope during the
21 last week that I have built up some faith and confidence
22 from you. I have done nothing to hide anything from you.
23 I have done everything I know how to bring the evidence to
24 you, and asked questions that I believe you would consider
25 relevant in this case.

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1 I am asking you to trust me that Ms. Ruthie has
2 proven that Carolina Pines was negligent in granting Dr.
3 Mincheff privileges, and Dr. Mincheff was in a position to
4 hurt Ms. Ruthie because of that negligence. I am asking
5 you to accept that.

6 What is fair compensation for Ruthie? What
7 elements of damages can a jury consider, and it is a
8 difficult task. My job is almost done. The easy part of
9 your calculation of what is fair involves Ruthie's medical
10 expenses. Instead of \$10,000 in medical expenses, if Dr.
11 Mincheff would have been competent doing this surgery, her
12 medical bills approached \$700,000. That calculation is
13 easy.

14 Ms. Ruthie's monthly cost, because of what
15 Carolina Pines and Dr. Mincheff did to her, involves adult
16 diapers, baby wipes that her daughter has to use because
17 she has a little bit of trouble reaching back there,
18 special nutritional drinks, because you see, she can't eat
19 like you and me. B-12 vitamin shots she has to inject into
20 herself, and prescriptions for medications for the rest of
21 her life, however long that may be.

22 In evidence is Ms. Ruthie's damage summary, that
23 indicates these items alone are about \$277 a month, or
24 \$3,300 a year. If you believe Ms. Ruthie has any permanent
25 damage at all, scars, emotional distress, disability, you

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1 are absolutely entitled to consider what the Judge will
2 tell you. South Carolina considers her life expectancy.
3 The Judge will tell you when you consider Ms. Ruthie's
4 damages, it is appropriate to consider an additional
5 thirty-three years.

6 Ms. Ruthie's wheelchair and special lift. She
7 has a seat at her home, so she can get up and out of her
8 chair, cost another seven thousand dollars.

9 The bottom line of the easy calculation is that
10 Ruthie's past, present, and future expenses are
11 approximately eight hundred thousand dollars.

12 We are getting into more difficult areas. A jury
13 must decide what is fair to compensate Ruthie's pain and
14 suffering. What is reasonable compensation for another
15 thirty-three years of Ruthie's torment? Ruthie's stomach
16 burns all the time. It hurts Ruthie to walk. You know
17 they had to take out the muscle from her leg to hold her
18 stomach back inside of her body, and now she does not walk
19 too well.

20 Her abdominal wound is getting a little bit
21 worse. The incision is coming apart. She is not a
22 candidate for anymore surgery after what's happened to her.
23 She is too much of a risk. The white portion, you see in
24 that photograph are her intestines.

25 Dr. DeMichele, a great compassionate human being

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1 of a doctor, and Ruthie's friend, told you he has treated
2 her for a long time. And he can look at her photographs,
3 and it is difficult to tell what you are looking at,
4 because she is so distorted. She is so disfigured.

5 It does not get any better than this for Ruthie.
6 It will get worse, but it will never get better. Ms.
7 Ruthie said, and Lori, what a dear daughter, Lori was
8 cleaning mama's wounds, it was a tough task to do. She
9 sucked it up and did it. But you know her mamma was in so
10 much pain, so much pain, and the smell was so bad. Now you
11 tell us what is fair.

12 Now, I have had the honor to have been an
13 attorney for about twenty-years. I have worked hard. I
14 did well in school. I went to law school. I came back to
15 help people. I spent a little time in Greenville. I have
16 seen lots of things. I have seen people hurt. But I can
17 tell you I don't of many people in the world, who have
18 suffered as much as this dear lady.

19 Ruthie used to always enjoy the Holidays. Ruthie
20 has a couple of adult children and three young grand
21 babies. Christmas time was always special to her. She
22 would go to her church and decorate the sanctuary. She
23 would cook for the members of her church. Christmas time
24 at Ms. Ruthie's house before this operation was very
25 special. Grand babies all over the place. Sitting on the

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1 floor opening gifts, playing with her grandchildren. Those
2 times are gone.

3 Ms. Ruthie used to like to go to church. Lori
4 and her mamma went to church one day, and you know Ms.
5 Ruthie had a colostomy bag. She had an accident. What is
6 fair compensation for her suffering? What is fair
7 compensation for anybody who wants Ms. Ruthie's job?

8 All of the time people will determine what is a
9 fair wage for somebody to do something unpleasant. What is
10 a fair wage to pay someone to sit in that chair?

11 Recall Dr. Oliver Wood's testimony. And, you know,
12 if you are proud of who you are --- The first thing out of
13 my mouth was in opening, I am proud, I represent Ms.
14 Person, no one else.

15 The people at Carolina Pines when they testified
16 did their best to try and persuade you that Health
17 Management Associates, Inc. really does not control
18 Carolina Pines.

19 I, under the law, have a right, and I believe a
20 duty, to use the power that I have to issue subpoenas. A
21 subpoena requires a party to produce the items that I
22 requested. If the party does not want to produce those
23 items, it can file a Motion with The Court, and say, please
24 don't make us produce this stuff Mr. Corbin wants. But The
25 Court also has a lot more power than I do to Order under

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1 full force of this Judicial System, a party to produce
2 something.

3 I issued a subpoena to Carolina Pines Regional
4 Medical Center requesting that they produce for me their
5 financial data. I issued a subpoena to Carolina Pines to
6 produce for me its income tax returns. You see, Ms. Person
7 and I have the duty to produce enough evidence to satisfy
8 you of what the net worth or the ability to pay of the
9 Defendant is.

10 I know of no other way I can get that information
11 from Carolina Pines other than issuing a subpoena, and
12 relying on the Court Order that you produce that. Carolina
13 Pines produced nothing about its financial condition. That
14 is why Dr. Wood, who is not cheap, was hired to help you
15 understand what Carolina Pines really is. Because Carolina
16 Pines violated the subpoena and the Court Order, Dr. Wood
17 was allowed to testify. Thank goodness Dr. Wood knew where
18 to look. You can't hide public records of the FEC.

19 Dr. Wood gathered and analyzed years of Health
20 Management Associate, Inc's financial data. Low and
21 behold, HMA merely uses the name Carolina Pines Regional
22 Medical Center to do its business. Dr. Wood told you,
23 after reviewing Mr. Castleberry's Deposition Transcript and
24 watching the video, and reviewing all the public records
25 that he could get, in his opinion, Carolina Pines is HMA.

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1 Why do you reckon the people I had deposed worked
2 so hard to avoid the answer to that question, who controls
3 Carolina Pines? I wish Carolina Pines spent more time
4 protecting its patients than taking care of its
5 corporation.

6 Dr. Wood told you, when you consider the ability
7 to pay of HMA, one good source to look at is how much do
8 they pay their people to work for a year. Is it fair to
9 consider what HMA pays its Chief Executive to work for a
10 year? Well, you consider what is fair to pay Ms. Ruthie
11 for the hard work she is going through.

12 Mr. Schoen, Chairman of the Board of Directors,
13 HMA, Inc., is in the corporate office in Naples, Florida.
14 You will not see him here.

15 Dr. Wood indicated that HMA felt reasonable
16 compensation for Mr. Schoen in 2005, was one million
17 dollars a year. Mr. Schoen earned every nickel of it. In
18 addition to the one million dollars pay Mr. Shawn also had
19 an additional twenty-six million dollars in HMA stock
20 options in just one-year, 2005. He earned every nickel of
21 his twenty-seven million dollars. On top of the twenty-
22 seven million dollars Mr. Schoen, and we are just talking
23 about one of many executives, also was given the right by
24 HMA to exercise anytime he wants another fifty million
25 dollars in stock.

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1 Do you reckon Mr. Shawn would trade places with
2 Ruthie? You decide what amount is just, and to fully
3 compensate Ruthie for thirty-three years of pain and
4 suffering.

5 What is the fair value of Ruthie's loss of
6 enjoyment of life? The Judge will tell you it is totally
7 appropriate for you to consider what the law calls the loss
8 of enjoyment of life.

9 Grandparents have some other terrific times with
10 their grandchildren. Ms. Ruthie loved Grandparent's Day at
11 school. It is very important to the grand kids. Grandma,
12 Grandparent's Day next week at school. Ms. Ruthie really
13 used to enjoy that. Grandma, please please don't go with
14 me, you look funny. Grandma, you embarrass me. Please
15 don't go with me to Grandparent's Day at school.

16 Ruthie is a strong person, but no one can take
17 pain time after time after time. Ms. Ruthie's pain will
18 never go away. And she thought about suicide as a way to
19 make it stop.

20 Thank God for Dr. DeMichele. Dr. DeMichele said,
21 he is all Ruthie has got. He scolded Ruth, don't hurt
22 yourself, don't do it, don't kill yourself. Remember
23 Ruthie's testimony, I thought about doing it, but I
24 couldn't. Not because she is scared to die. I suspect she
25 is looking forward to it. But because she did not want to

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1 hurt her family, and embarrass her grand kids. What is
2 fair compensation for that? Under the law, Ruthie is
3 entitled to fair compensation, and that is all we are
4 asking for, for her disfigurement.

5 I suspect the Defense, when they have their
6 opportunity to talk to you, will mention Ruthie was
7 disabled before Dr. Mincheff was given permission by
8 Carolina Pines to operate on her.

9 We have hid nothing from you. Ruthie was
10 disabled before this happened. If you believe her
11 injuries, those photographs, her belly burning, the
12 colostomy bag, and her suicide thoughts, were caused by
13 papillary necrosis, chronic fatigue, and Sickle Cell
14 Traits, take those out of there. I am not asking you for
15 that. I never have. I never will. Do not include any
16 calculations in your thought about damages, anything in the
17 world about papillary necrosis, chronic fatigue,
18 Fibromyalgia, or Sickle Cell Traits. Throw it out.

19 Emotional trauma and anxiety is another element
20 that you are entitled to consider involving actual damages
21 to Ms. Ruthie. Emotional trauma and anxiety.

22 I believe in angels and I have proof. That dear,
23 little lady, two or three-year's old. Her name is Kia.
24 Grandma, came home from Columbia, she had an open wound in
25 her stomach. Exhibits 10 and 13, you can look in there and

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1 see her intestines. You can look in there and see her
2 organs. Her belly was open. This angel would help Ruthie,
3 who she called Mamma, clean her open wound. We are talking
4 about a little girl. The other grandchild was afraid of
5 Ruthie. Kia would help Mamma.

6 The testimony was that Ms. Ruthie would have
7 nightmares. She would scream in terror, don't hurt me
8 anymore, don't kill me Dr. Mincheff, please. The little
9 girl would get out of her bed and comfort Mamma. She would
10 rock her like a baby, it will be all right, Ma'am, it will
11 be all right, Mamma, I love you. Little Kia wanted to do
12 something for Ruthie, Ruth said. Little Kia said, Mamma, I
13 made something for you, my doll looks like you, Mamma, I
14 want you to have my doll. Pretty good job for a two or
15 three-year-old. She got the leg wound, the iv sites, the
16 tracheotomy, that is on here, he bandage over the belly.
17 That little girl used a balloon for Mamma's colostomy bag.
18 Ruthie said, that is how my baby loves her Mamma.

19 You know, parents understand, and grandparents
20 too, that little children, four, five, K, first, second,
21 third grade, it is a big deal to them when you draw
22 pictures of your loved ones. Little children hang those
23 pictures in the hallways of their school.

24 Why has Ruthie fought so hard to get here? Who
25 would have the strength to fight HMA worth billions of

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1 dollars? Ruthie told you, and I want you to believe it, we
2 are here to save lives. Ruthie and I cannot save lives
3 without your help. Ruthie cannot even get the attention of
4 the Florida executives to come to the courtroom.

5 I guarantee you, with me off the team, because
6 I'm leaving soon and you are taking my place, Ruthie and
7 you can get the attention of HMA.

8 We have a major patient safety issue at Carolina
9 Pines, and cannot even get HMA's attention. I ask you to
10 use Ms. Ruthie's pain and suffering, scarring, disfigured
11 body as a tool to save lives. If your verdict speaks loud
12 enough for HMA to hear you, you will save lives. Ruthie
13 asks you to help prevent anyone else from suffering like
14 she does. Because a hospital recklessly failed to properly
15 evaluate a surgeon's training, education, and experience,
16 and let him do an operation that hurt a patient.

17 May we talk about punitive damages? That is why
18 we are here. Give her dollars and actual damages. That is
19 all it takes. We are here asking you to award punitive
20 damages in this case. The purpose of punitive damages is
21 to vindicate Ms. Ruthie's right as a human being. She is
22 not a guinea pig. She is not another body to learn how to
23 do an operation. If you believe that the evidence that
24 Ruthie presented was clear, and you are convinced that what
25 Carolina Pines did was wrong, she is entitled for you to

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1 consider punitive damages. I don't think anything can be
2 more clear and convincing when you go from two pigs to a
3 human being.

4 The purpose of punitive damages is to punish the
5 misconduct of someone who hurts someone else. The purpose
6 of punitive damages is to set the example so that other
7 hospitals will take steps to avoid another patient being
8 hurt like Ruthie.

9 Your decision today can change practices in sixty
10 hospitals, if you decide to award punitive damages to set
11 the example, in an effort to do all that you can do to save
12 lives, you can set the example not only for HMA's sixty
13 hospitals, but other hospitals. Not that everybody has
14 done what HMA has done in this case. But a wake-up call.
15 This is serious business.

16 Do you believe credentialing and privileging at
17 Carolina Pines is a serious endeavor? I think not. It
18 sounds good to say that we are concerned about patient
19 safety. It sounds good to say credentialing and
20 privileging is the most powerful tool we have. Carolina
21 Pines and HMA are not serious about credentialing.

22 How do you determine an appropriate amount for
23 punitive damages to effectively save lives? The Court will
24 tell you that Carolina Pines' ability to pay is appropriate
25 for your consideration.

1 What can you do to make punitive damages
2 meaningful in this case? I told you in Opening Statements
3 and warned you that I had to take you into Ruthie's world.
4 I gave you a heads-up. It would not be pleasant. And I
5 told you we were going into Ruthie's world.

6 We are going to a better place now, because when
7 you decide an appropriate amount of damages we leave
8 Ruthie's world and go to HMA's world in Florida.

9 You will have Doctor Wood's chart in
10 deliberations. But let's talk about HMA's world. Dr. Wood
11 told you that every week HMA makes profits of ten million
12 dollars. Dr. Wood told you that every week in the bank in
13 Florida HMA is so good at making money that it has about a
14 hundred and thirty-five million dollars in cash and cash
15 equivalents.

16 In other words, it sits there in deposit bonds
17 and money market accounts. A hundred and thirty-five
18 million dollars that was certificate deposits.

19 Dr. Wood told you that, in his opinion, HMA was
20 worth in excess of four billion dollars. The executive
21 compensation of Mr. Schoen was twenty-six million dollars
22 last year. How in the world do you get a billionaire's
23 attention? You know, people that have lots of money, and
24 billionaires like to look at pretty things.

25 Recently in Los Vegas, Steve Winn, a billionaire

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1 accidentally punched a hole into a hundred and thirty million
2 dollar, and he's a billionaire. Recently at an auction in
3 New York, someone sold a Picasso painting, very pretty,
4 very expensive, twenty-five million dollars. If you can
5 afford the race horse, and if you are a billionaire it will
6 set you back ten or fifteen million dollars.

7 I don't know if HMA headquarters in Naples,
8 Florida has Picasso's, or a multi million dollar Remington
9 bronze in its offices. But what I can tell you, and I
10 know, if they wanted it, they can afford it.

11 The Defense has an opportunity to do its Closing
12 Arguments. And during that argument ask yourself some of
13 these questions. If Dr. Mincheff was qualified to do Ms.
14 Ruthie's surgery in any other hospital in the country, why
15 didn't somebody from the other fifty nine hospitals come
16 and tell you about it.

17 If the Credentialing and Privileging Policies and
18 Procedures, those are good, but if they are practices at
19 Carolina Pines, are appropriate, why not a Credentialing
20 Specialist from, at least, one of the other fifty nine
21 hospitals. And sometimes, it tells you a lot because other
22 people don't testify.

23 The letters of recommendation. Remember Ms.
24 Voigt indicated that Dr. Mincheff was talking about letters
25 of recommendation. You had better have those in your

1 credentialing file. You had better have letters in your
2 credentialing file stating, I am qualified to do this
3 particular surgical procedure, and I know for a fact
4 because I have seen Dr. Mincheff do it, he can safely do
5 that surgery. That is an appropriate letter of
6 recommendation. Dr. Mincheff, no one else who knows your
7 surgery from anywhere will testify from the witness stand
8 that he did an appropriate job, will they? No one did.

9 Dr. Mincheff in 1996, 1998, 2000, 2002, and 2004,
10 five opportunities for you to have letters of
11 recommendation, written by somebody who is willing to come
12 forward and say, you can do the operation, and do it
13 safely. Where are those people? I don't think they have
14 anyone.

15 Dr. Mincheff, you don't have these letters. Can
16 you tell the jury who these people are that recommended
17 you? He can't do that either.

18 Ask yourself this question. Why didn't HMA
19 produce an expert witness, from one of this other fifty-
20 nine hospitals to talk about Dr. Mincheff's standard of
21 care? Why didn't they produce a Credentialing Specialist
22 like Ms. Enoch from one of its fifty-nine other potential
23 hospitals to testify to you?

24 I will have another chance after the Defense make
25 their closing arguments. I appreciate your time.

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1 **The Court:** Ladies and gentlemen, we are going
2 to take a break at this time. Please remain where you are
3 while our jury departs to the jury room.

4 (Whereupon, the jury exits the courtroom at
5 11:37 a.m..)

6 **The Court:** Ladies and gentlemen, The Court is
7 going to be in recess now approximately ten minutes. There
8 are restrooms out in the hall if y'all wish to take a
9 break. The Court will now be in recess.

10 (Whereupon, the Court takes a recess from
11 11:37 a.m. until 11:52 a.m.)

12 **The Court:** All right. Yes sir, Mr. Sweeney.

13 **Mr. Driggers:** We just want to note one
14 objection for the record. That would be the portion we
15 believe portions of Defense counsel's argument was
16 improper, under the case of Durham verses Vinson, any
17 reference to failure to provide something from his
18 credentialing file. It's specifically addressed by The
19 Court is that case. And that is the exact same
20 circumstances addressed in that case. We believe that was
21 done at the end portion Plaintiff's counsel's argument, for
22 the record, we want to note our objection.

23 **The Court:** All right. Do you have any response
24 to that, Mr. Corbin?

25 **Mr. Corbin:** Just briefly. The issue was that.

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1 Dr. Mincheff certainly would know outside of MEC meetings
2 who these people were, and they produced nothing.

3 **The Court:** All right. You objection is noted.
4 What are you asking This Court to do, or simply noting?

5 **Mr. Driggers:** Simply noting an objection, Your
6 Honor.

7 **The Court:** Very good. Are we ready for the
8 jury? Please bring in the jury.

9 **Mr. Sweeney:** We are, Your Honor.

10 **The Court:** Please bring in the jury.

11 (Whereupon, the jury comes into the
12 courtroom at 11:26 a.m.)

13 **The Court:** All right. Ladies and gentlemen,
14 welcome back. Let me talk to you just one moment about
15 heat, or lack of heat in the courtroom. We have turned the
16 system off. The system, the heat within the building is an
17 entire building system. That heat is not on today. It is
18 not available so we cannot turn the heat on in the
19 courtroom. But we did turn the fan off, so hopefully it
20 will be more pleasant. If there is anyone who needs a
21 jacket or something from the jury room, you are welcome to
22 get it. I see some of you already have it.

23 All right. As you will recall as I said, we will
24 start with the Plaintiff, then the Defense. The Court
25 recognizes Defendant's counsel for closing statement.

Closing Statement by Mr. Sweeney

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1 **Mr. Sweeney:** Thank you, Your Honor. May it
2 please The Court.

3 **The Court:** Yes, sir. Mr. Sweeney, let me get
4 you to speak up, if you will, sir. Remember you are faced
5 away from our court reporter. Thank you.

6 Closing Statement by Mr. Sweeney

7 11:50 a.m.

8 **Mr. Sweeney:** Good morning. I can just barely
9 say that this time has gone by. I want to thank you so
10 much for your attention in this case, the courtesy you have
11 shown to the witnesses, and the lawyers in this case, and
12 for your time. And I know that is not easy. I know there
13 are other places that you had rather be. And I know that
14 things have moved slowly and laboriously. To the extent
15 that I am at fault for that, but I apologize. I thank you
16 so much for the services you are rendering here today.

17 The burden, representing Carolina Pines Hospital
18 for a couple of years now. But this case has given us an
19 opportunity to see them in a light we don't always get to
20 do that just as lawyers. We have had a chance to deal with
21 various surgeons involved in this case. We have had a
22 chance to deal with the staff personnel. We have had a
23 chance to deal with the management of the hospital in this
24 case. And I can tell you, we are talking about a group of
25 compassionate and caring people, who are also very

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1 professional in what they do. I want you to know it is a
2 privilege in representing them in this case.

3 This case is a search for the truth. And this
4 case is going to be based on compassion, and warm feelings,
5 and concerns, and things like that. And we are kind of
6 wasting our time. We have to be seekers of truth to begin
7 with to make the system work. Otherwise, it would simply
8 be a system dependant upon who comes before you and tells
9 the saddest story.

10 There are sad aspects to this case. But that is
11 not what this case is about. This case involves
12 allegations made against the same surgeons and staff people
13 that I was telling you about, and these allegations have to
14 be proven. There is an obligation, on the part of the
15 Plaintiff, to prove the things against my client in order
16 to recover anything. To do that, they have to present to
17 you truth. Not just characterizations of truth, not just
18 the way they like to phrase things.

19 In that regard, the evidence in this case comes
20 from the witness stand, not from the lawyers involved in
21 the case. It does not come from the way we ask the
22 questions. But it comes from the things that the witnesses
23 themselves say. You have had a chance to view the
24 witnesses in this case, and see for yourself how they
25 respond to questions they have been asked. You have had a

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1 chance to evaluate them, as to, do you think they are
2 telling you the truth. And you have had a chance to weigh
3 what they have said, to decide if what they have said makes
4 sense to you.

5 Let me tell you what this case is not about, but
6 it raises an interesting question. This case is not about
7 whether you would like to have Ms. Voigt and Dr. DeMaria
8 making your medical decisions for you. Instead of the
9 people who live in this community and care about you, and
10 work hard every day, and see you in the street, or wherever
11 else it may be, in their churches, wherever else it is that
12 they go.

13 But it is interesting that counsel used that as
14 an example. You should hope if you are being wheeled down
15 the hallway to be operated on at Carolina Pines Hospital,
16 you should hope that the people making the decisions for
17 you, helping make those decisions are people who care about
18 you, people who live in your community, people who are
19 familiar with the people who are going to operate on you,
20 who know their skills, who know their abilities.

21 We should hope that those are the people making
22 the decisions for us, and not paid professional experts
23 like Ms. Voigt and Dr. DeMaria. I can tell you right now,
24 the surgeons involved in this case are not in this room,
25 because they are someplace else.

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1 Dr. Barker, who took a couple of days off so he
2 could be here, not knowing when he would be called, is
3 taking care of people in his family practice to the best of
4 his ability, and taking care of fifteen kids that he has
5 adopted who live with him. That is what he is doing in
6 this community.

7 Dr. Mincheff is with his sick wife, who has
8 cancer, and he is trying to tend to her today. And as soon
9 as that is over, he will be treating patients, taking care
10 of people in this community.

11 Dr. Bannister, is operating as we speak. He is
12 doing the best that he can, with the gifts that God gave
13 him, to do for his patients the things they need as best he
14 can.

15 Ms. Voigt is back at her office in Missouri
16 working on her next case. That is what she does for a
17 living, so that she can come into some other jurisdiction
18 someplace else, and tell us there were thirty-eight
19 violations, none of which he bothered to recite for us.

20 Dr. DeMaria does operate, there is no question
21 about it, at Duke Hospital, a nice touchy, feeley place.
22 And in his spare time, he has a little business that he
23 does. You heard him say he had thirty cases for which he
24 gets eight thousand dollars or more, depending on how you
25 do the math, per case. That's a pretty good side business.

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1 That is the difference between the witnesses they called
2 and the witnesses that we called in this case.

3 Counsel said to you, how come we didn't call our
4 hired gun to testify? How come we didn't call somebody
5 from Missouri, or somebody from Duke Hospital, and there is
6 a reason for that. It's a trial strategy, and I will tell
7 you what the strategy is. The strategy is, I think this
8 case has to rise and fall on your perception of the people
9 here that do surgery. And that is not going to get it then
10 nothing will.

11 I can't pay somebody to make these people look
12 better to you than they are. They are either good enough
13 or they are not. They are either compassionate, as I said
14 they were, or I am just lying to you. They are either
15 qualified to do the work, or you need to make that
16 determination for yourself.

17 That is why at the end of the three witnesses who
18 had the most, to do with Ms. Person's treatment we rested
19 our case.

20 As I said to you, The Judge will say that the
21 burden of proof is on the Plaintiff to prove the
22 allegations in this Complaint. To prove it to you by
23 evidence that's convincing to you, but more likely than not
24 happened.

25 There are two cases here that really need to be

1 proven in order for the Plaintiff to prevail. It is all
2 tied up in one case, but there are really two separate
3 cases.

4 The first is, that you have to have proven to you
5 that the hospital deviated from the standard of care,
6 generally accepted standard of care of other hospitals in
7 Credentialing and Privileging Dr. Mincheff to do the work
8 he did on Ms. Person.

9 Secondly, you have to conclude that Dr. Mincheff
10 committed medical malpractice in his treatment of Ms.
11 Person. Absent either of those elements the burden has not
12 been established.

13 So if you decide the hospital should not have let
14 him do it, but he did not commit malpractice, then you have
15 to find for the Defendant. Or if you find that the
16 hospital was justified in letting him do it, but he did
17 commit malpractice, you still have to find for the
18 Defendant. That is the truth of the case that we are
19 involved in here today.

20 I want to look at the evidence in this case
21 regarding the privileging and credentialing of Dr. Mincheff
22 to do this type of operation. What did he have going for
23 him as he came into this operation? First, he had done
24 them before. Not only was he credentialed and privileged
25 at our hospital, he had done this type of operation at

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1 other hospitals as well. Surely, the other places are not
2 also guilty of the same bad judgment we had.

3 He was chosen by Ms. Person herself, based on a
4 history of several Laparoscopic Procedures that he had done
5 for her before. Now, I know that she is not a medical
6 expert. I know that she can't choose the best doctor in
7 the world and know who that is. But I also know, as you
8 know, that when you have been operated on as many times as
9 she has, for as many different things as she has by a
10 person who is caring and compassionate for you, who has
11 bonded with you, and who has done this operation, you have
12 some idea of whether they are any good or not. And I think
13 that is one element you need to consider when you consider
14 Dr. Mincheff in this case.

15 More than that, Dr. Mincheff was recommended by
16 Dr. Smith, the Pulmonologist. Dr. Mincheff was recommended
17 by Dr. Barker, the Family Practitioner. He was recommended
18 by name, it wasn't just that you need to have this
19 operation, which she did. It was, you need to have Dr.
20 Mincheff, or somebody like Dr. Mincheff to do this
21 operation. These are people who know the skill, and
22 experience, and abilities of the various doctors in this
23 community. And from that group, they chose Dr. Mincheff.

24 We know he was assisted by Dr. Bannister. Dr.
25 Bannister does not do the Laparoscopic Nissen Procedure,

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1 but he does the Open Nissen Procedure. If Dr. Mincheff had
2 fallen dead, remember Dr. Bannister could take his place.

3 What that tell you is, you had two top guns
4 handling this case at the time it occurred. If you go to
5 Duke Hospital and have this operation, I'll tell you what
6 you're going to get. You are going to get students, or
7 people who are just learning the trade in that hospital.
8 And you will get a person operating on you who you have
9 never met, whose character you have no way of knowing, who
10 just like the one that showed up the other day, will take
11 your money and be glad his next word will be next.

12 You don't have that at Carolina Pines with Dr.
13 Mincheff, or Dr. Barker, or Dr. Bannister. You have
14 instead professionals who care. And they chose Dr.
15 Mincheff because Dr. Mincheff was the man for the job at
16 the time.

17 Dr. Bannister assisting him is the same as
18 saying, I know you've got the experience to do it, or else
19 Dr. Bannister wouldn't have done the operation himself.
20 Dr. Bannister would say, I will have no part of this, you
21 don't know what you are doing.

22 I asked Dr. Bannister on the stand, how much
23 attention he was paying to the operation. I would like to
24 think it was a lot, and he said it was. He said that he
25 was confident that the operation had been proceeding the

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1 way it was supposed to. Although he is not authorized to
2 do laparoscopic himself, he was comfortable with somebody
3 else who was. And that is Dr. Mincheff.

4 Even if it was just a matter of these doctors who
5 know each other presumably, who work together, who might be
6 biased in one another's favor, but before you could receive
7 any kind of privileging, Dr. Mincheff had to go through a
8 fairly complex procedure.

9 You know, Ms. Voigt made fun of that procedure,
10 oh, they only take ten files, they only do this, that, or
11 the other. That is her testimony. That's nobody else's
12 testimony as to how this is done. An Administrator, a
13 Surgeon, and a staff person come down and spend days
14 pouring over files and materials at random, so that nobody
15 knows who is going to be selected. They look at this, and
16 they decide whether or not there is proper credentialing
17 and privileging, of the doctors who do this. Interestingly
18 enough, there was no question that there was.

19 But the review process consisted of several
20 things. First the doctor has to say himself he can do it.
21 He has to apply for it. He has to have the courage and
22 conviction that he is able to do this and apply for it.
23 You say Dr. Mincheff, would he lie about that? Why, he has
24 no reason to lie about that.

25 The next thing he has to do is he has to go

1 through a series of three committees. A Credentialing
2 Committee, a Surgical Committee, the Medical Executive
3 Committee, and then finally the Board of Directors each of
4 these committees have doctors on them. Not all of them
5 surgeons, but a lot of them doctors. I think there is an
6 advantage to the fact that they are not all doctors. The
7 fact that they are people who are just regular folks who
8 work at the hospital, who will know other things about
9 persons, not just his skill-level. And through that
10 process, Dr. Mincheff was passed, not only passed, he was
11 passed unanimously.

12 Now, after that took place, and while that is
13 taking place there are several other things going on.
14 First of all, DHEC is around. Secondly, there is a group
15 that all the hospitals belong to. And this is the group
16 that sets the standards. Not a recommendation, but a
17 standard. And that group is called JCAHO. That is the
18 group of hospitals that bond together to decide what the
19 standards ought to be. They don't just decide those
20 standards. They then analyze those standards to see how
21 they are being performed in the various hospitals.

22 If you went to Duke Hospital, you would have a
23 very average performance in terms of the doctors and their
24 credentials, but good enough, two or three. But if you go
25 to Carolina Pines Hospital, you don't get anything but a

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1 one in credentialing. You don't get anything but absolute
2 best highest performance. There is no higher grade than an
3 "A." "A" is the best you can do. And that is what
4 Carolina Pines gets by this group that not only authorizes
5 them to do these things, but who monitor the fact they do
6 it at a later date.

7 Dr. Mincheff himself in addition to all of the
8 procedures that they look at, at the hospital of the
9 various surgeons, Dr. Mincheff himself was personally
10 reviewed by the Federal Regulatory Agency, and scored again
11 a one. There is not any higher grade that Dr. Mincheff
12 could have gotten. Everybody was looking at him with the
13 exception of Ms. Voigt, and Dr. DeMaria gave him a one.

14 Let me tell you another thing. Dr. Mincheff, Tom
15 Mincheff writes articles for JCAHO. Now, that doesn't
16 sound like much, except think about it. This is not a
17 letter to the editor. To get published in a publication, a
18 journal of medicine, you have to have the credentials to
19 write the article. They don't care what I write. If I
20 write it, I could write the best story you ever saw on how
21 to do Laparoscopic Surgery, and they don't care. It does
22 not matter because I don't have the authority to write that
23 kind of thing. I don't have the respect Dr. Mincheff does.
24 Not only does he have the respect to write it, but he has
25 the respect to write it about this specific type of

1 operation. The very fact that he would write the articles,
2 and have those articles published so they can be taught and
3 learned by other doctors, says a heck of a lot about what
4 kind of a doctor, Tom Mincheff is.

5 I think most telling of all in terms of
6 credentials and privileging of Dr. Mincheff was the
7 testimony of Dr. DeMaria himself. The Plaintiff's paid an
8 expert. What did he say? He said that the agency he
9 looked to for deciding whether or not a person is properly
10 credentialed was not SAGES, was not even asked about
11 Greeley. The agency he believes is the proper agency is
12 JCAHO. That is the standard. That is the one that all
13 hospitals belong to, his included, even though his does not
14 do as good of a job as we do.

15 In fact, the whole idea of ones, twos, and threes
16 is to compare it to all the other hospitals. Unless you
17 are one, compared to another hospital it doesn't mean
18 anything. All the other hospitals belong to this. And all
19 the credentialing privileging goes through this. Carolina
20 Pines gets a one, which means that they are better than the
21 guys who get two, three, four, five.

22 You heard the testimony, more than half the
23 hospitals don't get that kind of rating. It isn't
24 something they just give out, oh, yeah, we will come in and
25 look at two or three of your files, like Ms. Voigt said.

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1 And then we have got to go --- is there a good restaurant
2 in town, you know, or something like that. That isn't how
3 it happens. That is not truthful.

4 Dr. DeMaria said specifically that there was no
5 violation on any JCAHO standards he could point to by this
6 hospital, or by Dr. Mincheff. He said the standards are
7 cited in general terms such as, sufficient, adequate,
8 things of that nature. And the reason for that is because
9 of the experienced and ability of various doctors varied.
10 You have to bring judgment to bear, you have to be able to
11 make decisions, you have to give somebody a right to make a
12 choice. And that is why it is done that way.

13 He recognized, Dr. DeMaria recognized that
14 experience can be measured in other ways than how many
15 Nissen Funduplications you've done. He said there was
16 other surgeries that qualified. In fact, he went so far as
17 to say that if you did twenty or thirty, in the twenty or
18 thirty range you were qualified to do this procedure. As a
19 good, hired expert he then said, I don't think Dr. Mincheff
20 has done that. I said, do you know; well, no, I don't
21 know; why, the question wasn't asked. Well, if you were to
22 find out that he had done several hundred, what would your
23 statement be? It is pretty clear that by doing those
24 several hundred, Dr. Mincheff more than qualified according
25 to Dr. DeMaria's standard.

1 Not only does has Dr. Mincheff done several
2 hundred, he has done several thousand operations. We are
3 talking a guy that does operations, this is what he does.
4 He doesn't come into Court. He does not get paid money to
5 testify. He gets paid money to operate on people and do
6 things that will make people well, if he can.

7 I think Dr. DeMaria was our best witness. I
8 really think that he was the best witness the Defense could
9 ask for. Even though he did what he was paid to do, and
10 said that we violated the standard even though he did not
11 know whether we did or not.

12 The fact of the matter is, he said several things
13 that are very important. He said, SAGES really does not
14 apply. Even if you look at those, those had to do with
15 Laparoscopic Procedures. This lady wasn't injured in a
16 Laparoscopic Procedure. She was injured in an Open
17 Procedure.

18 When the procedure became open that is when the
19 problem arose. He further said that there were no problems
20 at all during the Lap. That the Lap itself did not lead to
21 any problems, that she was not injured at all. He also
22 said that having to convert from a Lap to Open is not a
23 sign of negligence. One in ten Laparoscopic Procedures
24 done by him had to be converted to an Open. And it is no
25 one's fault, that it has to be converted. It is, no one's

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1 fault at all, and not even foreseeable. He said further,
2 she was not hurt during the Laparoscopic. There are many
3 complications that he mentioned that are unfortunate, but
4 are not the fault of the doctor.

5 Now, whether Ms. Voigt is a clerk or not, I will
6 leave that to you. She is not even your clerk, she does
7 other things as well. But Dr. DeMaria was important also
8 to tell you she does not make the final decision that she
9 was trying to imply to you that she could make. She
10 gathers information is all that she does. Other people
11 make the decisions.

12 He said further, Dr. DeMaria said that the spleen
13 was not cut, that it had abrasions only, and a CT scan
14 would not show any cuts on the spleen.

15 Y'all have been taking notes, and thank you.
16 Thank you. I don't know --- When the case starts, you
17 don't know what to write down, you don't know what to put
18 down, because you don't know what the case is about yet.
19 But I know somewhere somebody has written down, at least, I
20 pray that you have, that the spleen was not damaged by any
21 cut. It was damaged by abrasion and manipulated and that
22 is not malpractice.

23 Dr. DeMaria, their expert, went on to say that
24 the lady's problem was because of pancreatitis, and that
25 the pancreatitis can be caused by three things that are

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1 unavoidable. The first is, it could be idiopathic, which
2 means nobody knows. It just comes. You're doing
3 everything you know to do, everything science says to do
4 and she still gets pancreatitis, and you can't tell why.
5 Nobody is that good.

6 The second is, it could be a from loss of blood,
7 shock develops in the body. And he further said that the
8 bleeding in this case was not a sign of malpractice. That
9 bleeding happens. That bleeding is something that is an
10 event that he warns his patients about every time before he
11 operates, because it is something that is a known
12 complication. He doesn't come from the doctor making a
13 mistake. It comes from the fact that we are all different.
14 Some people will bleed and some people don't bleed.

15 He said that the damage to the pancreas, if any,
16 was --- I'm sorry --- let me start again. He said the
17 third cause, that is not the fault of anyone that bruising
18 occurred, to the pancreas from manipulation. Again, that
19 would be, a normal situation. It is unfortunate, but it is
20 something that happens in the normal course of an
21 operation.

22 He said, that he thought it might be caused by a
23 cut to the pancreatic duct. because that possibility was
24 raised in, Dr. Mincheff's Transfer Notes. But he also goes
25 on - First he says he admits the doctors would have seen

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1 this if it had happened, and they would have fixed it.

2 Now, if you just have a student, next to you like
3 Dr. DeMaria does most of the time that might not be much.
4 But when you have Dr. Bannister, who is an experienced
5 surgeon, with more years and more gray hair than Dr.
6 Mincheff, he is going to see that, and they did not see
7 anything like that. It does not show up on a CT scan. The
8 CT report is an unreliable guide, because it is not
9 designed to show that kind of thing. Dr. DeMaria said that
10 as well.

11 Additionally, he admitted that no Operative Note
12 from Richland Memorial Hospital, or any place else later
13 on, indicated that there was a cut of any kind to the
14 pancreas. There is nothing at all to corroborate that that
15 took place.

16 Further, Dr. DeMaria --- And let me emphasize,
17 their expert, said that the bowel damage occurred at
18 Richland Memorial Hospital. That she had a drain already
19 in here. That after ten or twelve days she was sitting up
20 and eating they elected to remove the drain and did a
21 procedure that caused damage to her bowel. That was at
22 Richland Memorial Hospital, not at Carolina Pines.

23 He said further, the pictures that you've seen,
24 are a result not of what was done at Carolina Pines, but
25 what was done at Richland Memorial Hospital.

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1 Let me say something else about Dr. DeMaria. And
2 that is, there was a big discussion here about how much
3 experience my client had compared to Dr. DeMaria. I can't
4 tell you who does the most. It is probably him, it's
5 probably Dr. DeMaria. I don't know. I don't have his
6 records. I don't care to look at them. But what I can
7 tell you, is this. When he started, he didn't have anymore
8 credentials than Dr. Mincheff did. This is a pioneer type
9 of thing, Laparoscopic. You could not get Laparoscopic
10 twenty-years ago. People have learned things as they go
11 along. Somebody has to be the expert in the field like Dr.
12 Mincheff, who have done so many other procedures that the
13 transition is something that he can do with ease.

14 Dr. Mincheff has a stake in this. He testified
15 from the stand if he made a mistake, if he did some of
16 these things, it was his fault, and he would take the blame
17 for it. That is kind of refreshing for a lawsuit. You do
18 not see that a lot. But that is what he said.

19 He also wrote in his Transfer Note, look behind
20 me and make sure I did not make an error. And Richland
21 Memorial did look behind him, and there was no error.
22 There was no error noted on any kind of cut to the
23 pancreatic duct.

24 He has strong qualifications. He is a Fellow
25 just like Dr. DeMaria. I never knew what a Fellow was. He

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1 is a Fellow. He's Board Certified, and that means
2 something. He gets referrals locally from people in this
3 neighborhood, and he gets them throughout this area of the
4 State. He has done thousands of operations. This is his
5 first lawsuit. He has been published by SAGES.

6 I think we would all be comfortable with Dr.
7 Mincheff operating on us. I might be wrong, but I think
8 you would. I would. I would trust him. Not just myself,
9 but the people I hold more dearly. I think he is capable.
10 I think he is caring. I think you saw that. I don't know.
11 He looks to me like somebody you can trust, and that I
12 would trust.

13 The pictures in this case are horrific, there is
14 no question about that. And there is no question that Ms.
15 Person sustained some injuries. If you heard me saying or
16 trying to say she did not have an injury, please forgive me
17 for even implying that. That is not what we are implying.
18 But I think you have a right to know that you have a right
19 to know what her condition really is, and you need to know
20 that from medical professionals, and that has to be proved
21 to you.

22 They have Dr. DeMichele, who said, I'm all she
23 has got left. That is not true. That is not true. Dr.
24 DeMaria told you that every doctor she saw had her on a PRN
25 basis, which means come back if you need me. All the

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1 doctors, the Gastroenterologist, who are not involved in
2 this suit, everybody who treats the things that are really
3 wrong with this woman, not one of those people were called.
4 Instead Dr. DeMaria, who is a Neurologist was called.
5 Somebody who had treated her and this is most relevant to
6 what we are asking. This guy had treated her for years
7 before she ever had this operation. He had treated her for
8 all of these conditions. He was prescribing the same
9 medications for her before. There wasn't any change in
10 medications. He was seeing her more before this event than
11 he has seen her afterwards.

12 The regularity with which he saw her was greater
13 before the event than it was after the event. And that has
14 something to do with the nature and extent of the damages.
15 It also has something to do with the nature of what she
16 says is wrong. And we can look at the pictures and tell
17 that there is something wrong. But I can tell you that the
18 best evidence of that is not somebody's emotional reaction.
19 The best is the medical testimony from doctors who come in
20 and tells you what the condition is, from a
21 Gastroenterologist, from an Internal Medicine doctor, not
22 from a guy who comes in and says, I'm her last hope. That
23 wasn't true. He referred her to Dr. Floyd, a Surgeon in
24 Florence. Dr. Floyd said, I am not operating, there is
25 nothing to do here, there's not an operation that is

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1 necessary. He referred her to other doctors as well, all
2 of whom had seen her.

3 But if you, the jury, need to know what a real
4 medical condition is you need something a little better
5 than a Neurologist.

6 Let me just say one final thing. And that is,
7 there seems to be two things that the other side uses a
8 lot. The first is, the emotional theme of saddest of the
9 injury. And it is sad. But that does not make my client
10 liable for --- It doesn't prove the case. And the second
11 thing is, how much money my client has. And, you know,
12 that does not have anything to do with the case either.

13 Most places, and there is a statue of justice
14 outside of the law. And I think there is here. I did not
15 really see it, but I think it is there. If you will look at
16 that statue sometime what you are going to see is a lady
17 holding scales. The scales are going to be how you balance
18 the evidence. And as she holds those scales she is
19 blindfolded. And the reason she is blindfolded is because
20 it does not matter to her who the parties are. It does not
21 matter to her how sympathetic somebody is. Instead her
22 job, Lady Justice's job, is to do what is right no matter
23 who those people are.

24 Now, I don't think Carolina Pines is the evil. I
25 think you had a chance to see four of their people from the

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1 stand. And I don't think you can conclude from that that
2 these are a bunch of evil people out to manipulate this
3 society and do bad things, and they need to be punished for
4 it.

5 Sometimes it is hard to do what is right. But if
6 you do what is right you will see through it. The path is
7 open, you can see what is right.

8 Thank you again for all your time.

9 **The Court:** All right. Mr. Corbin, just for
10 scheduling purposes. How long do you believe your final
11 comments will be?

12 **Mr. Corbin:** Ten or fifteen minutes, Your Honor.

13 **The Court:** All right. Ms. Hines, we will give
14 you an opportunity if you wish to remain. Is your class
15 able to remain through the next fifteen minutes?

16 **Ms. Hines:** We will stay.

17 **The Court:** All right, very good. You may
18 proceed, counsel.

19 **Final Arguments by Mr. Corbin**

20 12:30 P.M.

21 **Mr. Corbin:** Dr. Barker, can you testify the
22 Joint Commission never reviewed Dr. Mincheff's care of Ms.
23 Ruthie? No, sir, I cannot.

24 Did Dr. Mincheff give you his article? Do you
25 reckon Dr. Mincheff believes this article is authoritative

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1 to his? Their consent, the cart before the horse.

2 Remember Dr. Barker and Dr. Mincheff agreed,
3 under Ms. Ruthie's consent, absolutely you better be
4 qualified to do the Laparoscopic Procedure. It is the
5 procedure listed. They want to put the cart before the
6 horse, and get away from Dr. Mincheff's laparoscopic
7 experience.

8 That comment he had been privileged at other
9 hospitals, done it before, these procedures before, to do
10 these procedures before. Never, a Laparoscopic Procedure
11 like Ms. Ruthie's, never. Two pigs to a human being.

12 I want to ask you to do something. Do not make Ruthie
13 a loser, because of a trick. Do not make Ruthie a loser,
14 because I dropped the ball. The oldest trick in the book
15 is Dr. DeMaria. If you said this in your Deposition, it
16 would be true, wouldn't it? Well, of course.

17 Remember Dr. Mincheff on the witness stand said
18 he had reviewed Dr. DeMaria's deposition whether he said
19 twenty or thirty. And it went like this: Question: Dr.
20 DeMaria, you don't have any information regarding any other
21 open procedures that Dr. Mincheff may have done to the
22 esophageal area or the stomach. And this is Dr. DeMaria's
23 answer. Tell me if you hear twenty or thirty here. I
24 would categorically state that if I were to learn, and I
25 know you told me to let you know sixty days ahead if I

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1 change my opinion, but if I were to learn, at some point in
2 this process, that he has done hundreds of Esphagectomies
3 or Gastrectomies, or what have you, that I would be glad to
4 amend my opinion on his experience.

5 I asked Dr. Mincheff himself, have you done
6 hundreds of these, and his response was, no. Don't let the
7 trick, and me dropping the ball, cause Ruthie to lose. The
8 case is more important than a trick.

9 I will never go to Carolina Pines for treatment,
10 and neither will my loved ones. You are the voice of this
11 community. You can protect this community. You're not
12 protecting me. I can see Carolina Pines' Grandmother in
13 the waiting room, she needs medical care and treatment.
14 Are you going to protect her?

15 I see a young mother, two or three children in
16 Carolina Pines' waiting room. Will you protect her? The
17 young boy playing football got hurt, went to Carolina
18 Pines. What can you do to protect him?

19 Ruthie's suffering may end pretty soon. She's
20 going to a better place. But I guarantee you none of us
21 will ever forget this humble, beautiful human being.

22 I am asking you to not let HMA ignore her. I
23 beseech you to not let HMA ignore you. I have done all I
24 can do. Ruthie has done all she can do to save us.

25 But you know what, no one else in this world at

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1 this moment in time has more power than you to save lives.

2 HMA is great at making money. So then, are you
3 great at making justice? Ms. Ruthie is too proud to want
4 your pity. She gets much of that. She does not need to
5 come here to get pity. Thank you.

6 **The Court:** All right, counsel, let me get you
7 to come up and let's talk about scheduling for a moment.

8 (Whereupon, a bench conference was held in
9 the presence of the jury but out of the hearing of the
10 jury.)

11 Charge on The Law

12 12:38 P.M.

13 **The Court:** Ladies and gentlemen, thank you for
14 your patience while we transition there, and took a look at
15 a couple of documents here, and also made a decision.

16 I am going to tell you about your lunch. I think
17 Mr. Suggs has already had some discussion with you about
18 that. And we try our best not to inconvenience you by
19 having a lunch that arrives hot and gets cold while you
20 wait for it, while you are here in the courtroom, or have
21 you ready sitting for lunch that it is not here.

22 What we have done is, we have gone ahead and
23 ordered it. Based on our previous experience from times of
24 delivery, I believe that about the time we conclude here
25 and you go back to the jury room, it will be arriving.

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1 Now, as I told you when we began --- Excuse me
2 just one moment. The last person you would hear from
3 before you retire to consider your verdict, would be The
4 Court giving you the detailed charge on the law. And
5 that's where we find ourselves here at this juncture.

6 Let me say though before I actually begin with
7 the formal part of the charge, that you may recall I told
8 you when we started last Monday, Monday a week ago, that I
9 know that every one of you brings a very busy life with you
10 to the courtroom, with many pressing concerns, whether it
11 be work or family. And I also know that this case has
12 spilled over to a second week, which has been difficult for
13 you. But all those things you have set aside.

14 I sit logistically here in the courtroom where I can
15 look beyond a witness, or beyond counsel and see the jury.
16 And you have probably noted that I do that consistently
17 when a case is in progress, because I want to be
18 comfortable about your comfort level, and where you find
19 yourselves. And every time that I have looked up and
20 consistently watched you, you have sat there with wrapped
21 attention, and close focus on what's happening before you.
22 And I just appreciate the level of commitment and focus
23 that you've given to this important matter.

24 The reason I say that is just simply this. When
25 you retire to deliberate and determine the facts of the

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1 case, and you've heard conflicting evidence from which you
2 are going to have to determine the facts, you are going to
3 be in a position to do that simply because you have
4 listened, and you have given of your best talents, and put
5 aside the pressures that you have on you when you walk
6 outside this courtroom. And I appreciate again the level
7 of commitment you have given here.

8 Now, as you are aware, the Plaintiff claims that
9 she has been injured and damaged by the actions of the
10 Defendant, Carolina Pines Regional Medical Center, that's
11 the Plaintiff, Ms. Person, and that this is her claim in
12 bringing the lawsuit. And claims that Defendant should
13 compensate her for these injuries and these damages. And
14 this is an action which is authorized by South Carolina
15 Law. Now, that is the case before us.

16 Now, as I said to you when we began, our
17 Constitution our Code of Laws, make you the judges of the
18 facts. That is, you are the finders of the fact in the
19 case. I am the Judge of the law. I want to say to you
20 again, that throughout this trial I have tried not to,
21 through ruling or whatever issue may be before me, somehow
22 send you a message about how I felt about the evidence. I
23 tell you again, I don't have a position on the evidence.
24 That's your province. And so please take no inference from
25 any rulings that I have made here in your presence during

1 the course of this trial.

2 Another thing I told at the beginning, and I will
3 repeat it, because of the importance of it. In order to
4 determine the facts of the case, when you have witnesses
5 that testify to different or inconsistent things, then you
6 are going to have to gauge the credibility or
7 believability of the witnesses before you can actually find
8 the facts.

9 Some of the things you may want to look to, but
10 again, you use what criteria you believe in your own sound
11 and good judgment indicate credibility and believability.
12 But some of the things you may want to look to is: What
13 is the manner and appearance of a witness who testified?
14 Was it straightforward; is it hesitant; how did a witness
15 come to know what it is they are talking about? If they
16 are an expert, what are the qualifications that that
17 witness claims to possess. Is the testimony of the witness
18 consistent, even with itself; is it weakened or
19 strengthened by the other evidence in the case? And then
20 in light of the global evidence, as you find that global
21 evidence to be, how reasonable is what that witness is
22 saying. And then finally, might there be a reason a
23 witness would want to help or hurt one side or the other of
24 a case. Might that witness have a bias or prejudice.

25 I will tell you in determining the facts, you may

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1 believe as much or as little of any witnesses' testimony
2 you think proper. You can believe one witness against a
3 whole group of witnesses, or you may do just the opposite.
4 You may believe part of what a witness says, and completely
5 disbelieve the rest.

6 I will say to you, of course, you do not
7 determine the truth by counting up the number of witnesses
8 on one side or the other. Nor must you accept any
9 testimony, even if it is not controverted as true and
10 accurate, because you must first gauge the credibility of
11 the witness through which it comes.

12 Throughout this process I will tell you, you have
13 one objective. And that is to search for and find the
14 truth, regardless again from which witness, or from what
15 side of the case it may come.

16 Now you also heard during the course of this
17 trial several witnesses who were expert witnesses, who had
18 special knowledge, or skill, or experience, training, or
19 education in a particular profession, or occupation. And
20 they came in and gave their opinions as experts about
21 matters in which they are skilled.

22 Now, in determining what weight to be given such
23 an opinion, you should consider the qualifications and the
24 credibility of the experts as you determine that to be.
25 And the reasons they give for their opinions, and the bases

1 upon which they make that opinion. You are not bound by
2 that opinion. It is not given for the purpose of
3 controlling you. It is given to assist you in determining
4 matters of fact which are before you. And you give it what
5 weight, if any, you deem that expert testimony to be
6 entitled to.

7 Certain testimony was also presented in evidence
8 by deposition. I will tell you that a deposition is
9 testimony taken under oath before trial, and preserved in
10 writing or by either video or mechanical means. And you
11 should consider that testimony as if the witness had given
12 it in Court, because it is given under oath, with both
13 attorneys present, with an opportunity for both direct and
14 cross examination.

15 Now, there are two types of evidence that comes
16 before you in cases such as these. There is direct
17 evidence and there is circumstantial evidence.

18 Direct evidence is the testimony by a witness of
19 what that witness personally saw, or heard, or did. I
20 would call that eyewitness testimony. That's direct
21 testimony.

22 Circumstantial evidence on the other hand is
23 indirect evidence. It is proof of a set or chain of facts
24 which then indicate the existence of yet another fact.
25 That's indirect evidence.

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1 I will tell you, that you should consider both,
2 direct and indirect evidence in your deliberations. The
3 law does not require any greater degree of one over the
4 other, or any more certainty of one over the other. You
5 should weigh all of the evidence. And it is for you to
6 decide how much weight to give any evidence in this case.

7 Now the same Constitution that makes you the
8 judge of the facts makes me the judge of the law. I want
9 to say to you that we all come to the courtroom with some
10 preconceived notions or ideas of about what the law is, or
11 what the law should be. But, please, accept the law as I
12 give it to you here in this Charge. Not what you think
13 would be a better idea, or what you have heard on the
14 street the law is. Please accept the law as I give it to
15 you, apply to the facts as you find them. And from that,
16 you will reach a verdict which is just and true.

17 Now the questions of fact which you are to
18 determine in a case such as this are the papers called
19 Pleadings. We discussed this initially when the case began
20 and we chose you as a jury.

21 The Plaintiff files a Complaint. The Defendant
22 files an Answer. I will tell you under South Carolina Law
23 that in order to state a cause of action against a
24 Defendant, the law requires of the Plaintiff to set out
25 three essential claims.

1 This is basically what they are:

2 Number one, that the Defendant was negligent in
3 one or more ways claimed in the Complaint. And in just a
4 moment I will talk a little bit more about negligence.

5 Number two: That the Plaintiff was personally
6 injured.

7 Number three: That the negligence of the
8 Defendant was the proximate cause, and that word is
9 proximate cause, of the Plaintiff's injuries. In just a
10 moment I will talk to you a little more about proximate
11 cause.

12 I will tell you that in the Plaintiff's Complaint
13 she set forth these three essential claims against Carolina
14 Pines, each of which, of course, has been denied by the
15 Defendant.

16 Now in this case, Carolina Pines has alleged that
17 --- Excuse me, let me say that again. In this case, the
18 Plaintiff has alleged that Carolina Pines Regional Medical
19 Center was negligent in allowing Dr. Mincheff, the surgeon,
20 to perform the specific operation on Ms. Person that he
21 performed.

22 To prevail on that claim, the Plaintiff must
23 establish two things to your satisfaction.

24 First, the Plaintiff must establish that Carolina
25 Pines, by granting privileges to Dr. Mincheff to perform

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1 the operation on its premises, breached a duty of care to
2 her, and that the hospital's privileging of Dr. Mincheff
3 was a proximate cause of her damages.

4 I will tell you that under South Carolina Law,
5 and I charge you, that South Carolina Law holds that
6 Carolina Pines owed a duty to Ms. Person to use reasonable
7 care to insure that physicians granted surgical privileges
8 are competent. In this case, Carolina Pines owed Ms.
9 Person a duty to properly evaluate Dr. Mincheff's
10 education, training, and experience to determine whether he
11 could perform her April 25, 2001, surgery in a reasonably
12 safe manner.

13 I further charge you, that negligent
14 credentialing claims arise out of a hospital's failure to
15 satisfy its independent duty, to grant and continue staff
16 privileges only to competent staff physicians. And, of
17 course, the Plaintiff's allegations here are a Negligent
18 Credentialing claim.

19 All right. Going back to what I was saying
20 earlier. The second thing that the Plaintiff must
21 establish, is that Dr. Mincheff's conduct of the operation
22 itself was negligent. And that that negligence cause the
23 Plaintiff's injury.

24 All right. Now, let's talk a little bit more
25 about negligent credentialing. The first facet of the

1 Plaintiff's case, is that she must establish, by the
2 preponderance of the evidence, that Carolina Pines'
3 granting of privileges to Dr. Mincheff to perform the
4 Nissen Fundoplication Operation on Ms. Person breached the
5 required standard of care to her.

6 The law does not require perfect or even an
7 extraordinarily high standard of care by a hospital. The
8 law does require, that the hospital use that degree of
9 knowledge, care and skill ordinarily used by hospitals in
10 the same or similar circumstances. And that the hospital
11 follow the generally accepted practices and procedures in
12 the profession.

13 The Plaintiff must establish by a preponderance
14 of the evidence, and that would be by expert testimony
15 also, the practices and procedures of the profession that
16 are applicable to the hospital in granting privileges to
17 surgeons.

18 The degree of care and skill a hospital must use
19 in privileging a surgeon to perform an operation, is that
20 which a reasonable hospital in the same or similar
21 circumstances would de regarding the same operation.

22 You are not required nor permitted to set up a
23 standard of your own in deciding whether the surgeons'
24 education, training, experience, skill, and diligence
25 fulfill the duties imposed on the hospital. You must apply

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1 the standard of care as I have explained it to you. And
2 using the standard of care that I have just described, you
3 as the find of fact, will be asked to decide whether the
4 hospital breached the standard of care. And, if so,
5 whether the hospital's action in giving Dr. Mincheff
6 privileges was a proximate cause of Ms. Person's injuries.

7 I will give you the instructions on these two
8 facts after I describe the standard of care for the second
9 part of the Plaintiff's case, that she must establish that
10 Dr. Mincheff committed medical malpractice while perform
11 the operation on Ms. Person.

12 Now, the Plaintiff claims that the doctor
13 committed, the surgeon here medical malpractice, or
14 professional negligence. Malpractice, is the failure to
15 treat a patient following good and accepted medical
16 practices, resulting in harm to the patient. And it is a
17 form of carelessness or negligence.

18 In order to establish medical malpractice, the
19 Plaintiff must prove by a preponderance, or greater weight
20 of the evidence, what the standard of care the surgeon owed
21 to the Plaintiff in treating the Plaintiff was.

22 When a doctor treats a patient, the law does not
23 require absolute accuracy, either in practice or in
24 decision making. The law does not hold the doctor or the
25 surgeon to a standard of perfection. It does not even

1 require the highest degree of care and skill of which the
2 human mind is capable.

3 The law does require that the doctor use that
4 degree of knowledge, care, and skill ordinarily used by
5 doctors, in good standing, under the same or similar
6 circumstances. And that the doctor follow the generally
7 accepted practices and procedures in the profession.

8 The degree of skill and care a doctor or a
9 surgeon must use, is that which would be used by a
10 competent doctor or surgeon in his or her field of
11 medicine, and not that which would be exercised by the
12 profession generally.

13 A surgeon must use reasonable care and diligence
14 in using this skill and applying his knowledge. You are
15 not permitted to set up a standard of your own in deciding
16 whether the surgeon's learning, skill, and conduct fulfill
17 the duties imposed on him or her in any situation. You
18 must use the standard of care that I have explained to you.

19 Now let's talk about departure from the standard
20 of care. Next, after proving the standard of care, the
21 Plaintiff must prove that the hospital, and also the
22 surgeon negligently departed from the standard of care,
23 relevant to them, in granting privileges to the surgeon, or
24 in operating on and treating the Plaintiff.

25 Negligence, is the failure to do what an

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1 ordinarily careful hospital or surgeon would have done
2 under the same or similar circumstances, or doing of
3 something that an ordinarily careful hospital or surgeon
4 would not have done under the same or similar
5 circumstances.

6 A hospital's duty in privileging a surgeon, and
7 the surgeon's duty in operating on and treating a patient
8 are to be measured by both the hospital's and the surgeon's
9 skill, education, training, experience, and diligence. If
10 because of the lack of the required skill, education,
11 training, experience, and diligence you find that the
12 hospital failed to properly evaluate the surgeon's
13 education, training, experience, skill, and diligence, and
14 the surgeon failed to properly treat or operate on the
15 patient, causing the patient's injury, then the hospital
16 would be responsible for any injury proximately caused to
17 the patient. Both elements must be proved for the hospital
18 to be held liable.

19 The hospital is not liable if its decision to
20 grant privileges to the surgeon, based on his skill,
21 education, training, experience, and diligence was
22 reasonable. If the hospital's decision to grant privileges
23 to the surgeon was reasonable, it has no liability, even if
24 the surgeon negligently failed to use the required skill or
25 diligence, or is not as careful in operating on, or

1 treating of the Plaintiff as he should have been.

2 Neither a surgeon nor a hospital is an insurer of
3 a cure or even of a positive result. Therefore, the mere
4 fact that surgery or treatment does not benefit the
5 patient, or that it even harms the patient, does not, in
6 and of itself, mean that either the hospital or the surgeon
7 was negligent.

8 A bad result, injury, death, or failure to cure
9 is not, by itself, enough to show that the hospital or
10 surgeon was negligent.

11 If you find that the hospital used due care in
12 evaluating the skill, education, training, or experience of
13 the surgeon, and that the surgeon used due care and skill
14 in treating the patient, but despite this, the patient
15 suffered damages, injuries, or death, you should return a
16 verdict for the hospital.

17 Similarly, a hospital's or a surgeon's mistake or
18 error in making a decision, or performing surgery, alone
19 does not constitute negligence. If, however, a hospital or
20 surgeon fails to gather and assess information reasonably
21 available, which a reasonable hospital or surgeon would
22 have gathered and assessed before making a decision, or
23 performing surgery, the hospital or surgeon fails to comply
24 with the recognized standard of care, which would be
25 exercised by a similar hospital or surgeon under similar

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1 circumstances.

2 The fact that a doctor acts on the advice of
3 another doctor, who is a specialist, is not an absolute
4 defense to a claim that the surgeon failed to use the
5 required skill in treating or operating on his patient.

6 The difficulties and uncertainties in the
7 practice of medicine, and the unpredictable variations in
8 the response to treatment, are such that no hospital and no
9 surgeon can guarantee a result. Where there is more than
10 one recognized diagnosis or treatment, and no one of them
11 is used exclusively and uniformly by all doctors in good
12 standing, it is not negligence for a doctor, in making a
13 decision, to choose one of the approved methods, even when
14 the choice later turns out to be a wrong selection.

15 Qualified doctors and experts may differ as to
16 what constitutes the best course of treatment, and these
17 differences do not amount to malpractice.

18 Where doctors in good standing disagree, or when
19 medical authorities are divided with regard to a specific
20 course of treatment or care, then the doctor is bound only
21 to exercise his or her best judgment in determining which
22 course, on the whole, is best for the patient.

23 Just because another doctor might have used a
24 different course or treatment, does not make the doctor
25 negligent. However, if a surgeon does not have the degree

1 of education, training, experience, skill, and learning
2 required, or if the doctor does not use the care and skill
3 required, it is no defense to a charge of negligence that
4 the doctor did the best that he could.

5 In considering whether the hospital or the
6 surgeon made a reasonable decision, you must consider the
7 decision in relation to the facts as they existed at the
8 time, and not in light of what hindsight may reveal.

9 Now earlier I talked to you about proximate
10 cause. And I said that the negligence, if you find
11 negligence, must be the proximate cause of the Plaintiff's
12 injuries. So let's talk about that.

13 The Plaintiff must prove that the hospital's and
14 the surgeon's negligence proximately caused the Plaintiff's
15 damages. Now, proximate cause is something that produces a
16 natural chain of events, which, in the end, brings about
17 the injury. It is the direct cause of the injury.

18 To prove that the hospital and surgeon's
19 negligence proximately caused the Plaintiff's injury, the
20 Plaintiff must first prove, number one, causation in fact.
21 This proven by showing that the injury would not have
22 occurred, but for the hospital and the surgeon's
23 negligence. That is causation in fact.

24 The Plaintiff must also prove what we call legal
25 cause. That's number two. Legal cause is proven by

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1 showing that the injury was foreseeable. This means that
2 the injury occurred as a natural and probable consequence
3 of the hospital and surgeon's negligence.

4 The Plaintiff must prove that some injury from
5 the hospital and the surgeon's negligence was foreseeable,
6 but it does not have to prove, or she does not have to
7 prove, that the particular injury that occurred was
8 foreseeable. However, the hospital cannot be held
9 responsible for something which is unpredictable, or could
10 not be expected to happen.

11 Proximate cause does mean the only cause. A
12 Defendant's act can be a proximate cause of the Plaintiff's
13 injury if it was at least one of the direct concurring
14 causes of the injury.

15 All right. Now, let's talk about the burden of
16 proof, because we said throughout the burden of proof, is
17 on the Plaintiff. I say to you, Madame Forelady, and
18 members of the jury, the mere fact that the Plaintiff's
19 internal organs are not functioning, or that she was
20 injured, standing alone, does not permit you, the jury, to
21 conclude that their lack of proper function, or their
22 injury, was caused by anyone's negligence. Rather, the
23 Plaintiff has the burden of proving her claims in this
24 case.

25 She must meet this burden by what we call, the

1 greater weight, or the preponderance, of the evidence. I
2 will tell you that the preponderance of the evidence means
3 that the facts ought to be proved is more likely than not.
4 That's the preponderance of the evidence, more likely than
5 not.

6 The same thing is meant by the greater weight of
7 the evidence. I can show you an example of greater weight
8 of the evidence. Early there was a reference to the scales
9 of justice, the statue of justice. If you think about the
10 times you have seen those statues, scales held in the hands
11 of justice, well, those scales are even. And that is
12 really where if the statue is appropriate done, and that is
13 where they were when this case began.

14 Well, now, we are at the end of the case, and if
15 the scales remain even, or if they tip, even if it is ever
16 so slightly in favor of the Defendant, then the Plaintiff
17 has failed to meet the burden of proof. And your verdict
18 should be for the Defendant.

19 However, on the other hand, if the scales tip,
20 and even if it is ever so slightly, in favor of the
21 Plaintiff, then the Plaintiff has met the burden of proof.
22 And your verdict, to some degree, should be for the
23 Plaintiff.

24 Now, of course, there's not a set of scales back
25 there in your jury room. That's because weighing the

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1 evidence is entirely a mental process. I will say to you,
2 that evidence which weighs with you is evidence which
3 convinces you of its truth. Again, regardless of from
4 which witness or from which side of the case, that it may
5 come.

6 All right. Now, let's talk about damages. We
7 talked about liability for a few minutes, now let's talk
8 about damages.

9 Should you decide that the Plaintiff is entitled
10 to a verdict, your next step is to decide how much money
11 the Defendant should be required to pay, and we call that
12 award damages.

13 There are two categories of damages in South
14 Carolina. There are actual damages and there are punitive
15 damages.

16 Actual damages are intended to compensate an
17 injured party. That is, to put that injured party, as near
18 as possible, in the same position that the injured party
19 was in prior to the incident occurring, as best as monetary
20 damages can do that.

21 In other words, actual damages are the actual
22 losses and expenses that the Plaintiff has suffered because
23 of the Defendant's negligence and carelessness.

24 Now, punitive damages that was, actual damages.
25 Punitive damages, on the other hand, are different. As the

1 name implies, they are awarded to punish a Defendant for
2 reprehensible conduct, and to deter the Defendant and other
3 persons from similar conduct. That is, to make an example
4 of the Defendant. I will discuss punitive damages with
5 later.

6 First I want to talk about actual damages. In
7 this case, the Plaintiff has requested actual damages. And
8 actual damages are intended to compensate an injured party
9 to them in, as I just said a moment ago, as near as
10 possible the same position they were in before the incident
11 occurred.

12 In other words, actual damages are the actual
13 losses and expenses which the Plaintiff suffers as a result
14 of the hospital's actions, and the proximately caused
15 damages.

16 There can be no actual damages against the
17 hospital, unless you determine that the doctor was
18 negligent and the hospital was also negligent.

19 I will tell you that actual damages for a
20 Plaintiff, who has been physically injured can include the
21 following: Out of pocket expenses, medical expenses,
22 including physicians, hospital, medicines, physical therapy
23 expenses, rehabilitation expenses, and transportation
24 expenses connected with medical the treatment, any future
25 damages resulting from permanent injuries --- And, I'll

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1 talk with you a little bit further about that in a moment.
2 Disfigurement, loss of family services, deprivation of
3 normal life expectancy, alteration of lifestyle,
4 psychological trauma, mental distress, apprehension,
5 anxiety, emotion injury, psychological injury, depression,
6 sexual dysfunction, pain and suffering, and loss of
7 enjoyment of life.

8 I will tell you that the Plaintiff bears the
9 burden of proving these elements by the preponderance of
10 the evidence.

11 I further want to charge you specifically on pain
12 and suffering, and tell you that pain and suffering is a
13 material element of damages, on which recovery may be
14 grounded.

15 A Plaintiff is entitled to compensation for pain
16 and suffering that directly results from the wrongful acts
17 of the Defendant. An award for pain and suffering
18 compensates an injured person for physical discomfort and
19 emotional response to the sensation of pain that is caused
20 by the injury itself.

21 In making an estimate of damages to be awarded
22 for pain and suffering you may consider the following:
23 The nature and extent of the injuries and the suffering
24 occasioned by them and its duration, and prospective
25 duration, the age, health, habits, and condition of the

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1 injured party before the injury as compared with that
2 person's condition afterwards. The Plaintiff's use of
3 sedatives and other drugs to relieve pain and their effect,
4 and any aggravation of pre-existing disorders by the
5 incident in question.

6 Pain and suffering, ladies and gentleman, have no
7 market price. There are not capable of some exact
8 measurement. There is no fixed rule whereby damages for
9 pain and suffering can be measured. The amount of damages
10 for pain and suffering must be left to the sound judgment
11 of you, the jury. Additionally, you may include such
12 damage for pain and suffering as it is reasonably certain
13 will of necessity result in the future from the injury.

14 The future pain and suffering on the part of the
15 Plaintiff and consequences of the injuries constitute a
16 proper element of damages which may be allowed, provided
17 there is requisite certainty that such pain and suffering
18 will result.

19 I also want to charge you on mental anguish.
20 That was the discussion on pain and suffering. Mental
21 anguish is another element for which a Plaintiff should be
22 compensated, or may be compensated, should you find it
23 appropriate.

24 An injured party may recover for mental anguish
25 brought about by bodily injury and suffering. Where a

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1 party's negligence is directly responsible for physical
2 injury to another person, the injured party may recover for
3 both the actual physical injury sustained, and for the
4 concomitant mental and emotional suffering, which flows of
5 natural consequence of that wrongful act.

6 When connected with a physical injury the term,
7 mental anguish, includes both the resultant mental
8 sensation of pain, and also the accompanying feelings of
9 distress, fright, and anxiety. That is, mental anguish
10 covers not only the pain associated with the injury, but
11 also the mental reaction to that pain, and the possible
12 consequences of the injury.

13 Mental anguish, is more than mere disappointment,
14 anger, worry, resentment, or embarrassment, although it may
15 include all of these. And it includes mental sensation of
16 pain resulting from such painful emotions as grief, severe
17 disappointment, indignation, and wounded pride. I should
18 also say in addition to wounded pride there may be shame,
19 despair, and humiliation. I will tell you that mental
20 anguish can be composed of fright, nervousness, grief,
21 anxiety, worry, mortification, humiliation, embarrassment,
22 terror, or ordeal.

23 If you find the injured party is entitled to
24 recover damages, you may consider as an element of those
25 damages such mental anguish as you find, to a reasonable

1 certainty, will occur in the future as a result of these
2 injuries.

3 In assessing mental anguish, you may take into
4 account anxiety and worry about the possible future
5 occurrence or condition resulting from the injury that the
6 Plaintiff received. If you are satisfied, to a reasonable
7 certainty, that the Plaintiff will suffer such anxiety or
8 worry. You may award damages for mental anguish where the
9 evidence shows, for example, the Plaintiff suffered shock,
10 fright, emotional upset, and/or humiliation as the result
11 of the Defendant's negligence.

12 I further want to charge you about the loss of
13 enjoyment of life. I charge you that loss of capacity to
14 enjoy life, resulting from a personal injury is a proper
15 element of damages. If you find evidence of loss of
16 enjoyment of life, you may award damages for this loss.

17 Damages for loss of enjoyment of life compensate
18 for the limitations, resulting from the Defendant's
19 negligence on the injured person's ability to participate
20 in and derive pleasure from the normal activities of daily
21 life, or for the individual's inability to pursue his
22 talents, recreational interests, hobbies, or avocations.
23 Loss of enjoyment of life damages compensate the Plaintiff
24 not only for the subjective knowledge that one can no
25 longer enjoy all of life's pursuits, but also for the

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1 objective loss of the ability to engage in these
2 activities.

3 All right. I further charge you that a Plaintiff
4 is never entitled to recover conjectural or speculative
5 damages. I want to talk to you a little bit about future
6 damages, which I mentioned briefly a moment ago. If you
7 find the Plaintiff, is entitled to a verdict for actual
8 damages, your verdict should include an amount to cover any
9 past, present, and future damages which were proximately
10 caused by the Defendant, if you find that future damages
11 were proved by the Plaintiff.

12 Any future damages must be reasonably certain to
13 occur in the future as a result of the Defendant's
14 negligence. The reason that future damages are allowed in
15 this proceeding, should you find them to be appropriate, is
16 because the Plaintiff in this case has only one right of
17 action for recovery in which these damages must be set
18 forth.

19 Any future damages must be reasonably calculated
20 to have resulted from the alleged injury or the damage
21 occurred. I will also tell you that future damages must be
22 reduced to present cash value. That is, any amount for
23 future damages must be reduced to present cash value.

24 All right. If you find that the Plaintiff was
25 permanently injured as a result of the Defendant's actions,

1 then you must decide how, if at all, that injury will
2 affect the rest of the Plaintiff's life.

3 A person's life expectancy is determined by a
4 life expectancy table, which is part of the Statute of our
5 State. The life expectancy table is only an estimate of
6 the probably average remaining length of the life of all
7 persons in our State of a given age. The Plaintiff, for
8 purposes of the use of this table, is presently thirty-
9 eight and a half years old, with a life-expectancy,
10 according to the life expectancy, of 33.6 years. I'll tell
11 you again, that's 33.6 years. This fact is to be
12 considered by you along with any other facts and
13 circumstances in evidence, bearing on the Plaintiff's life
14 expectancy, including habits, health at the time of injury
15 deciding the amount of damages to be awarded to the
16 Plaintiff.

17 **Mr. Corbin:** Excuse me, you said thirty-eight
18 years of age. She is forty eight years of age.

19 **The Court:** I'm sorry. I said thirty-eight and
20 a half, I believe I meant to say forty-eight and a half.
21 Thank you, Mr. Corbin.

22 **Mr. Corbin:** Yes, sir.

23 **The Court:** That was my misstatement. The
24 Plaintiff is forty-eight and a half for purposes of this
25 table. And that generates a life expectancy, according to

1 the table, of 33.6 years. Again, the figure that I gave
2 you for the life expectancy was correct. Thank you again,
3 Mr. Corbin.

4 **Mr. Corbin:** Yes, sir.

5 **The Court:** Now, let's talk again about proving
6 actual damages by the greater weight of the evidence. That
7 is the same burden of proof I gave you earlier on the
8 liability issues in the case. But this doesn't mean that
9 they have to be proved to some mathematical certainty,
10 evidence produced of the precise amount of damages.
11 Rather, the evidence put forth by the Plaintiff should be
12 such as to enable you the jury to determine what amount of
13 damages is fair, just, and reasonable under the
14 circumstances.

15 Again, the universal principal of actual damages
16 is to put an injured party, who is entitled to
17 compensation, back in a position that they were in prior to
18 the injury, again as far as monetary damages can do that.
19 Now that is, actual damages.

20 Let's talk about punitive damages. An award of
21 punitive damages is appropriate only where you find the
22 conduct of a party to have been reckless, wanton, or
23 willful. Reckless or willful conduct, is conduct which
24 demonstrates a conscious disregard for the rights of
25 others, and is beyond mere negligence. Conduct is reckless

1 or willful, when it is committed with a deliberate
2 intention, and under such circumstances that a person of
3 ordinary reason and caution would be conscious of it as an
4 invasion of another's rights. Punitive damages are
5 awarded, not only as punishment for wrong, but also as a
6 vindication of a private right.

7 If you conclude in this case that the Defendant
8 did act in a willful, or with a willful or wanton disregard
9 for the rights for the Plaintiff, then you would determine
10 whether to award punitive damages.

11 In awarding punitive damages, if any, you should
12 consider whether the Defendant's conduct was reprehensible,
13 the ability of the Defendant to pay the amount, and number
14 three, the amount of punishment that should be meted out
15 under the circumstances.

16 I will tell you that punitive damages may not be
17 awarded unless you conclude that the Plaintiff is entitled
18 to an award of actual damages also. In other words, if you
19 don't find actual damages, you cannot find punitive
20 damages.

21 Now the burden of proof for punitive damages is
22 different than actual damages. Actual damages, remember
23 the preponderance of the evidence or greater weight of the
24 evidence. But the burden of proof for punitive damages is
25 by clear and convincing evidence. That burden is on the

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1 Plaintiff.

2 In other words, the Plaintiff must prove punitive
3 damages to you by clear and convincing evidence. Clear and
4 convincing evidence is evidence that is clear, specific,
5 definite, and convincing in its nature. It is a higher
6 standard than the preponderance of the evidence standard
7 for actual damages.

8 All right. Now, Madame Forelady and members of
9 the jury, in just a few moments you are going to retire to
10 begin your deliberations. As you do that, and I know you
11 are, I want to make sure that you are mindful of the
12 importance of your responsibility.

13 You are not called upon often to serve as jurors.
14 And for that, you probably say, well, thank goodness. But
15 you recall what we discussed on Monday, the fact that you
16 are exempted from jury service if you serve, and you cannot
17 be required to serve more than one time in three years in
18 the same court. Well, there is a reason for that rule.
19 And the reason for that rule is because jury service can be
20 difficult. And it requires you and I to reach the height
21 of freeing our minds of all outside and improper
22 influences, because we are acting for this community in
23 seeing that every trial here is fair, and every verdict is
24 just.

25 I am sure that you have observed throughout this

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1 trial that the presiding officer is referred to as Your
2 Honor, which that is me. I know you know that is not some
3 title given to me by privilege or burden. It is a title
4 assigned to a position, which I am privileged to hold. And
5 the reason for that is if this Court is entrusted with the
6 honor of this Community, this County, this State, and
7 indeed this Nation in seeing that every case tried here
8 receives fair and impartial justice.

9 In just a moment you are going to take the
10 preservation and the honor of this Community, County,
11 State, Nation into the jury room with you to decide this
12 case.

13 Now when I tell you that, please don't think I'm
14 telling you how to decide this case, or how I think you
15 should. That would be inappropriate. That is not my
16 purpose.

17 My purpose is simply this, it is of vital
18 importance to me, as presiding officer, that whatever
19 verdict you reach is going to be the result of you going
20 back to the jury room, and confining your deliberations to
21 the evidence put forth in this courtroom, weighing it
22 fairly, weighing it impartially, then applying it to the
23 law which I have given you here in this charge, and
24 reaching a verdict, which is just, and which is fair.

25 I have every confidence that that is what you

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1 will do. And I will tell you that everyone in this case is
2 entitled to justice, nothing more, and nothing less. We
3 owe no support to any party, we owe no sympathy to any
4 party.

5 And again, I am of the confirmed opinion that
6 whatever verdict you will reach will represent truth and
7 justice for all the parties.

8 Now, Madame Forelady, let me say to you, Ms.
9 Brooks, and colleagues, your verdict must be unanimous. I
10 have the Verdict Form in front of me, and you really cannot
11 see that from where you are. But you will have it with you
12 in the jury room. It basically ask you three questions.
13 And then it gives you some information as to where to go on
14 the form depending on how you answer the questions.

15 Let me just simply say as the foreperson my
16 experience has been that the foreperson is someone who is a
17 moderator of discussion, a facilitator of opinions, because
18 again, it has to be unanimous verdict.

19 Your jury room is large, some people may be
20 standing at the window, some people may be seated over by
21 the table. Please make sure that everyone who wishes to be
22 heard on some point in discussion is given that ability to
23 be heard.

24 The first question simply says this: With
25 regard to the Plaintiff, Ruth Person's claims against the

1 Defendant, Carolina Pines Regional Medical Center, we find
2 --- and then there are two choices.

3 Now when I have two choices, I can't give them
4 both to you on the form at the same time. One must come in
5 front of the other. But there is no priority here. It is
6 simply one listed before the other.

7 The first is for the Defendant.

8 The second is for the Plaintiff.

9 And if you find for the Plaintiff, and award the
10 amount of, blank actual damages. Meaning that you will
11 have to determine the amount of damages, if you find for
12 the Plaintiff that you award the actual damages.

13 Then you go to question two. And question two
14 simply asks about punitive damages. And it says that, the
15 actual question: Do you find that the actions of the
16 Defendant, Carolina Pines, has been intentional, reckless,
17 wanton, and willful based on clear and convincing evidence,
18 and that the Plaintiff is entitled to an additional award
19 of punitive damages? There is a no, and there is a yes.
20 If there is a no, then you end your deliberations, which is
21 what it tells you. If there is a yes, then you go to
22 question three. Which ask you to calculate the amount of
23 damages. I will tell you that under South Carolina Law,
24 this is why we use the word additional, that is to
25 calculate the total, the actual and punitive damages are

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1 added together. It is the sum of the two that is the total
2 verdict.

3 Now, what I am going to ask you to do, and we may
4 have a report here in a moment or two about your lunch.

5 **Bailiff:** It is here, sir.

6 **The Court:** Well, we won't hold you up any
7 longer. I am going to ask you to go back to your jury
8 room, and I think the best thing probably is not to begin
9 your deliberations, just enjoy your lunch in peace among
10 yourselves. You won't be disturbed. We will make sure
11 that you have what you need. When you finish your lunch,
12 if you will knock on the door, we will remove whatever
13 remains from lunch. We will bring, into you the exhibits,
14 the evidence, the Verdict Form and the other things you
15 need. We will make whatever arrangements are necessary to
16 assist you, if you need paper, pencil, you tell us what you
17 need. If you need a calculator, whatever it is you need, a
18 viewing apparatus, we will be responsive to whatever your
19 request is. And then and only then will we send all that
20 in to begin your deliberations.

21 All right. With that understanding, we will let
22 you go back to the jury room. Enjoy your lunch ladies and
23 gentlemen, and we will expect a knock whenever you finish
24 lunch. You may take your notes with you, they are yours
25 now for use.

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1 (Whereupon, the jury departs for lunch at
2 1:17 p.m.)

3 **The Court:** All right. I have heard the door
4 close. Are there objections or exceptions to the charge
5 from the plaintiff?

6 **Mr. Corbin:** Masterful charge. No exceptions.

7 **The Court:** You are kind. That is overstated.
8 From the defendant?

9 **Mr. Driggers:** No exceptions, Your Honor.

10 **The Court:** All right. Gentlemen, will you come
11 up and work with our Clerk and our court report to make
12 sure that we have the evidence in order. We will print a
13 new Verdict Form to make sure that you have an opportunity
14 to review that please.

15 (Whereupon, the Clerk, the attorneys, and
16 the court reporter review the evidence to be taken back to
17 the jury.)

18 **The Court:** All right. Ms. Person, I would like
19 to speak to both parties before you leave. Do you need to
20 leave now, or are you able to wait a moment?

21 **Mr. Corbin:** Are you okay, Ruthie?

22 **Ms. Person:** Yes, sir. I can stay.

23 **The Court:** You just stay right there where you
24 are ma'am. And, I will speak with both of you in just a
25 moment, when we finish looking at the evidence.

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1 (Pause)

2 The Court: Is there anyone here for Carolina
3 Pines?

4 Mr. Driggers: I let them go a few minutes ago.

5 (Whereupon, a brief recess was taken.)

6 The Court: All right. Is the evidence clear?

7 Madame Court Reporter: The Evidence is clear.

8 The Court: The Verdict Form is coming. Now,
9 counsel, we will give permission, and when we give
10 permission, and when they knock without further interaction
11 with the Court, in goes the evidence and the Verdict Form
12 and out comes the lunch debris. Is that fine with
13 everyone?

14 Mr. Corbin: Yes, sir.

15 The Court: So, you don't need to be here. If
16 y'all don't need to be here. If y'all want to step away
17 you are welcome to, but please make sure that Mary Ashley
18 or Scott has a cell phone in case we have a question from
19 the jury before you leave out.

20 (Whereupon, the Court is in recess awaiting
21 a verdict from the jury.)

22 (Whereupon, the jury begins their
23 deliberations at 1:37 p.m.)

24 (Whereupon, the Jury announces they have a
25 verdict at 3:09 p.m.)

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1 **The Court:** All right. I am told that there is
2 a verdict. Is there anything for our record before we
3 bring the jury in to have the verdict published? From the
4 plaintiff?

5 **Mr. Corbin:** None, Your Honor.

6 **The Court:** From Defense?

7 **Mr. Driggers:** None, Your Honor.

8 **The Court:** Very good. All right. If your jury
9 is ready, please bring in the jury. And, Mr. Suggs, are
10 you going to publish?

11 **Clerk of Court:** Yes, sir.

12 (Whereupon, the jury enters the courtroom at
13 3:08 p.m.)

14 **Verdict**

15 **The Court:** All right, ladies and gentlemen,
16 welcome back to the courtroom. Ms. Brooks, I am told that
17 the jury has reached a verdict; is that correct?

18 **Ms. Brooks:** Yes, sir. We have.

19 **The Court:** Please give your verdict to, Mr.
20 Suggs. Thank you.

21 (Whereupon, Madame Forelady gives the
22 Verdict Form to the Clerk of Court.)

23 **The Court:** All right. Let's the Record reflect
24 that the Verdict Form is appropriately filled out, and has
25 been signed by the foreperson, and Mr. Clerk, please

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1 publish the verdict.

2 **Clerk of Court:** Yes sir, Your Honor. This is
3 Case Number 2004-CP-26-322, Ruth J. Person the Plaintiff,
4 Carolina Pines Regional Medical Center Defendant. Verdict.
5 Question One. With regards to the Plaintiff, Ruth J.
6 Person's, claims against the Defendant, Carolina Pines
7 Regional Medical Center, we find for the Defendant. If
8 chosen, that ends deliberations. Signed Foreperson Gloria
9 Brooks, November 14, 2006. If this is your verdict, say
10 yea all by raising your hands please.

11 **The Court:** Let the record reflect that all the
12 jurors raised their hands by raising their hands in
13 response to the Clerk's question. Now, while we are in the
14 presence of the jury, are there any questions for which a
15 jury response may be necessary. From the plaintiff?

16 **Mr. Corbin:** None.

17 **The Court:** From the Defendant?

18 **Mr. Driggers:** None, Your Honor.

19 **The Court:** All right. Ladies and gentlemen,
20 that your service in this case is concluded, and I thank
21 you for your service for rendering a Verdict which is just
22 and true, as you have determined justice in this case to
23 be. And, in a day or so the County is going to send you a
24 small stipend for your service, and you may have --- Do you
25 have that already? That is going to be the County's

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1 expression of gratitude, but I am going to extend mine by
2 coming down and shaking your hand as you leave the jury
3 box.

4 This case has been extraordinarily well tried by
5 both attorneys, and parties conducted themselves with
6 dignity. I appreciate that. We are at the end of our
7 term, actually beyond the term. I do not know whether you
8 have questions as a juror that you want to ask here in the
9 courtroom. I will give you an opportunity to ask any
10 questions; or you may having been here for the length of
11 time that you have been may just be ready to go. I will
12 be glad to answer any questions that you have. Well,
13 hearing none, then what I am going to do is come over, and
14 express my expression of gratitude by shaking your hand for
15 your service. Again I appreciate your service this week as
16 a juror.

17 (Pause)

18 The Court: All right. The door is closed. The
19 jury has departed the courtroom. Now, out of the presence
20 of the jury, are there any Motions for which a Court
21 response would be necessary, from the plaintiff?

22 Mr. Corbin: None.

23 The Court: From the Defendant?

24 Mr. Driggers: None, Your Honor.

25 The Court: All right. Then ladies and

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1 gentlemen, I will say to you again, what I said in front of
2 the jury. I want to say to you I appreciate the way this
3 case has been tried. I appreciate the dignity Ms. Person
4 that you have shown. I appreciate the professionalism that
5 Carolina Pines have shown, and the dignity also the
6 physicians did and the surgeons did. I wish you well as we
7 move on from this day, and life goes on for everyone. I
8 just wish both sides well.

9 This case has been an interesting one, a
10 challenging one, and I now declare this record adjourned.

11 -- END OF TRANSCRIPT --

12 (Whereupon, this trial was concluded on 3:15
13 p.m. on Tuesday, November 14, 2006.)

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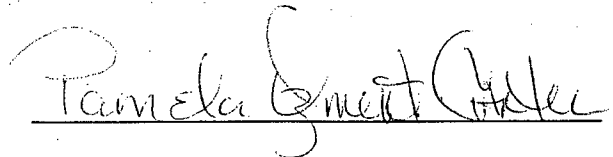
Certificate of Reporter

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I, the undersigned, Pamela Ozment-Cartee, official for the Fourth Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete, transcript of record, except for the selection of the jury, of all the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas, Darlington County, South Carolina, beginning November 6, 2006 through November 14, 2006.

I do further certify that am neither, of kin, counsel, nor interest of any party hereto.

January 27, 2008

A handwritten signature in cursive script, reading "Pamela Ozment-Cartee", written over a horizontal line.

Pamela Ozment-Cartee
Circuit Court reporter

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOURTH JUDICIAL CIRCUIT
COUNTY OF DARLINGTON	)	CASE NO. 2004-CP-16-322
RUTH J. PERSON,	)	
	)	
Plaintiff,	)	
	)	<u>ADVERSE OR NEGATIVE INFERENCE</u>
v.	)	
	)	
CAROLINA PINES REGIONAL	)	
MEDICAL CENTER,	)	
	)	
Defendant.	)	
_____	)	

Under the South Carolina Rules of Civil Procedure ("Rules"), Ms. Person had the legal right to receive from Carolina Pines answers to the following questions:

- (1) Since January 1, 1995, until the present time, what physicians have had surgical privileges at Defendant Carolina Pines Regional Medical Center to perform Nissen fundoplication procedures?
- (2) Other than Thomas V. Mincheff, M.D., did any other surgeon perform a laparoscopic Nissen fundoplication surgical procedure at Carolina Pines from January 1, 1995, until the present time; and, if so, which surgeon and on what date?
- (3) How many laparoscopic Nissen fundoplication surgical procedures each year were performed at Carolina Pines during each of the following years: 1995, 1996, 1997, 1998, 1999, and 2000?
- (4) Since January 1, 1995, until the present time, what physicians have had surgical privileges at Defendant Carolina Pines Regional Medical Center to perform open Hill procedures?
- (5) Other than Thomas V. Mincheff, M.D., did any other surgeon perform an open Hill surgical procedure at Carolina Pines from January 1, 1995, until the present time; and, if so, which surgeon performed each procedure and on what date?

- (6) How many open Hill surgical procedures each year were performed at Carolina Pines during each of the following years: 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, and 2006?
- (7) What is the surgical complication rate of Thomas V. Mincheff, M.D. at Defendant Carolina Pines Regional Medical Center?
- (8) What is the surgical complication rate of C. Brooks Bannister, M.D. at Defendant Carolina Pines Regional Medical Center?

Carolina Pines violated the Rules and failed to answer the questions for Ms. Person. The Court ordered Carolina Pines to provide answers to Ms. Person no later than October 26, 2006. Carolina Pines violated the Court's Order. Under the law, you are allowed, but not required, to have an adverse or negative inference against Carolina Pines. Under an adverse or negative inference, you may assume Carolina Pines violated the Rules and this Court's Order because the answers would have hurt its defense.

IT IS SO ORDERED.

J. Michael Baxley
Chief Administrative Judge
Fourth Judicial Circuit

Darlington, South Carolina

November ____, 2006

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOURTH JUDICIAL CIRCUIT
COUNTY OF DARLINGTON	)	CASE NO. 2004-CP-16-322
RUTH J. PERSON,	)	
	)	
Plaintiff,	)	
	)	<u>ADVERSE OR NEGATIVE INFERENCE</u>
v.	)	(failure to produce information
	)	involving surgical complications
CAROLINA PINES REGIONAL	)	of Dr. Mincheff and Dr. Bannister)
MEDICAL CENTER,	)	
	)	
Defendant.	)	
_____	)	

Under the South Carolina Rules of Civil Procedure ("Rules"), Ms. Person had the legal right to receive from Carolina Pines answers to the following questions:

What is the surgical complication rate of Thomas V. Mincheff, M.D. at Defendant Carolina Pines Regional Medical Center?

What is the surgical complication rate of C. Brooks Bannister, M.D. at Defendant Carolina Pines Regional Medical Center?

Ms. Person also had the right to the following records from Carolina Pines:

Complete and legible copies of all written or recorded information of any surgical complications involving patients upon whom Thomas V. Mincheff, M.D., performed surgery anytime from January 1, 1990, until the present time.

Carolina Pines violated the Rules and failed to answer the questions and produce the records for Ms. Person. The Court ordered Carolina Pines to answer the questions and provide the documents to Ms. Person no later than October 26, 2006. Carolina Pines violated the Court's Order. Under the law, you are allowed, but not required, to have an adverse or negative inference against Carolina Pines. Under an adverse or negative inference, you may assume Carolina Pines violated the Rules and this Court's Order because the answers and records

would have hurt its defense.

IT IS SO ORDERED.

J. Michael Baxley
Chief Administrative Judge
Fourth Judicial Circuit

Darlington, South Carolina

November ____, 2006

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOURTH JUDICIAL CIRCUIT
COUNTY OF DARLINGTON	)	CASE NO. 2004-CP-16-322
 RUTH J. PERSON,	)	
	)	
Plaintiff,	)	
	)	<u>ADVERSE OR NEGATIVE INFERENCE</u>
v.	)	(failure to produce Carolina Pines'
	)	Operative Notes and Discharge/Transfer
CAROLINA PINES REGIONAL	)	Summaries of Dr. Mincheff and
MEDICAL CENTER,	)	Ms. Person's radiology films)
	)	
Defendant.	)	

Under the South Carolina Rules of Civil Procedure ("Rules"), Ms. Person had the legal right to receive from Carolina Pines the following records:

Complete and legible copies of any and all (approximately 11) Operative Reports and Discharge or Transfer Summaries involving patients of Thomas V. Mincheff, M.D., for open Hill surgical procedures and laparoscopic Nissen fundoplication surgical procedures performed at Byerly Hospital or Carolina Pines Regional Medical Center anytime from January 1, 1991, until the present time. [Please note Carolina Pines shall redact or blackout from all such documents the patients' names, social security numbers, addresses, insurance information, telephone numbers, and other similar identification language prior to Mr. Castelberry's production of them to Plaintiff Person's counsel at his deposition.]

All originals and copies of any and all radiology films of Ms. Ruth J. Person (social security no: 115-50-7187; date of birth: 02/05/58) including, but not limited to, the following: (a) CT Scans; (b) MRI's; and (c) x-ray films dated anytime between April 1, 2001, and the present time.

Carolina Pines violated the Rules and failed to produce the records for Ms. Person. The Court ordered Carolina Pines to provide the documents to Ms. Person no later than October 26, 2006. Carolina Pines violated the Court's Order. Under the law, you are allowed, but not required, to have an adverse or negative inference against Carolina Pines. Under an

adverse or negative inference, you may assume Carolina Pines violated the Rules and this Court's Order because the records would have hurt its defense.

IT IS SO ORDERED.

J. Michael Baxley
Chief Administrative Judge
Fourth Judicial Circuit

Darlington, South Carolina

November ____, 2006

001918

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOURTH JUDICIAL CIRCUIT
COUNTY OF DARLINGTON	)	CASE NO. 2004-CP-16-322
RUTH J. PERSON,	)	
	)	
Plaintiff,	)	
	)	<u>ADVERSE OR NEGATIVE INFERENCE</u>
v.	)	(failure to produce financial data
	)	and income tax returns)
CAROLINA PINES REGIONAL	)	
MEDICAL CENTER,	)	
	)	
Defendant.	)	
_____	)	

Under the South Carolina Rules of Civil Procedure ("Rules"), Ms. Person had the legal right to receive from Carolina Pines an answer to the following question:

What is the net worth of Hartsville HMA, Inc.?

Ms. Person also had the right to the following records from Carolina Pines:

- (1) Complete and legible copy of Defendant Carolina Pines' most current financial statements.
- (2) Complete and legible copies of any and all federal and state income tax returns, including all schedules, filed on behalf of Carolina Pines Regional Medical Center for the years of 2001 until the present date.

Carolina Pines violated the Rules and failed to answer the question and produce the records for Ms. Person. The Court ordered Carolina Pines to answer the question and provide the records to Ms. Person no later than October 26, 2006. Carolina Pines violated the Court's Order. Under the law, you are allowed, but not required, to have an adverse or negative inference against Carolina Pines. Under an adverse or negative inference, you may assume Carolina Pines violated the Rules and this Court's Order because the answer and records

would have hurt its defense.

IT IS SO ORDERED.

J. Michael Baxley
Chief Administrative Judge
Fourth Judicial Circuit

Darlington, South Carolina

November ____, 2006

001920

STATE OF SOUTH CAROLINA

COUNTY OF DARLINGTON

RUTH J. PERSON,

Plaintiff,

v.

THOMAS V. MINCHEFF, M.D.,
HARTSVILLE SURGICAL CENTER,
AND CAROLINA PINES
REGIONAL MEDICAL CENTER,

Defendants.

IN THE COURT OF COMMON PLEAS
FOURTH JUDICIAL CIRCUIT
CASE NO. 2001-CP-16-813

RULE 45 SUBPOENA

TO: MS. MELODY TRIMBLE
HOSPITAL ADMINISTRATOR
CAROLINA PINES REGIONAL MEDICAL CENTER
1304 W. BOBO NEWSOM HIGHWAY
HARTSVILLE, SC 29550

 YOU ARE COMMANDED to appear in the above named court at the place, date and time specified below to testify in the above-entitled case.

PLACE OF TESTIMONY:	COURTROOM:
	DATE AND TIME:

 YOU ARE COMMANDED to appear at the place, date and time specified below to testify at the taking of a deposition in the above-entitled case.

PLACE OF DEPOSITION:	DATE AND TIME:
----------------------	----------------

 X YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects): See Exhibit A attached hereto.

001921

PLACE: Corbin Law Firm 227 W. Evans Street Post Office Box 447 Florence, SC 29503	DATE AND TIME: February 20, 2003 at 10:00 a.m.
--	---

Any subpoenaed organization not a party to this suit is hereby admonished pursuant to Rule 30(b)(6), South Carolina Rules of Civil Procedure, to file a designation with the Court specifying one or more officers, directors, or managing agents, or other persons who consent to testify on its behalf, and shall set forth, for each person designated, the matters on which he will testify or produce documents or things. The person so designated shall testify as to matters known or reasonably available to the organization.

ISSUING OFFICER'S NAME, ADDRESS, AND PHONE NUMBER
Corbin Law Firm (843)667-6119
Daryl J. Corbin
227 West Evans Street
Florence, SC 29501

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1) AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

ISSUING OFFICER'S SIGNATURE AND TITLE (INDICATE IF ATTORNEY FOR PLAINTIFF OR DEFENDANT)
ATTORNEY FOR PLAINTIFF



DATE: February 6, 2004

Florence, South Carolina

SCCA FORM 254 (7/93)

(See Rule 45, South Carolina Rules of Civil Procedure, Parts (c)&(d) attached)

001922

EXHIBIT "A"

Complete and legible copies of the following:

- (1) All documents involving the hospital credentialing or granting of hospital, clinical, and/or surgical privileges to Thomas V. Mincheff, M.D., from January 1, 1990, until the present time.
- (2) All documents involving the hospital credentialing or granting of hospital, clinical, and/or surgical privileges to C. Brooks Bannister, M.D., from January 1, 1990, until the present time.
- (3) Complete and legible copies of any and all written or recorded information that Carolina Pines Regional Medical Center reviewed in making its decision to grant or continue to grant Thomas V. Mincheff, M.D., hospital privileges to perform Nissen Fundoplication surgery.
- (4) Complete and legible copies of any and all written or recorded information that Carolina Pines Regional Medical Center reviewed in making its decision to grant or continue to grant C. Brooks Bannister, M.D., hospital, clinical, and/or surgical privileges to perform Nissen Fundoplication surgery.
- (5) Complete and legible copies of any and all written or recorded information that Carolina Pines Regional Medical Center reviewed in making its decision to grant or continue to grant Thomas V. Mincheff, M.D., hospital, clinical, and/or surgical privileges to perform Laparoscopic surgery.
- (6) Complete and legible copies of any and all written or recorded information that Carolina Pines Regional Medical Center reviewed in making its decision to grant or continue to grant C. Brooks Bannister, M.D., hospital, clinical, and/or surgical privileges to perform Laparoscopic surgery.
- (7) Complete and legible copies of any and all written or recorded information that Carolina Pines Regional Medical Center reviewed in making its decision to grant or continue to grant Thomas V. Mincheff, M.D., hospital, clinical, and/or surgical privileges to perform open Hill surgery.
- (8) Complete and legible copies of any and all written or recorded information that Carolina Pines Regional Medical Center reviewed in making its decision to grant or continue to grant C. Brooks Bannister, M.D., hospital, clinical, and/or surgical privileges to perform open Hill surgery.

- (18) Complete and legible copies of any documentation involving any disciplinary action involving C. Brooks Bannister, M.D., from January 1, 1990, until the present time.
- (19) Complete and legible copies of all materials Carolina Pines Regional Medical Center evaluated involving Thomas V. Mincheff, M.D., for appointment or reappointment to the medical staff or for delineation of privileges of Thomas V. Mincheff, M.D., anytime from January 1, 1990, until the present time.
- (20) Complete and legible copies of all materials Carolina Pines Regional Medical Center evaluated involving C. Brooks Bannister, M.D., for appointment or reappointment to the medical staff or for delineation of privileges of Thomas V. Mincheff, M.D., anytime from January 1, 1990, until the present time.



State of South Carolina
The Circuit Court of the Fourth Judicial Circuit

J. MICHAEL
BAXLEY
JUDGE

531 EAST CAROLINA AVENUE
HARTSVILLE, SOUTH CAROLINA 29550
TELEPHONE: (843) 383-4114
FAX: (843) 383-4116
E-MAIL: jbxaley@sccourts.org

September 22, 2006

Daryl J. Corbin, Esquire
Attorney at Law
Post Office Box 447
Florence, SC 29503

Martin S. Driggers, Jr., Esquire
Sweeney, Wingate & Barrow, PA
323 W. Home Avenue
Hartsville, SC 29550

Re: Person v. Carolina Pines RMC
C/A No.: 04-CP-16-322

Counsel:

At the close of the hearing in this matter on September 5, this Court took the Defendant's motion for summary judgment under advisement. Please accept this letter as notice of the Court's decision.

Essentially, Plaintiff claims that the Defendant was negligent in its credentialing process, which allowed a surgeon to inappropriately perform an operation that led to Plaintiff's significant injury. In response, the Defendant argues that there is no precedent in this jurisdiction for a suit over "negligent credentialing; that credentialing proceedings are privileged pursuant to S.C. Code Ann. § 40-71-10 and 20; and, that no duty extends from the hospital to the patient in this setting.

In reply, Plaintiff argues that Dr. Mincheff has waived any confidentiality protections of the statute, that the **outcome** of credentialing proceedings is not protected pursuant to McGehee v. Bruce Hospital Systems, 439 S.E. 2d 257 (1993), and that other physicians on the credentialing committee admit in their depositions that they have a duty to the patient to properly evaluate physicians performing procedures within the hospital for the safety of hospital patients.

FILED

2006 SEP 25 PM 1:44

CLERK OF COURT/R.D.
DARLINGTON COUNTY, S.C.

TRUE COPY
CLERK OF COURT/R.D.
DARLINGTON COUNTY, S.C.

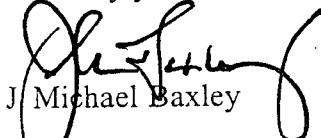
001925

After review of the arguments, memoranda, and documents presented in this case, it appears that this is a matter of first impression for this jurisdiction. Plaintiff argues that this issue should be analyzed in a traditional tort perspective -- the existence of a duty, the breach thereof, and proximate injury. The Court accepts this argument. The Defendant's argument that this suit will eviscerate the privileges and protections of the credentialing statute is not persuasive. In this case, with the facts of this incident, the physician's waiver of the statutory protections, and the admissions by other physicians who sit on the credentialing committee, it appears that there is sufficient evidence before this Court for the Plaintiff to proceed. Under the circumstances of this particular case, and the allegations raised by the Plaintiff, this Court is not in the position at this juncture to say, as a matter of law, that Plaintiff's claim may not be maintained.

For these reasons, Defendant's motion for summary judgment is denied. Attorney Corbin is requested to prepare an Order within ten (10) days of the date of this letter detailing the decision stated herein and forward the same to opposing counsel. Attorney Driggers is not asked to agree or consent to the Order, but is requested to review it for mistake of fact or misstatement of your party's position; thereafter, Attorney Corbin is asked to forward the finalized Order to the Court. Attorney Corbin is requested to send an electronic copy in Word format on disk or via email (jbaxleylc@sccourts.org) to my office for signature, which will then be finalized, signed, and returned to Attorney Corbin for filing and formal service on the parties.

Thank you for the professional way in which this issue was argued and presented. By copy of this letter, I am returning all hearing exhibits to the custody of the Clerk of Court.

Sincerely yours,


J. Michael Baxley

JMB/jlc

cc: Honorable Scott B. Suggs (for filing) ✓

FILED
2006 SEP 25 PM 1:44
SCOTT B. SUGGS
CLERK OF COURT/R.O.D.
DARLINGTON COUNTY, S.C.

001926

STATE OF SOUTH CAROLINA)

COUNTY OF DARLINGTON)

RUTH J. PERSON,)

Plaintiff,)

v.)

CAROLINA PINES REGIONAL)
MEDICAL CENTER,)

Defendant.)
_____)

IN THE COURT OF COMMON PLEAS
FOURTH JUDICIAL CIRCUIT
CASE NO. 2004-CP-16-322

RULE 45 SUBPOENA
**(Deposition Appearance and
and Document Production)**

**TO: MR. DAVID CASTLEBERRY
CAROLINA PINES REGIONAL MEDICAL CENTER
1304 W. BOBO NEWSOM HIGHWAY
HARTSVILLE, SC 29550**

 YOU ARE COMMANDED to appear in the above named court at the place, date and time specified below to testify in the above-entitled case.

PLACE OF TESTIMONY:	COURTROOM:
	DATE AND TIME:

 X **YOU ARE COMMANDED** to appear at the place, date and time specified below to testify at the taking of a deposition in the above-entitled case.

PLACE OF DEPOSITION: Carolina Pines Regional Medical Center 1304 W. Bobo Newsome Highway Hartsville, SC 29550	DATE AND TIME: October 26, 2006 10:00 a.m.
--	--

 X **YOU ARE COMMANDED** to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects): **See Exhibit A attached hereto.**

001927

PLACE:

Carolina Pines Regional Medical Center
1304 W. Bobo Newsome Hwy
Hartsville, SC 29550

DATE AND TIME:

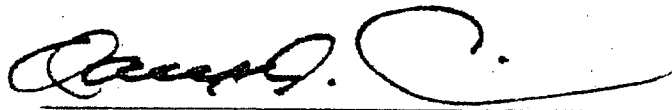
October 26, 2006
10:00 a.m.

Any subpoenaed organization not a party to this suit is hereby admonished pursuant to Rule 30(b)(6), South Carolina Rules of Civil Procedure, to file a designation with the Court specifying one or more officers, directors, or managing agents, or other persons who consent to testify on its behalf, and shall set forth, for each person designated, the matters on which he will testify or produce documents or things. The person so designated shall testify as to matters known or reasonably available to the organization.

ISSUING OFFICER'S NAME, ADDRESS, AND PHONE NUMBER

Corbin Law Firm (843)667-6119
Daryl J. Corbin
227 West Evans Street
Florence, SC 29501

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45©(1) AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.



ISSUING OFFICER'S SIGNATURE AND TITLE (INDICATE IF ATTORNEY FOR PLAINTIFF OR DEFENDANT)

ATTORNEY FOR PLAINTIFF

DATE: October 13, 2006

Florence, South Carolina

SCCA FORM 254 (7/93)

(See Rule 45, South Carolina Rules of Civil Procedure, Parts (c)&(d) attached)

001928

EXHIBIT A

1. Complete and legible copies of any and all recorded or written materials in possession of Carolina Pines Regional Medical Center or to which you have access involving any credentialing materials, seminar materials, fee agreement, notices to persons at Carolina Pines about any seminars or lectures, and internal memoranda or documents involving The Greeley Company, or other materials involving The Greeley Company or any of its affiliated entities, including, but not limited to the Healthcare Compliance Company, HCPPro, or the Credentialing Resource Center.
2. All originals and copies of any and all radiology films of Ms. Ruth J. Person (social security no: 115-50-7187; date of birth: 02/05/58) including, but not limited to, the following: (a) CT Scans; (b) MRI's; and (c) x-ray films dated anytime between April 1, 2001, and the present time.
3. Complete and legible copies of any and all (approximately 11) Operative Reports and Discharge or Transfer Summaries involving patients of Thomas V. Mincheff, M.D., for open Hill surgical procedures and laparoscopic Nissen fundoplication surgical procedures performed at Byerly Hospital or Carolina Pines Regional Medical Center anytime from January 1, 1991, until the present time. Please note Carolina Pines shall redact or blackout from all such documents the patients' names, social security numbers, addresses, insurance information, telephone numbers, and other similar identification language prior to Mr. Castelberry's production of them to Plaintiff Person's counsel at his deposition.
4. Complete and legible copies of any and all Operating Agreements, Management Agreements, or any similar documents involving control of Health Management Associates, Inc. ("HMA"), over Carolina Pines Regional Medical Center.
5. Complete and legible copies of any and all insurance policies of Health Management Associates, Inc., and/or Carolina Pines Regional Medical Center applicable to Ms. Ruth J. Person's claim in this matter.
6. Complete and legible copies of any and all federal and state income tax returns, including all schedules, filed on behalf of Carolina Pines Regional Medical Center for the years of 2001 until the present date.
7. Complete and legible copies of any and all employment agreements between Carolina Pines Regional Medical Center's CEOs or executives and Health Management Associates, Inc., including, but not limited to, Mr. David Castleberry, Ms. Melody Trimble, and Ms. Page Vauhn.

8. Complete and legible copies of any and all monetary lending agreements or leasing contracts between Health Management Associates, Inc., and Carolina Pines Regional Medical Center.
9. Complete and legible copies of any and all written or recorded transmissions, correspondence, memoranda, facsimile transmissions, emails, or other communications between Health Management Associates, Inc., and Carolina Pines Regional Medical Center involving Mr. Person's lawsuit.
10. Complete and legible copies of any and all declaration pages of insurance policies involving vehicles used by Carolina Pines Regional Medical Center.
11. Complete and legible copies of any and all vehicle or equipment leasing agreements involving vehicles or equipment used by Carolina Pines Regional Medical Center.
12. Complete and legible copies of records or documents that show Carolina Pines Regional Medical Center is under the control of Health Management Associates, Inc.
13. Complete and legible copies of any and all records or documents involving any communications between Health Management Associates, Inc., and Carolina Pines Regional Medical Center about Bylaws or any "policies and procedures."

001930

STATE OF SOUTH CAROLINA)

COUNTY OF DARLINGTON)

RUTH J. PERSON,)

Plaintiff,)

v.)

CAROLINA PINES REGIONAL)
MEDICAL CENTER,)

Defendant.)
_____)

IN THE COURT OF COMMON PLEAS
FOURTH JUDICIAL CIRCUIT
CASE NO. 2004-CP-16-322

CERTIFICATE OF SERVICE

I, the undersigned, an employee of Daryl J. Corbin, Esquire, attorney for the Plaintiff, do hereby certify that I have served a copy of the foregoing **Rule 45 Subpoena (Deposition Appearance and Document Production)** via hand-delivery on October 13, 2006, addressed to the person(s) as indicated below.

Mr. David Castleberry
Hospital Administrator
Carolina Pines Regional Medical Center
1304 W. Bobo Newsom Highway
Hartsville, SC 29550

Christina Stewart
Christina B. Stewart

Florence, South Carolina

001931

IN THE COURT OF COMMON PLEAS
FOURTH JUDICIAL CIRCUIT
CASE NO. 2004-CP-16-322

Plaintiff,

v.

CAROLINA PINES REGIONAL
MEDICAL CENTER,

Defendant.

NOTICE OF VIDEO DEPOSITIONS
[Rule 30(h) Video Depositions]

PLEASE TAKE NOTICE that the attorney for the Plaintiff will take the videotape depositions of the following witnesses, on oral examination, pursuant to Rule 30(h) of the *South Carolina Rules of Civil Procedure*, before a Notary Public or before some other officer authorized by law to take depositions, said deposition to continue from day to day until completed.

You are hereby notified to appear and take such part in the examinations as you may be advised and as shall be fit and proper.

DEPONENT

LOCATION

DATE & TIME

Mr. David Castleberry

Carolina Pines
1304 Bobo Newsom Hwy
Hartsville, South Carolina

October 31, 2006.
10:00 a.m.

Gary Barker, M.D.

Carolina Pines
1304 Bobo Newsome Highway
Hartsville, South Carolina

October 31, 2006
1:00 p.m.

Ms. Charmaine Enoch

Carolina Pines
1304 Bobo Newsom Hwy
Hartsville, South Carolina

October 31, 2006
3:00 p.m.

001932

RESPECTFULLY SUBMITTED,

CORBIN LAW FIRM

227 West Evans Street
Post Office Box 447
Florence, SC 29503
(843)667-6119

BY:



DARYL J. CORBIN
Attorney for Plaintiff

Florence, South Carolina

October 23, 2006

001933

)
)
)

$$\begin{array}{c}) \\) \\) \\) \\) \\) \\) \\) \\) \end{array}$$

Plaintiff,

V.

Defendant.

1934

STATE OF SOUTH CAROLINA
COUNTY OF DARLINGTON

THE COURT OF COMMON PLEAS
FOURTH JUDICIAL CIRCUIT
2004-CP-16-0322

Ruth J. Person,)
)
Plaintiff,)
vs.)
)
Carolina Pines Regional Medical)
Center,)
)
Defendants.)

AFFIDAVIT OF
MARTIN S. DRIGGERS, JR.

2006 NOV -6 AM 8:51
DARLINGTON COUNTY, S.C.

FILED

Personally appeared before me, Martin S. Driggers, Jr., who after being duly sworn, deposes and says:

1. I am an attorney with Sweeny, Wingate, & Barrow, P.A. and am the attorney representing the Defendant Carolina Pines Regional Medical Center, in the above-entitled action.

2. Plaintiff mailed a Rule 45 Subpoena for the taking of the deposition of and for the production of documents by B. Todd Heniford, MD to me as attorney for Defendant Carolina Pines by letter dated September 22, 2006. See letter and Subpoena attached as Exhibit 1.

3. By my signature I accepted service of said Rule 45 Subpoena and notified Plaintiff's attorney of my acceptance of service by returning his signed letter by facsimile dated September 26, 2006. See attached signed letter, facsimile cover sheet and facsimile transmission report attached as Exhibit 2.

4. The Rule 45 Subpoena was scanned and e-mailed to B. Todd Heniford, MD on September 27, 2006. See e-mail attached as Exhibit 3.

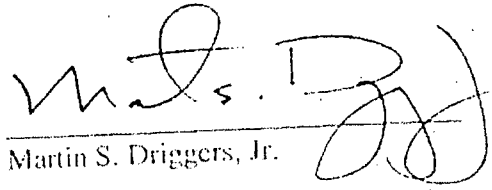
5. I informed Plaintiff's attorney of my objections to the Rule 45 Subpoena by letter sent by facsimile and mail along with a copy of Dr. Heniford's Curriculum Vitae (CV) dated September 28, 2006. See letter attached as Exhibit 4.

6. I provided Plaintiff's attorney copies of articles and a course syllabus by hand delivery on October 12, 2006. See letter attached as Exhibit 5.

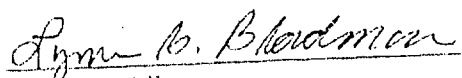
TRUE CERTIFIED COPY,
Martin S. Driggers, Jr.
CLERK OF COURT
DARLINGTON COUNTY, S.C.

001935

Further Affiant sayeth naught.


Martin S. Driggers, Jr.

Sworn to and subscribed before me
this 4 day of November, 2006.


Notary Public

My Commission Expires:
10/28/08

2006 NOV -6 AM 8:51
CLERK OF COURT
DAKOTA COUNTY, S.C.

FILED

001936

Corbin Law Firm

227 WEST EVANS STREET
POST OFFICE BOX 447
FLORENCE, SOUTH CAROLINA 29503

DAVID J. CORBIN
ATTORNEY AT LAW

TELEPHONE: (843)667-6119
FACSIMILE: (843)664-9180

September 22, 2006

Via Facsimile Transmission (843)383-6150
and Regular US Mail

Martin S. Driggers, Jr., Esquire
Sweeny, Wingate, & Barrow, P.A.
323 W. Home Avenue
Hartsville, SC 29551

Re: Ruth J. Person v. Carolina Pines Regional Medical Center
(Case No. 2004-CP-21-322)

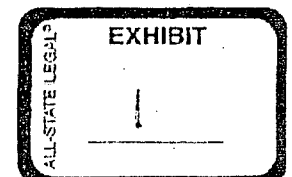
Dear Martin:

Please find enclosed a Subpoena requiring B. Todd Heniford, M.D. ("Heniford"), to produce some items for me involving his October 2, 2006, deposition at Carolinas Medical Center in Charlotte, North Carolina, in the Person case. Please note I am requiring Dr. Heniford to produce the items for me to review at 9:00 a.m. on October 2, 2006, before his 1:30 p.m. deposition. I will review the items without the requirement of his presence so I can minimize review time during his deposition.

Accordingly, please have Dr. Heniford deliver the items to the deposition location (Carolinas Medical Center, 1000 Blythewood Blvd., MEB601 in Charlotte) no later than 9:00 a.m. on October 2, 2006. I anticipate arriving shortly after 9:00 a.m. to review the items prior to Dr. Heniford's 1:30 p.m. deposition. I would appreciate if Dr. Heniford could identify the location of a copy machine which I could use if I need to copy some of the written items.

Please sign the bottom of this letter acknowledging Dr. Heniford will produce the items noted in the subpoena for my review at 9:00 a.m. on October 2, 2006, so I can avoid having him served by a deputy sheriff. Since I previously cooperated with you involving Ms. Voigt and her file materials, I hope you will extend the same courtesy to me. If you require formal service of the Subpoena upon Dr. Heniford, please IMMEDIATELY let me know.

001937



Martin S. Driggers, Jr., Esquire
September 22, 2006
Page 2

Thank you; and, with warm regards, I am

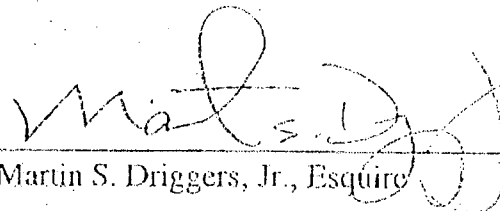
Sincerely yours,



Daryl J. Corbin

DJC/cbs/6069
Enclosure

I hereby agree to accept on behalf of B. Todd Heniford, M.D., the enclosed Rule 45
Subpoena.



Martin S. Driggers, Jr., Esquire Date

001938

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PLACE: Carolinas Medical Center 1000 Blythe Blvd., MEB601 Charlotte, NC 29203	DATE AND TIME: October 2, 2006 9:00 a.m.
--	---

Any subpoenaed organization not a party to this suit is hereby admonished pursuant to Rule 30(b)(6), South Carolina Rules of Civil Procedure, to file a designation with the Court specifying one or more officers, directors, or managing agents, or other persons who consent to testify on its behalf, and shall set forth, for each person designated, the matters on which he will testify or produce documents or things. The person so designated shall testify as to matters known or reasonably available to the organization.
ISSUING OFFICER'S NAME, ADDRESS, AND PHONE NUMBER Corbin Law Firm (843)667-6119 Daryl J. Corbin 227 West Evans Street Florence, SC 29501

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1) AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.



ISSUING OFFICER'S SIGNATURE AND TITLE (INDICATE IF ATTORNEY FOR PLAINTIFF OR DEFENDANT)

ATTORNEY FOR PLAINTIFF

DATE: September 22, 2006

Florence, South Carolina

SCCA FORM 254 (7/93)

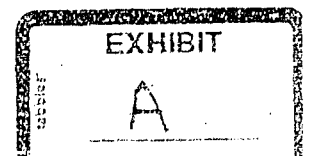
(See Rule 45, South Carolina Rules of Civil Procedure, Parts (c)&(d) attached)

001940

ITEMS FOR B. TODD HENIFORD, M.D., TO PRODUCE
(Carolinas Medical Center, MEB601, at 9:00 a.m. on October 2, 2006)

1. The complete file including all materials you have involving Ms. Ruth Person's case.
2. Copies of any and all drafts or final reports you have prepared or read involving Ms. Ruth Person's case.
3. Copies of any and all emails you have sent or read involving Ms. Ruth Person's case.
4. A blank copy of any general surgery clinical privileges forms involving laparoscopic Nissen fundoplication surgery used at Carolinas Medical Center or any other hospital where you have surgical privileges.
5. All documents indicating the requirements a surgeon must satisfy to perform a laparoscopic Nissen fundoplication surgical procedure at Carolinas Medical Center.
6. A copy of any guideline or other written or recorded material that you believe is reasonably reliable in defining minimum qualifications of a surgeon involving performance of laparoscopic Nissen fundoplication surgery.
7. A copy of any medical literature that you believe supports the proposition that Thomas V. Mincheff, M.D., was qualified to perform laparoscopic Nissen fundoplication surgery on or before April 25, 2001.
8. Originals or legible copies of any journal articles, textbooks, textbook chapters, letters, replies, or other medical literature or teaching materials of which you are an author involving laparoscopic Nissen fundoplication surgery.
9. All course syllabuses, outlines, reference materials, CD-ROMS, recordings, and other written or recorded materials used by you or which you provided to other persons at any lecture, training session, medical seminar, CME program, convention, roundtable discussion, or other programs involving your teaching of physicians or discussions about laparoscopic Nissen fundoplication surgery anytime during the last ten (10) years.

001941



STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF DARLINGTON) FOURTH JUDICIAL CIRCUIT
CASE NO. 2004-CP-16-322

RUTH J. PERSON,)

Plaintiff,)

v.)

CERTIFICATE OF SERVICE

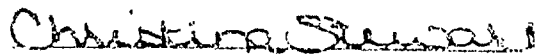
CAROLINA PINES REGIONAL)
MEDICAL CENTER,)

Defendant.)

I, the undersigned, an employee of Daryl J. Corbin, Esquire, attorney for the Plaintiff, do hereby certify that I have served a copy of the foregoing **Rule 45 Subpoena** by transmitting via facsimile and United States Mail, postage prepaid, on September 22, 2006, addressed to the attorney(s) as indicated below.

Via Facsimile Transmission (843)383-6150
and Regular US Mail

Martin S. Driggers, Jr., Esquire
Sweeny, Wingate, & Barrow, P.A.
323 W. Home Avenue
Hartsville, SC 29551


Christina B. Stewart

Florence, South Carolina

001942

BLACKMON PARALEGAL SERVICES
123 N. ERVIN STREET
DARLINGTON, SC 29532

Lynn G. Blackmon
Paralegal

Phone: (843) 398-1282
Fax: (843) 398-1772
E-mail: lgbusc@bellouth.net

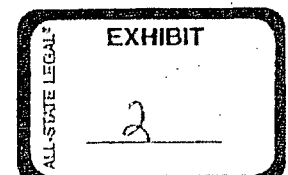
DATE: September 26, 2006 FAX NO.: (843) 664-9180
TO: Daryl Corbin, Esq. COMPANY: Corbin Law Firm
FROM: Lynn G. Blackmon
NUMBER OF PAGES: 3

Re: Ruth J. Person vs. Carolina Pines Regional Medical Center
Darlington County 2004-CP-16-0322

Martin S. Driggers, Jr. of Sweeny, Wingate & Barrow, P.A. is defending Carolina Pines Regional Medical Center in the above-referenced matter. I am paralegal to Mr. Driggers.

Please your letter dated September 22, 2006 which has been signed by Mr. Driggers accepting the Rule 45 Subpoena to B. Todd Heniford, MD.

001943



Corbin Law Firm

227 WEST EVANS STREET
POST OFFICE BOX 447
FLORENCE, SOUTH CAROLINA 29503

DARYL J. CORBIN
ATTORNEY AT LAW

TELEPHONE: (843)664-6119
FACSIMILE: (843)664-9180

September 22, 2006

Via Facsimile Transmission (843)383-6150
and Regular US Mail

Martin S. Driggers, Jr., Esquire
Sweeny, Wingate, & Barrow, P.A.
323 W. Home Avenue
Hartsville, SC 29551

Re: Ruth J. Person v. Carolina Pines Regional Medical Center
(Case No. 2004-CP-21-322)

Dear Martin:

Please find enclosed a Subpoena requiring B. Todd Heniford, M.D. ("Heniford"), to produce some items for me involving his October 2, 2006, deposition at Carolinas Medical Center in Charlotte, North Carolina, in the Person case. Please note I am requiring Dr. Heniford to produce the items for me to review at 9:00 a.m. on October 2, 2006, before his 1:30 p.m. deposition. I will review the items without the requirement of his presence so I can minimize review time during his deposition.

Accordingly, please have Dr. Heniford deliver the items to the deposition location (Carolinas Medical Center, 1000 Blythewood Blvd., MEB601 in Charlotte) no later than 9:00 a.m. on October 2, 2006. I anticipate arriving shortly after 9:00 a.m. to review the items prior to Dr. Heniford's 1:30 p.m. deposition. I would appreciate if Dr. Heniford could identify the location of a copy machine which I could use if I need to copy some of the written items.

Please sign the bottom of this letter acknowledging Dr. Heniford will produce the items noted in the subpoena for my review at 9:00 a.m. on October 2, 2006, so I can avoid having him served by a deputy sheriff. Since I previously cooperated with you involving Ms. Voigt and her file materials, I hope you will extend the same courtesy to me. If you require formal service of the Subpoena upon Dr. Heniford, please IMMEDIATELY let me know.

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Martin S. Driggers, Jr., Esquire
September 22, 2006
Page 2

Thank you; and, with warm regards, I am

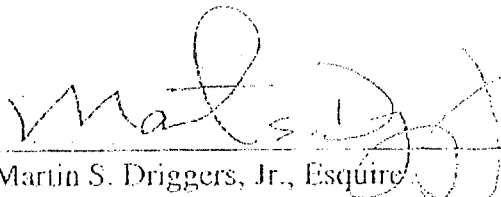
Sincerely yours,



Daryl J. Corbin

DJC/cbs/6069
Enclosure

I hereby agree to accept on behalf of B. Todd Heniford, M.D., the enclosed Rule 45
Subpoena.



Martin S. Driggers, Jr., Esquire Date

TRANSMISSION VERIFICATION REPORT

TIME : 09/26/2006 16:13
NAME : BLACKMON PARALEGAL
FAX : 8433981772
TEL : 8433981282
SER. # : 800M4J409971

DATE, TIME	09/26 16:12
FAX NO./NAME	6549180
DURATION	00:01:06
PAGE(S)	03
RESULT	OK
MODE	STANDARD
	ECM

001946

From: Lynn Blackmon [lgbnsc@bellsouth.net]
Sent: Monday, October 02, 2006 2:39 PM
To: 'Martin S. Driggers, Jr.'
Subject: RE: Heniford Subpoena
Martin,

I scanned and e-mailed the Rule 45 Subpoena to Michelle for Dr. Heniford on Wednesday, 9/27/06.

We identified Dr. Heniford as our expert in Defendant's Supplemental Answers to Plaintiff's Interrogatories served 8/11/06.

Lynn G. Blackmon
Blackmon Paralegal Services
123 N. Ervin Street
Darlington, SC 29532
W: (843) 398-1282
F: (843) 398-1772
Email: lgbnsc@bellsouth.net

From: Martin S. Driggers, Jr. [mailto:MSD@swblaw.com]
Sent: Monday, October 02, 2006 1:08 PM
To: lgbnsc@bellsouth.net
Subject: Fw: Heniford Subpoena

Also, When did we identify Heniford.
Martin S. Driggers, Jr., Esq.
Sweeny, Wingate & Barrow, P.A.
323 West Home Avenue
Hartsville, South Carolina 29550
Phone: 843-383-2146
Facsimile: 843-383-6150
Electronic Mail: msd@swblaw.com

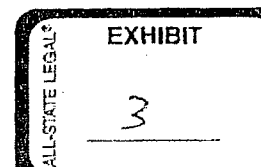
-----Original Message-----

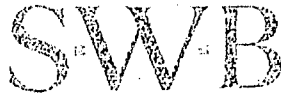
From: Martin S. Driggers, Jr. <MSD@swblaw.com>
To: 'lgbnsc@bellsouth.net' <lgbnsc@bellsouth.net>
Sent: Mon Oct 02 12:54:18 2006
Subject: Heniford Subpoena

Lynn,

Out of interest, When did we fax the subpoena from Corbin to Heniford's office?
Martin S. Driggers, Jr., Esq.
Sweeny, Wingate & Barrow, P.A.
323 West Home Avenue
Hartsville, South Carolina 29550
Phone: 843-383-2146
Facsimile: 843-383-6150
Electronic Mail: msd@swblaw.com

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SWEENEY WINGATE & BARROW P.A.

September 28, 2006

Reply to: Pee Dee Office

Martin S. Driggers, Jr.
(843) 383-2146 x
msd@swblaw.com
Also Admitted in NC

VIA FACSIMILE

Daryl J. Corbin, Esquire
Corbin Law Firm
227 West Evans Street
Post Office Box 447
Florence, South Carolina 29503

RE: Ruth J. Person v. C. Brooks Bannister, M.D., Hartsville Surgical Center, and
Carolina Pines Regional Medical Center
Civil Action No.: 2004-CP-16-322
Our File: 1863/4975

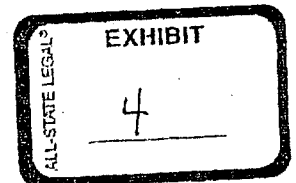
Dear Daryl:

I have been able to make arrangements for you at the Carolinas Medical Center in preparation for Dr. Heniford's deposition. They will have a room available beginning at 10:00 a.m. in the Medical Executive Building somewhere near room 601, which is where Dr. Heniford's office is located. The deposition is still set to begin at 1:00 p.m. When you arrive at the Medical Executive Building, you need to ask for Dr. Heniford's assistant, Michelle, who will direct you to the conference room that they have been able to reserve. I also wanted to voice an objection we have to your subpoena that was sent to Dr. Heniford. I will go through the list and attempt to respond as best as we can and voice the objections that we have.

1. The complete file including all materials you have involving Ms. Ruth Person's case.

RESPONSE: Dr. Heniford has reviewed the depositions of Dr. Mincheff, Dr. Bannister, Dr. Barker, Dr. Cooler, Dr. Robinson, Dr. Demaria and Ms. Ruth Person. He has also reviewed the Carolina Pines Regional Medical Center's medical bylaws that have been produced in this case. Finally, he has reviewed the deposition testimony and file material from Ms. Laura Voight.

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2. Copies of any and all drafts or final reports you have prepared or read involving Ruth Person's case.

RESPONSE: Dr. Heniford has not prepared any reports in this case.

3. Copies of any and all e-mails you have sent or read involving Ms. Person's case.

RESPONSE: Dr. Heniford has not received any e-mails from anyone involving Ms. Ruth Person's case.

4. A blank copy of any general surgical clinical privileges forms involving laproscopic Nissen fundoplication surgery used at Carolinas Medical Center or any other hospital where you have surgical privileges.

RESPONSE: We object to this request as simply items that are not readily in the possession of or available for Dr. Heniford to produce. If you would like to seek these documents from the Carolinas Medical Center itself, they may be able to provide them to you.

5. All documents indicating the requirements a surgeon must satisfy to perform a laproscopic Nissen fundoplication surgical procedure at Carolinas Medical Center.

RESPONSE: See response to No. 4. Dr. Heniford may very well be able to testify and answer some questions surrounding this request; however, he will not be able to produce any written materials.

6. A copy of any guideline or any other written or recorded material that you believe is reasonably reliable in defining minimum qualifications of a surgeon involving performance of laproscopic Nissen fundoplication surgery.

RESPONSE: Dr. Heniford is unable to respond to this request at this time without specific questions regarding the privilege in question. Once the questions are asked then certain documents may be referred to and copies obtained following the deposition.

7. A copy of any medical literature that you believe supports the proposition that Thomas V. Mincheff, M.D., was qualified to perform laparoscopic Nissen fundoplication surgery on or before April 25, 2001.

RESPONSE: We object to this request as simply too broad to respond to at this point. There could be various items of medical literature supporting this proposition stated in the request, some of which are provided in Dr. Heniford's curriculum vitae.

8. Original or legible copies of any journal articles, textbooks, textbook chapters, letters, replies or other medical literature or teaching materials of which you are an author involving laproscopic Nissen fundoplication surgery.

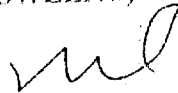
RESPONSE: A copy of Dr. Heniford's curriculum vitae has been provided and will be attached again to this letter. However, Dr. Heniford is unable to go back and obtain copies of all these materials before the deposition.

9. All course syllabuses, outlines, reference materials, CD roms, recordings and other written and recorded materials used by you or which you have provided to other persons in lecture, training session, medical seminar, CEM program, convention, round table discussion or other programs involving laproscopic Nissen fundoplication surgery.

RESPONSE: See response to request no. 8. Dr. Heniford's various teaching items and materials have been listed in his curriculum vitae. He would be unable to collect such material prior to his deposition.

Yours truly,

SWEENEY, WINGATE & BARROW, P.A.

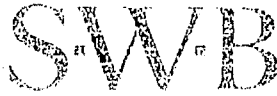


Martin S. Driggers, Jr.

MSD/mt

Enclosure: Curriculum Vitae

001950



SWEENEY WINGATE & BARROW P.A.

October 11, 2006

Reply to: Pee Dee Office

Martin S. Driggers, Jr.
(843) 383-2146
msd@swblaw.com

MR DARYL J CORBIN
CORBIN LAW FIRM
PO BOX 447
FLORENCE SC 29503

Re: Ruth J. Person vs. Carolina Pines Regional Medical Center
Darlington County 2004-CP-16-322
Our File No. 1863/4975

Dear Daryl:

Enclosed please find the articles and course syllabus you requested in this matter.

Also there is a charge of \$105 for the gathering and copying of this information. Please send a check payable to Michelle Amabile to:

Michelle Amabile
Fellowship Coordinator
Carolinas Laparoscopic & Advanced Surgery Program
Carolinas Medical Center
1000 Blythe Blvd
MEB 601
Charlotte, NC 28203

With kind regards, I remain

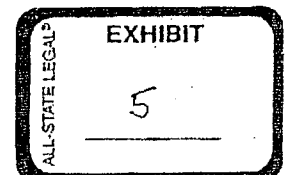
Yours truly,

SWEENEY, WINGATE & BARROW, P.A.

Martin S. Driggers, Jr.

Martin S. Driggers, Jr.

MSD/lgb
Enclosures



001951

STATE OF SOUTH CAROLINA
COUNTY OF DARLINGTON

) THE COURT OF COMMON PLEAS
)
) FOR THE FOURTH CIRCUIT

Ruth J. Person,

Plaintiff,

v.

Carolina Pines Regional Medical Center,

Defendants.

) Civil Action No.: 2004-CP-16-322
)
)

)
) AFFIDAVIT OF
) B. TODD HENIFORD, M.D.
)
)

PERSONALLY APPEARED BEFORE ME, the undersigned, B. Todd Heniford, M.D.,
who after being duly sworn, deposes and says:

1. I am B. Todd Heniford, M.D., a licensed general surgeon practicing primarily at the Carolinas Medical Center in Charlotte, North Carolina, specializing in advanced laparoscopic surgery.

2. I was retained as an expert witness in the above-referenced matter by the Defendant, Carolina Pines Regional Medical Center. My deposition was taken in conjunction with my role as an expert witness on October 2, 2006. This was in anticipation of the trial of this case set for November 6, 2006.

3. Prior to the trial date, I was informed that my testimony had been excluded by the court and therefore, there was a great deal of uncertainty as to whether I would be allowed to testify at the trial of this case.

4. On November 6, 2006, I was informed by counsel for Defendant Carolina Pines Regional Medical Center, that the court had reversed its decision and would indeed allow my testimony at the trial of the case.

5. At that point, the only date I had available on my schedule to testify was Wednesday, November 8, 2006. I had a previous long-standing engagement to teach specific

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medical procedures to a group of physicians in the State of Arizona, beginning on Thursday, November 9, 2006 and carrying through November 12, 2006.

6. Over the course of my time in Arizona, I was informed by counsel for Defendant Carolina Pines Regional Medical Center that the case was going over into a second week, beginning November 13, 2006. I was asked at that time to take steps to see if I could appear at trial during that second week.

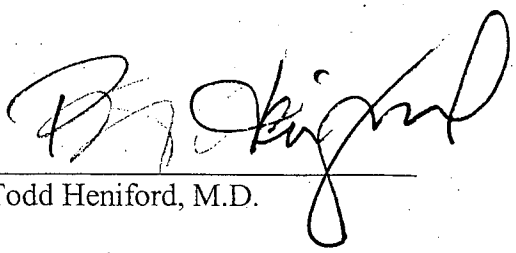
7. Unfortunately, I had moved a great number of surgical procedures, meetings, and appointments into the week of November 13, 2006. Furthermore, I was obligated to attend a including a Board Meeting of the American College of Surgeons at the end of that week.

8. After returning to Charlotte, North Carolina, on November 13, 2006, I attempted to rearrange my schedule in hopes of appearing and testifying at the trial of this case.

9. Those efforts to clear my schedule continued even until the morning of November 14, 2006. However, I was ultimately forced to inform counsel for Defendant Carolina Pines Regional Medical Center that I would not be able to travel to Darlington, South Carolina to testify at the trial of the case that day or any other day that week.

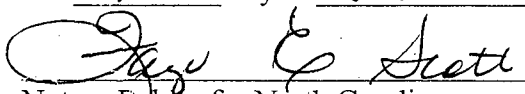
10. My staff and I spent a great deal of time attempting to rearrange my and other surgeons' schedules in order to make myself available for testimony at trial, but these last minute efforts simply were not successful.

FURTHER AFFIANT SAYETH NOT.


B. Todd Heniford, M.D.

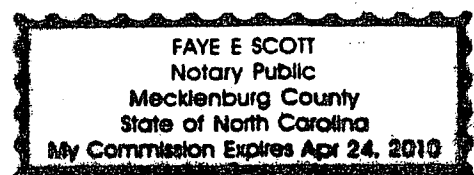
SWORN TO and subscribed before me

this 19 day of December, 2006

 (L.S.)
Notary Public for North Carolina

My commission Expires: 4/24/2010

001953





State of South Carolina
The Circuit Court of the Fourth Judicial Circuit

J. MICHAEL
BAXLEY
JUDGE

531 EAST CAROLINA AVENUE
HARTSVILLE, SOUTH CAROLINA 29550
TELEPHONE: (843) 383-4114
FAX: (843) 383-4116
E-MAIL: jbaxley@sccourts.org

August 15, 2007

Daryl J. Corbin, Esquire
Attorney at Law
Post Office Box 447
Florence, SC 29503

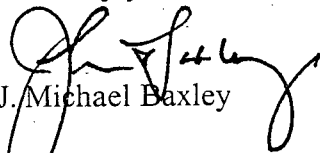
Re: Ruth J. Person v. Carolina Pines RMC (C/A No.: 04-CP-16-322)

Dear Mr. Corbin:

On March 6, 2007, you appeared before this Court on a Motion for Relief from a jury verdict in the above entitled matter. At that time, you requested an opportunity to take depositions and gather further evidence. It was my request to you at that time that this post trial discovery be done quickly. Unfortunately, in spite of several contacts to your office, the discovery has not been completed and we have not yet received your final position in this matter.

Please accept this letter as notice that this matter will be held open for twenty (20) additional days from the date of this letter. Within that time, the Court expects to receive a memorandum with any relevant evidence attached that bears on the issue of relief from the jury verdict. Thereafter, Mr. Driggers shall have thirty (30) days to reply in written form. Thereafter, the Court will decide whether to grant a further hearing or decide the issue on the memoranda. Because the ongoing continuation of this matter results in expense and further legal entanglement for the Defendant, which was found by the jury to not be liable for Plaintiff's injuries, I cannot grant further an extension of your already overdue response. Thank you for your immediate attention to this matter.

Sincerely yours,


J. Michael Baxley
JMB/jlc

cc: Martin S. Driggers, Jr., Esquire
Honorable Scott B. Suggs (for filing)

001954

STATE OF SOUTH CAROLINA

COUNTY OF DARLINGTON

Ruth J. Person,

Plaintiff,

v.

C. Brooks Bannister, M.D., Hartsville
Surgical Center, and Carolina Pines
Regional Medical Center,

Defendants.

THE COURT OF COMMON PLEAS

FOR THE FOURTH CIRCUIT

Civil Action No.: 2004-CP-16-322

AFFIDAVIT OF
LOU JEAN GAINNEY

SCOTT B. SUGGS
CLERK OF SUPERIOR COURT
DARLINGTON COUNTY, S.C.

2007 OCT -14 AM 11:10

FILED

1. My name is Lou Jean Gainey and I am the Director of Health Information Management at Carolina Pines Regional Medical Center.

2. I have worked at Carolina Pines Regional Medical Center and its predecessor, the Byerly Hospital for the last 21 years, all in the medical record's department of both of those facilities. I have been the manager of the Health Information Management for Carolina Pines Regional Medical Center since March of 1998.

3. Our hospital keeps certain hardcopy records from the years 2004 through the present. For hardcopy records older than the 2004 date, our records are kept off site at Iron Mountain Record Storage in Florence, South Carolina. Carolina Pines Regional Medical Center has contracted with Iron Mountain to house these records since April 28, 2004.

4. While the Iron Mountain Florence facility houses our records, they are still filed according to a system maintained by Carolina Pines Regional Medical Center. Due to changes in our medical records keeping over the years, there are various numbers and codes that are used to track the medical records held and stored at Iron Mountain.

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5. Due to the different numbers and codes, when searching for specific records for a patient or procedure, it is common for the personnel at Iron Mountain to initially retrieve records for a particular patient or date, only to find out that the record retrieved is not the correct record. The likelihood of finding incorrect records increases when the patients in question have multiple procedures during the course of their lifetime at Carolina Pines Regional Medical Center. This is because the records produced are often for the correct patient name, but not the correct procedure or date of treatment. There is oftentimes several conversations between our department and Iron Mountain when tracking down older records.

6. I was actively and intimately involved with the above-referenced case during the course of its litigation, up to and including October and November of 2006 when the case was approaching its trial.

7. On the above-referenced case, the Health Information Management department had been involved with producing the medical records for Ms. Person at the initial stages of the litigation.

8. My department subsequently became involved on or about October 17, 2006. It was on or just prior to this date that we received a request from Ms. Stephanie Foreman, the risk manager for Carolina Pines Regional Medical Center, for older medical records for certain patients of Dr. Thomas Mincheff and for radiological films for Ms. Ruth Person. The medical records included procedures for several different patients. Ms. Foreman indicated to us that a Subpoena had been received requesting these records.

9. Regarding the prior medical records for patients of Dr. Thomas Mincheff, after taking time to determine what patients met the criteria for the procedures that the Plaintiff was requesting, Ms. Foreman then asked us to locate operative notes and discharge summaries for these

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particular patients. A copy of our initial request sent to Iron Mountain is attached to this Affidavit as Exhibit A, which is a fax request form sent by Ms. Shelly Poston, another employee in the Health Information Management System's department who worked for me in October of 2006.

10. As stated above, when such requests were made for Iron Mountain, it was not uncommon for them to call Carolina Pines for further direction on where the records may be located. Often times, there would be multiple conversations with the Iron Mountain personnel as they were attempting to track down a particular record. The same was true for these records that we were requesting for the above-referenced litigation.

11. After our initial request on October 17, 2006, over the course of the next several days and weeks, myself and Ms. Poston had multiple conversations with the Iron Mountain personnel over the records we had requested. There were several incidences where the Iron Mountain personnel would provide us with medical records they believed were responsive to our request, only to learn that they had provided either the wrong patient name, or the wrong procedure. We would then have to call them back to let them know what they had provided was not what we were looking for and they needed to look further for the records in question.

12. Through November 8, 2006, I continued to have phone conversations with Iron Mountain personnel regarding the requested records. The records provided from Iron Mountain had been for the correct patients, but were neither the correct procedures nor the correct dates of service.

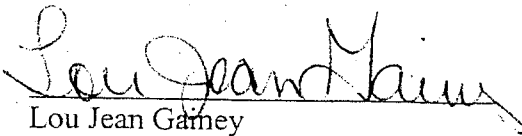
13. When the correct records had not been received by November 10, 2006, I again phoned Brian Tapper, another employee of Iron Mountain Records Management. After speaking with Mr. Tapper, I faxed the request to Iron Mountain and their personnel that were present at the facility, Mr. Tapper and Gavin Brown. A copy of our follow up request sent to Iron Mountain is

attached to this Affidavit as Exhibit B. Through our working on November 10 and 11, 2006, my department was able to finally obtain the records originally requested on October 17, 2006. I immediately informed Mr. Martin S. Driggers, Jr., counsel for Carolina Pines that we had the subpoenaed records in hand.

14. I was instructed by Mr. Driggers to appear with him at the Darlington County Courthouse on Monday morning, November 13, 2006, as there may be questions from the Court regarding the production of these records and the search for them over the last several weeks prior to that date. I did appear and was available at the Darlington County Courthouse before the Honorable J. Michael Baxley, prior to the trial restarting on November 13, 2006.

15. At court, Mr. Driggers explained the efforts we had gone through to find these records and that he had provided them to the attorney for the Plaintiff's over the weekend as my department was providing them to him.

16. After reviewing the records, Plaintiff's counsel represented that there would be no need to question me or anyone else from the Health Information Management department of Carolina Pines Regional Medical Center. I was then excused and left the Courtroom on that Monday morning.


Lou Jean Gailey

SWORN TO and subscribed before me

this 1st day of October, 2007

Cindy Blackwell (L.S.)
Notary Public for South Carolina

My commission Expires: 2-15-2017

001958

STATE OF SOUTH CAROLINA
COUNTY OF DARLINGTON

) THE COURT OF COMMON PLEAS
)
) FOR THE FOURTH CIRCUIT

Ruth J. Person,

Plaintiff,

v.

Carolina Pines Regional Medical
Center,

Defendant.

) Civil Action No.: 2004-CP-16-322
)

) AFFIDAVIT OF
) MARTIN S. DRIGGERS, JR.
)

SCOTT B. SUGGS
CLERK OF COURT/RO.D.
DARLINGTON COUNTY, S.C.

2004 OCT -4 AM 11:44

FILED

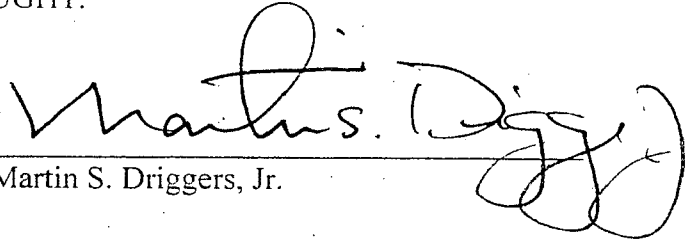
Affiant, first being duly sworn, deposes and says:

1. That affiant is the attorney for Defendant Carolina Pines Regional Medical Center.
2. That during the course of the case, the Defendant received a subpoena from Plaintiff's counsel requesting certain information, including prior radiological films for Ms. Ruth J. Person and certain records for prior surgical procedures performed by Dr. Thomas Mincheff.
3. That after requesting the radiological films for Ms. Ruth J. Person from the Department of Radiology, I was informed that those films were no longer in the possession of the Department of Radiology. Information from the Department of Radiology indicated that Ms. Person or someone associated with her had taken the films with her when she was transferred from Carolina Pines to Palmetto Health Richland in Columbia, South Carolina.
4. This information regarding the radiological films was confirmed by the records obtained from Palmetto Health Richland, which show that on her transfer to Palmetto Richland Ms. Person's medical records were transferred with her. (See Transfer Intake Form from Palmetto Richland (attached as Exhibit. A)).
5. That after working with personnel from Health Information Management at Carolina Pines for several days and weeks, Defendant was able to produce the responsive prior medical records of Dr. Thomas Mincheff.

6. That on November 11, 2006 I attempted to fax documents received from Iron Mountain relating to operative notes and discharge summaries for surgical procedures performed by Dr. Thomas Mincheff at Carolina Pines Regional Medical Center. When the facsimile would not go through after several attempts to Plaintiff's office I provided the records by electronic mail.

7. That during the trial of this matter I called a number of witnesses, including Dr. Mincheff, to testify. Plaintiff's counsel thoroughly cross-examined Dr. Mincheff on November 13, 2006. Plaintiff's counsel did not use the prior operative notes or discharge summaries in his cross-examination.

FURTHER AFFIANT SAYETH NAUGHT.


Martin S. Driggers, Jr.

Sworn to and subscribed before me
this the 1 day of October, 2007.


Notary Public

My Commission Expires:

10/28/08

001960

PALMETTO RICHLAND MEMORIAL HOSPITAL

Intra-Hospital Transfer Record

Admission Date: 4/30 Transfer Date: 6/15/1 Time: 1900
 From: STICU 524 To: 834

Reason for Transfer: ADL orderedDiagnosis: pancreatitis, ruptured colostomy, pleural eff.

Operation(s) / Date(s):

NOTIFICATION	NAME	YES	NO	IF NO, WHY?	NOTIFIED BY	TIME
ATTENDING MD	<u>Dr. Byrnes</u>	☒				
CONSULTANT						
FAMILY	<u>Wendy (daughter) 843-383-1663</u>					

IV FLUID	RATE	COUNT	DEVICE	SITE	INSERT DATE	PCP/CARE PLAN	INITIALS
<u>NS 100cc/h + cc/cc</u>	<u>NS</u>	<u>100</u>	<u>Replacement</u>	<u>PICC</u>	<u>RAC</u>	REVIEWED	☒
						UPDATED IN COMPUTER	☒
						COMMUNICATED	☒
						TRANSFERRED	☒

DRESSINGS: ☐ No Site: abd vac dsg to sxn. Describe: AD 6/15 21500 per skin care nurse.☒ Yes Site: trachDescribe: #40 stomy capped.TUBES/DRAINS: ☐ No Site: ostomyDescribe: stoma pink bag to sxn. Replacing cc/cc output NS 986☐ Yes Site: foley, SFT

Describe:

LIST ANY RECURRING LAB ORDERS:

DISPOSITION OF BELONGINGS: ☒ With Patient☐ To Family☐ Kept on Unit

Other:

DISPOSITION OF VALUABLES: ☒ To Cashier☐ To Family

Name:

TRANSFERRED WITH PATIENT: ☒ Medications☐ Special IV Fluids☒ Old Records

TRANSFERRING

UNIT
TPR

99', 110, 18

BP

125/78

TIME

1600

ADULT
HEALTH
STATUS

HEALTH STATUS PARAMETERS

AFTER THE ASSESSMENT, PLACE A ☒ IN THE BOX IF THE FOLLOWING CRITERIA ARE NORMAL. PLACE AN X IN THE BOX IF ABNORMAL. AN X IN THE BOX DENOTES A FINDING THAT REQUIRES FURTHER ASSESSMENT IN COMMENTS/EXCEPTIONS.

NEUROLOGICAL STATUS

ALERT AND ORIENTED TO PERSON, PLACE AND TIME, BEHAVIOR APPROPRIATE TO SITUATION, PUPILS EQUAL AND REACTIVE TO LIGHT, ACTIVE ROM OF ALL EXTREMITIES WITH SYMMETRY OF STRENGTH, NO PARESTHESIA, VERBALIZATION CLEAR AND UNDERSTANDABLE, SWALLOWING WITHOUT COUGHING OR CHOKING ON LIQUIDS AND SOLIDS, STEADY GAIT.

RESPIRATORY STATUS

RESPIRATIONS 10-20 PER MINUTE AT REST, CHEST EXPANSION EQUAL, BREATH SOUNDS CLEAR THROUGH BOTH LUNG FIELDS, SPUTUM CLEAR, NOT SUPPORTED BY MECHANICAL VENTILATION OR OTHER RESPIRATORY AIDS.

#40 stomy
2 LNC

GASTROINTESTINAL STATUS

NO ORAL PROBLEMS, ABDOMEN SOFT, BOWEL SOUNDS ACTIVE (5-34/MIN), NO PAIN WITH PALPATION, TOLERATES PRESCRIBED DIET WITHOUT NAUSEA AND VOMITING, HAVING BOWEL MOVEMENTS WITHIN OWN NORMAL PATTERN AND CONSISTENCY, AND HAS COMPLETE CONTROL OF ELIMINATION.

abd vac dsg
stoma
foley

GENITOURINARY STATUS

ABLE TO EMPTY BLADDER WITHOUT DYSURIA, AND HAS COMPLETE CONTROL, HAS NO PERCEIVED CHANGES IN URINARY OUTPUT (INCREASE OR DECREASE), NO CHANGE IN CHARACTER OR COLOR OF URINE, HAS NO DISCHARGE FROM GENITALIA. FOR FEMALES: HAS NO UNUSUAL VAGINAL BLEEDING OR PELVIC PAIN.

☐ PREGNANT

LAST MENSTRUAL PERIOD

INTEGUMENTARY STATUS

SKIN COLOR WITHIN PATIENT'S NORM, SKIN WARM, DRY & INTACT, MUCOUS MEMBRANES MOIST & INTACT.

BRADEN SCALE SCORE

MUSCULOSKELETAL STATUS

ABSENCE OF JOINT SWELLING & TENDERNESS, NORMAL RANGE OF MOTION OF ALL JOINTS, NO MUSCLE WEAKNESS.

CARDIOVASCULAR STATUS

REGULAR APICAL PULSE, S1 & S2 AUDIBLE, NECK VEINS FLAT AT 45 DEGREES, CAPILLARY REFILL TIME LESS THAN 3 SECONDS, PERIPHERAL PULSES PALPABLE AND 3+, NO EDEMA, NO CALF TENDERNESS, NAIL BEDS AND MUCOUS MEMBRANES PINK.

RECEIVING
UNIT
TPR

BP

TIME

COMMENTS/EXCEPTIONS:

Nurse:

Barbara Watson, RN

Receiving Nurse:

001961

Exh. A

1961

STATE OF SOUTH CAROLINA) THE COURT OF COMMON PLEAS
COUNTY OF DARLINGTON) FOR THE FOURTH CIRCUIT

Ruth J. Person,) Civil Action No.: 2004-CP-16-322

Plaintiff,)

v.)

AFFIDAVIT OF
THOMAS MINCHEFF, M.D.

C. Brooks Bannister, M.D., Hartsville
Surgical Center, and Carolina Pines
Regional Medical Center,

Defendants.)

2007 OCT -4 AM 11:49
CLERK OF COURT/R.O.D.
DARLINGTON COUNTY, S.C.

FILED

1. My name is Thomas Mincheff, M.D. I am a general surgeon who practices with the Hartsville Surgical Associates in Hartsville, South Carolina. I have privileges to practice general surgery at Carolina Pines Regional Medical Center.

2. I was involved in the above-referenced litigation, initially as a party, and then as a witness at the trial of the case in November of 2006.

3. As part of the litigation, I responded to any and all written discovery requests sent to me by the Plaintiff and participated in a deposition on November 25, 2003..

4. During the course of my involvement in litigation, I was questioned extensively both in terms of written discovery from the Plaintiff and also during my deposition testimony. At no time during my involvement in litigation or during my deposition testimony was I asked to provide any operative reports or discharge summaries for any of the prior patients on which I had performed nissen fundoplication or hill fundoplication procedures. I was questioned about the number of procedures I had done and also any other complications that had arisen on any of my prior procedures. I answered those questions truthfully when asked by the Plaintiff's counsel.

5. I have performed Nissen fundoplication procedures, Hill fundoplication procedures, and other similar esophogeal surgeries on many other patients, both prior to and after the surgery

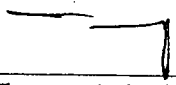
001962

that I performed on the Plaintiff which was the subject of this litigation. At no other time have I ever had any complications arising out of these procedures.

6. Attached to this Affidavit as Exhibit A are, according to my records, all of the other Nissen fundoplication procedures, Hill fundoplication procedures, and other similar esophogical surgeries that I have performed at Carolina Pines Regional Medical Center. It is my understanding that this information was provided to the counsel for the Plaintiff prior to November 13, 2006.

7. During the course of the trial of this case, which began on November 6, 2006 and proceeded on through November 14, 2006, I was subpoenaed by Plaintiff's counsel to be available for trial testimony during the entire course of the case. I actually appeared on two separate occasions and during the course of the trial, to provide trial testimony. Initially, I testified on or about November 6 or 7, 2006, and then again on November 13, 2006. On both occasions I was questioned by counsel for the Plaintiff.

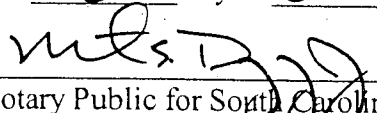
8. At no time during my testimony at the trial of this case was I asked to provide any records regarding my nissen fundoplication or hill fundoplication procedures. Also, at no time during my testimony at the trial of this case, was I asked about any of these specific surgeries procedures by counsel for the Plaintiff.



Thomas Mincheff, M.D.

SWORN TO and subscribed before me

this 28th day of September, 2007

 (L.S.)
Notary Public for South Carolina

My commission Expires: 7.25.10

001963

THE BYERLY HOSPITAL

DISCHARGE SUMMARY

HOSPITAL #15399
ADMITTED 7-01-96
DISCHARGED 7-03-96

ADMITTING DIAGNOSIS: Gastroesophageal reflux disease.

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESSES:

is a 60-year-old white female who was referred to us by Dr. Bell. The patient has a history of severe heartburn. She has been on medications, H2 blockers and Propulsid, for quite some time. She also has a history of a hiatal hernia. She has had no relief with medications. She recently underwent an EGD which showed a hiatal hernia and esophagitis as well as gastritis. She also had some duodenitis. The patient underwent a 24-hour pH probe and esophageal manometry studies, which confirmed gastroesophageal reflux disease, and an antireflux procedure was recommended. The patient was scheduled for a laparoscopic Nissen fundoplication.

PAST HISTORY: Unremarkable.

OPERATIONS: EGD with biopsy.

ALLERGIES: SULFA AND DAYPRO.

CURRENT MEDICATIONS: Tagamet 400 mg., Estrace 1 mg., Propulsid 10 mg.

FAMILY HISTORY: Unremarkable.

INVENTORY BY SYSTEMS: Noncontributory.

SOCIAL HISTORY: Alcohol yes, socially. Drugs none. Tobacco none. Patient lives with family.

PHYSICAL EXAM: General appearance - Sixty-year-old white female in no apparent distress, alert and oriented x3. HEENT - BOMI, PERRLA. Neck - Supple. Chest - Symmetric. Lungs - Clear to A&P. Cor - Regular rhythm. Breasts - No masses. Abdomen is soft, nontender. The patient does have some fullness and burning in the epigastric area. Pelvic - No discharge. Rectal exam - No rectal masses. Extremities - Full range of motion. Pulses - 2+ bilaterally equal. Neurologic status - Grossly intact.

LABORATORY FINDINGS: CBC and urine analysis were unremarkable. HIV antibody test was completed. HIV nonreactive.

CHEST X-RAY was negative.

001964

W3667 9000 10 APR

#15399

HOSPITAL COURSE: On the 1st of July 1996, the patient was admitted and underwent a 360 degree laparoscopic Nissen fundoplication.

The postoperative course was essentially unremarkable. The patient had one elevated temperature up to 101 postop, possibly secondary to atelectasis. The patient was allowed to ambulate and her temperature fell within normal limits.

Clinically, the patient was doing very well. Postoperatively, the patient was given a clear liquid diet which was advanced to a soft diet the following day. This was well tolerated. The abdomen remained soft and nontender. The wounds were clean and dry.

On the 3rd of July 1996, the patient was then discharged home.

DISCHARGE INSTRUCTIONS:

MEDICATIONS: Lortab 500 - 1-2 tablets q. 4-6 hours p.r.n. pain.
The patient is allowed to resume her previous medications.

DIET: The patient has been advised to stay on a soft diet. She is not allowed to eat any bread. She has also been advised to chew her food carefully and to slice her meat in small pieces.

ACTIVITIES: The patient is allowed to do light activities.

SPECIAL INSTRUCTIONS: The patient is to followup in our office in one week for suture removal.

CONDITION ON DISCHARGE: Improved.

FINAL DIAGNOSES: (1) Hiatal hernia.
(2) Gastroesophageal reflux disease.

THOMAS V. MINCHEFF, M. D.

TVM: mg
D 7-03-96
T 8-05-96

cc: T. James Bell, Jr., M. D.

THE PYERLY HOSPITAL

OPERATIVE NOTE

NAME:
HOSPITAL # 20507
ROOM:
DATE: 12-17-96

PREOPERATIVE DIAGNOSES: GASTROESOPHAGEAL REFLUX DISEASE.

POSTOPERATIVE DIAGNOSES: SAME.

OPERATION: LAPAROSCOPIC NISSEN FUNDOPPLICATION.

SURGEON: Dr. Mincheff.

FIRST ASSISTANT: Dr. Harris.

ANESTHESIA: General endotracheal.

INDICATIONS FOR THE PROCEDURE: is a 32-year-old white male who has had severe symptoms consistent with gastroesophageal reflux disease. He is status post laparoscopic cholecystectomy. For quite some time now, the patient has been receiving Zantac and later Prilosec as well as Reglan to relieve symptoms, however, the medications were ineffective. The patient's workup which consisted of an EGD, upper GI, 24 hour PH probe and esophageal motility studies showed that the patient has gastroesophageal reflux disease. The patient has been refractive to medications and has been found to be a candidate for a nissen fundoplication.

DESCRIPTION OF THE PROCEDURE: The patient is taken to the Operating Room and placed in a supine position upon the operation table. Preoperative antibiotics are given. Pneumatic sequential compression stockings are placed on the lower extremities. After induction of general anesthesia and endotracheal intubation, the entire abdomen is shaved and then prepped with Betadine solution. Sterile towels as well as sterile drapes were applied in the usual manner. A 16 French nasogastric tube was inserted and a 16 French Foley catheter was also inserted. Staying 3 cm. above the umbilicus, and 3 cm. to the left, using the 15 blade scalpel, an incision is made in the skin. The skin incision is transverse. The incision is carried down the subcutaneous layers. The underlying fascia is incised transversely, exposing the underlying rectus muscle which is spread and the posterior rectus fascia is opened. The abdominal cavity is entered using the Hasson procedure. Fixation sutures are placed on either side of the fascia using 2-0 Polysorb. A 10-12 mm. Trocar is then passed through the abdominal wall and secured in place with the fixation sutures. The abdominal cavity is then inflated with 4-6 liters of CO₂, reaching a pressure of 15 mm. of Mercury. A 0 degree camera is then inserted through the cannula and the abdominal

001968

cavity is explored. No abnormalities are seen. No adhesions from previous surgery were encountered. Using the 15 blade scalpel, a small transverse skin incision is made in the left subcostal area. A 10 mm. trocar is passed through the abdominal wall under direct vision. The same is performed on the right subcostal area passing a 10 mm. trocar through the abdominal wall, again through direct vision. A small vertical incision is made in the subxiphoid area and a 10 mm. trocar is passed through the abdominal wall, again under direct vision. Staying 4 cm. above the umbilicus and 4 cm. to the right, through a separate stab wound through the abdominal wall, another 10 mm. trocar is passed through the abdominal wall. Through the subxiphoid cannula, a liver retractor is inserted and the left lobe of the liver is raised and retracted cephalad, thereby exposing the upper portions of the stomach and esophagus. Using the harmonic scalpel, the gastrohepatic ligament is divided. Through careful blunt dissection, the right crura of the diaphragm is exposed. The peritoneum anterior to the esophagus is incised with the harmonic scalpel and the dissection is carried to the left side. Again using careful blunt dissection, the left crura is identified. The 0 degree camera is then replaced using the 30 degree camera and the retroesophageal space is then developed. The dissection is carried up into the mediastinum. Once the esophagus has been completely freed, a vessel loop is then placed at the GE junction and the vessel loop is used for traction. The patient was found to have a significant amount of a reaction around the esophagus which may be result of his reflux disease. The short gastric vessels were then divided using the harmonic scalpel. Staying along the greater curvature of the stomach a distance of 10 cm. were freed. During the case, to facilitate dissection, the patient was placed in a reverse Trendelenburg position. The nasogastric tube was then replaced by passing down a 58 French Maloney dilator through the esophagus. The Bougie or dilator was carefully passed down, and using my dissector I could feel the dilator as it passed the GE junction. Careful attention was made not to angulate the GE junction. The dilator passed easily through the esophagus into the stomach. Once this has been performed, the esophageal hiatus is carefully narrowed by approximating the left to the right crura using 0 Surdek sutures. After this has been completed, the Bougie is carefully pulled back and the fundus of the stomach is grasped and brought behind the esophagus and preparations are made for the wrap. The Bougie is then carefully reinserted and the Nissen fundoplication is then completed by placing three sutures using 0 Surgitek approximating the left side of the stomach to the right, taking a bite of the anterior esophagus and then securing the sutures. Extracorporeal knot tying was conducted and I placed a clip just

H20597

above the knot and then divided the suture. The same procedure was used with the crural sutures. The wrap was high on the esophagus and extended for approximately 2 cm. A good result was obtained. After the wrap was completed, the bougie was removed. I also secured the wrap with placement of Expa sutures to the stomach and right and left crura. Small amount of fluid, which had collected beneath the liver and behind the stomach was suctioned. Good hemostasis was obtained and there was minimal bleeding. The liver fan retractor was removed. The individual cannulas were removed and the abdominal cavity was deflated. The cannulas were individually removed and there was no bleeding from the entry sites. The two supraumbilical ports were closed in layers. The fascia was closed with 0 Polysorb and 2-0 Polysorb interrupted sutures. The patient was returned to a normal supine position. The skin was closed with staples. The skin was cleansed and dried. Sterile dressings were applied. Postoperatively, the nasogastric tube and Foley were removed. The patient was later transferred to the Recovery Room in stable condition.

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: Minimal.

FLUIDS: Crystalloids.

ADDENDUM: During the dissection the anterior and posterior vagus nerves were identified and preserved.


THOMAS V. MINCHEFF, M.D.

TVM: tj
D 12-17-96
T 12-20-96

001968

BYERLY HOSPITAL
DISCHARGE SUMMARY

NAME:

HOSPITAL #: 20507
ADMITTED: 12/17/96
DISCHARGED: 12/19/96

ADMITTING DIAGNOSIS:

1. Gastroesophageal reflux disease.

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS:

is a 32 year old white male who for the last several months has been complaining of severe heartburn and epigastric pain. He is status post laparoscopic cholecystectomy for biliary dyskinesia. He has been on medications for quite sometime and he has not responded well to the medications. Gastroenterology consultation with Dr. Isaac was obtained. The patient underwent an upper GI as well as EGD. He also underwent a 24 hour pH probe and esophageal manometry studies which confirmed gastroesophageal reflux disease. Since the patient has not improved on medical management we have elected to proceed with a laparoscopic Nissen fundoplication.

PAST HISTORY: The patient denies any serious illnesses.

OPERATIONS: Appendectomy, arthroscopic left knee surgery. Orchiectomy. Laparoscopic cholecystectomy. Tonsillectomy.

ALLERGIES: ASPIRIN.

CURRENT MEDICATIONS: Prilosec and Reglan.

FAMILY HISTORY: Unremarkable.

INVENTORY BY SYSTEMS: Noncontributory.

PHYSICAL EXAMINATION:

GENERAL APPEARANCE: 32 year old white male in no apparent distress, alert and oriented times three.

VITAL SIGNS: Stable. Afebrile.

HEENT: EOMI, PERRLA.

NECK: Supple. No goiter or nodules. Trachea is in the midline. No carotid bruits. No venous distention.

CHEST: Symmetric.

LUNGS: Clear to A&P.

HEART: Regular rate and rhythm. No murmurs, gallops or rubs.

BREAST: No masses.

ABDOMEN: The patient is mildly over weight. Abdomen is soft, nontender. Bowel sounds positive. No masses. No organomegaly.

001969

BYERLY HOSPITAL
DISCHARGE SUMMARY

NAME:

HOSPITAL #: 20507
ADMITTED: 12/17/96
DISCHARGED: 12/19/96

Page Two

MALE GENITALIA: The patient has one testicle.
RECTAL: No rectal masses.
EXTREMITIES: Full range of motion of all joints.

PREOPERATIVE LABORATORY FINDINGS: Within normal limits.

HOSPITAL COURSE: The patient was admitted on the 17th of December 96. The patient underwent a laparoscopic Nissen fundoplication on the 17th of December 96. The postoperative course was essentially unremarkable. On the day of surgery postop the patient was allowed to have ice chips and on the first postop day was started on clear liquids and the diet was slowly advanced to a soft diet. Postoperatively the patient did have a temperature up to 101 which later fell within normal limits. The patient was ambulating well and was tolerating a soft diet. Postoperatively the patient was given analgesics, Demerol 50-75 mgs IM q 4-6 hours prn for pain with Phenergan 25 mgs IM q 4-6 hours prn for pain. When the patient was tolerating po intake he was switched to po analgesics, Loracet Plus 1/2 to 1 tablet po q 6 hours. Overall the patient did well. The wounds remained clean and dry. On the 19th of December 96 the patient was then discharged home.

DISCHARGE INSTRUCTIONS: Discharge medications - Loracet Plus 1/2 to 1 tablet po q 6 hours. Diet - soft. The patient has been advised to refrain from eating bread foods. Activities - are restricted. No heavy lifting, however, the patient has been encouraged to ambulate. The patient is allowed to shower.

SPECIAL INSTRUCTIONS: The patient is to follow-up with me in one week for staple removal.

CONDITION ON DISCHARGE: Good.

001970

BYERLY HOSPITAL
DISCHARGE SUMMARY

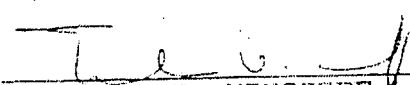
NAME:

HOSPITAL #: 20507
ADMITTED: 12/17/96
DISCHARGED: 12/19/96

Page Two

FINAL DIAGNOSIS:

1. Gastroesophageal reflux disease.


THOMAS V. MINCHEFF, M.D.

TVM:72ms
dd: 12/19/96
td: 01/07/97
t: 235
i: 5544

001971

THE BYERLY HOSPITAL

DISCHARGE SUMMARY

HOSPITAL # 14731
ADMITTED 7-6-98
DISCHARGED 7-9-98

ADMITTING DIAGNOSES: (1) Reflux esophagitis.
(2) Gastroesophageal reflux disease.

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESSES:

is a 35-year-old white male who has been complaining of reflux symptoms since the age of 18. He has been treated medically since then but symptoms have worsened and have not responded to medical management. The patient was hospitalized over a month ago, had a foreign body lodged in the esophagus. The patient subsequently had an esophagogastroduodenoscopy which showed marked reflux esophagitis intractable to medical management. The patient was referred for esophageal manometry and 24 hour PH Probe studies which revealed severe reflux disease. The patient is now scheduled for a laparoscopic Nissen Fundoplication. The patient was referred to me by Dr. Bullard.

PAST HISTORY: Significant for gastroesophageal reflux disease since the age of 18, hiatal hernia.

OPERATIONS: Adenoids and tonsils, eye surgery, EGD.

ALLERGIES: IVP DYE.

Current medications - Zantac and Tums.

FAMILY HISTORY: Unremarkable.

INVENTORY BY SYSTEMS: Noncontributory.

SOCIAL HISTORY: Alcohol occasionally. Drugs none. Tobacco none. The patient lives with his family. He is married, has two children, and works for A.O. Smith.

GENERAL APPEARANCE/PHYSICAL EXAM: 35-year-old white male in no apparent distress. Vital signs stable, afebrile. HEENT, EOMI, PERRLA. Neck is supple. Chest is symmetric. Lungs are clear to A&P. Heart - Regular rhythm. No murmurs, gallops, or rubs. Breasts - No masses. Abdomen - Soft, nontender. Male genitalia within normal limits. Rectal exam within normal limits. Extremities - Free range of motion.

LABORATORY FINDINGS: Within normal limits.

HOSPITAL COURSE: On the 6th of July, 1998, the patient underwent a laparoscopic Nissen Fundoplication. For further details, please see operative note. The postoperative course was

001972

WJ07:7 9002 001000

PAGE 2
DISCHARGE SUMMARY

14731

unremarkable. Postoperatively, the patient was given ice chips. On postop day #1, the patient was advanced to a clear liquid diet. Ice chips were well tolerated. The IV was placed on KVO. The patient had some right shoulder pain postoperatively, which was a result of positioning upon the operating room table and also probably air within the abdominal cavity. This resolved with analgesics.

On postop day #2, the patient was noted to have tolerated clear liquids and was placed on a soft diet. The patient was allowed to shower. The wounds remained clean and dry.

On the 9th of July, 1998, the patient had tolerated a soft diet and was doing well. He was discharged to home on the 9th of July 1998.

DISCHARGE INSTRUCTIONS: Medications - Darvocet N 100 1-2 tabs p.o. q. 4-6 hours p.r.n. for pain. The medication needs to be crushed and given with water.

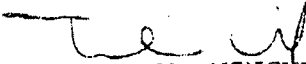
DIET: The patient is to resume or continue soft Puree diet for a period of 4-6 weeks. The patient has been advised not to eat any bread or chunks of meat.

ACTIVITIES: The patient is allowed to light activity but no heavy lifting.

SPECIAL INSTRUCTIONS: The patient has been given a work excuse. The patient is to follow up with me in one week for staple removal.

Conditioning on discharge was good.

FINAL DIAGNOSES: (1) Reflux esophagitis.
(2) Gastroesophageal reflux disease intractable to medical management.


THOMAS V. MINCHEFF, M. D.

TVM:lt
D 7-9-98
T 7-22-98

cc: Dr. Bullard

001973

NOV 10 2006 4:40PM

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0009813

DATE: 08/09/99

PREOPERATIVE DIAGNOSIS:

1. Gastroesophageal reflux disease.

POSTOPERATIVE DIAGNOSIS:

1. Gastroesophageal reflux disease.

PROCEDURE PERFORMED:

1. Laparoscopic fundal plication.

SURGEON:

1. DR. MINCHEFF.

FIRST ASSISTANT:

1. DR. BANNISTER.

ANESTHESIA:

1. GENERAL ENDOTRACHEAL.

INDICATIONS FOR THE PROCEDURE:

is a 64-year-old black female who has had symptoms consistent with gastroesophageal reflux disease. The patient has undergone multiple studies including an upper GI, esophagogastroduodenoscopy, 24-hours pH probe studies, and esophageal manometry. The patient has been on Prilosec for quite some time and has not done well on medical management. We now elected to proceed with a laparoscopic fundal plication.

DESCRIPTION OF THE PROCEDURE: The patient is taken to the operating room and placed in a supine position upon the operating room table. Preoperative IV antibiotics were administered. After induction of general anesthesia and endotracheal intubation, a 16-French Foley catheter was inserted and a 16-French nasogastric tube was inserted. Pneumatic sequential compression stockings are placed on the lower extremities. The entire abdomen is then prepped with Betadine solution and sterile towels as well as sterile drapes are applied in the usual manner. Staying approximately 3 cm above and to the left of the umbilicus, a small transverse skin incision is made with the 15 blade scalpel. The abdominal cavity is entered using an open procedure. On the other side of the fascia, two fixation sutures were placed using 0 Polysorb and a 10 to 12 mm trocar is inserted. A total of 5 trocars are used for the procedure. Through a separate stab wound in the epigastric area, a 10 mm trocar was inserted. In the right upper quadrant, just beneath the subcostal margin, another 10 mm trocar was inserted again under direct vision. Staying approximately 4 cm above and to the right of the umbilicus, another 10 mm trocar was inserted through the abdominal wall, again under direct vision. On the left side, beneath the subcostal margin, the fifth 10 mm trocar was inserted. The patient was then repositioned in a reverse Trendelenburg position. A Babcock clamp was then inserted and the stomach is grasped and retracted downwards. The gastrohepatic ligament was opened and a window was developed using the Harmonic scalpel as well as careful

001974

FILE COPY

- PAGE 1 -

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0009813

blunt dissection. Once this has been performed, the 0 degree scope was replaced with a 30 degree scope and the retroesophageal area was carefully dissected. The posterior vagus is identified and preserved. The right crus was carefully identified as well as the left crus. The peritoneal attachments anterior to the esophagus are carefully freed and the gastrophrenic ligament was divided using the harmonic scalpel on the left. A good retroesophageal window was developed. A vessel loop was then brought around the esophagus and this was used for traction. The head does not appear to be too wide. The patient is noted to have a small hiatal hernia. This was reduced during the dissection. The dissection is carried up into the mediastinum so that a good length of esophagus is brought down into the abdominal cavity. Prior to repairing the hiatus, I elected to proceed in dividing the short gastrics. This was done using the Harmonic scalpel. Going along the curvature and fundus of the stomach, the short gastrics are divided with the Harmonic scalpel. The dissection was carried over to the cardia of the stomach. The gastrophrenic ligament was divided further. After this had been completed and adequate stomach had been mobilized for the wrap, I then proceeded in closing the hiatus. This was performed with a 0 surgideck suture using the endostitch device. An extra corporal knot tying technique was used. After this was completed, a Babcock clamp is then placed in the retroesophageal window and passed around and a portion of the stomach is then brought around in a 360 degree wrap. The wrap was then sutured using again three individual 0 Surgideck sutures and an extra corporal knot tying technique is performed. This wrap was performed after placement of a 56 French Bougie which was easily passed down through the esophagus without difficulty. After completion of this, we removed the Bougie and attempted to place a nasogastric tube and had difficulty placing the nasogastric tube. After close inspection, the wrap appeared to be too low and I elected to proceed in taking down the wrap and redoing it. The sutures were divided and the wrap was performed once again in a similar manner. At this time, I placed the wrap a little bit higher along the esophagus including the anterior esophageal muscle in the suture. The 306 degree wrap was done again using the 56 French Bougie. After completion of this, the Bougie was then removed and replaced with a nasogastric tube and this time there was no problem passing the nasogastric tube. The wrap looked good and then I added an additional suture, suturing the stomach up to the crus, thereby preventing any slippage of the wrap into the mediastinum. Irrigation fluid was then suctioned. The vessel loop was removed. Through the epigastric port, a fan was inserted enabling us to lift up the left lobe of the liver, providing exposure to the GE junction and the hiatus. After the admission fundal plication was completed, the fan was closed and pulled out through the port. The area was checked for hemostasis. There was no bleeding. The area was dry. The patient was returned to a normal supine position. The individual cannulas were removed. The port site which was then opened was then closed in layers. The fascia was closed with interrupted 0 Polysorb sutures. The skin was closed with staples. The other four incision sites or puncture sites were closed merely with staples. The skin was cleansed and dried. Sterile dressings were applied. After extubation, the Foley was removed. The pneumatic

FILE COPY

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CAROLINA PINES REGIONAL HOSPITAL

OPERATIVE NOTE

HOSPITAL#: 0009813

Stockings were left on. The patient was transferred to the
blood loss was minimal.

001976

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0009813

ADMITTED: 08/09/99

DISCHARGED: 08/18/99

ADMITTING DIAGNOSIS: Gastroesophageal reflux disease.

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS: is
a 64-year-old black female complaining of severe dysphagia for the last
five to six years. She has become progressively worse. She has had an
upper GI, EGD, 24 hour pH probe, and esophageal manometry studies. The
final results revealed moderate to severe gastroesophageal reflux.
disease. Medical management has been ineffective and the patient is now
scheduled for a laparoscopic Nissen fundoplication.

PAST HISTORY: Significant for pancreatitis two weeks ago. The patient
also has a history of seizure activity. She also has a past medical
history significant for electrolyte abnormalities, hypocalcemia,
hypomagnesemia, and hypokalemia. She also has a history of chronic
anxiety.

SURGICAL HISTORY: Significant for a hysterectomy, laparoscopic
cholecystectomy, and thyroidectomy. The patient is on Darvocet, K-Dur,
Prilosec, Adalat, Celebrex, Dilantin, Mag-Ox and Ativan.

ALLERGIES: None.

FAMILY HISTORY: Significant for mother with high blood pressure and
cerebral vascular accident. Father significant for CVA.

INVENTORY BY SYSTEMS: Gravida five, para five, A0.

SOCIAL HISTORY: Alcohol positive. Drugs none. Tobacco none. The
patient lives alone.

PHYSICAL EXAMINATION:

General appearance: A 64-year-old black female in no apparent
distress, alert and oriented times three.

HEENT: EOMI, PERRLA.

Neck: Supple.

Chest: Symmetric.

Heart: Regular rhythm.

Lungs: Clear to auscultation and percussion.

Breasts: No masses.

Abdomen: Midline lower scar, soft, nontender, no masses, no
organomegaly.

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001977

PAGE 1

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0009813

Pelvic exam: Status post hysterectomy.

Rectal exam: Revealed no masses.

Extremities: Free range of motion.

Neurologic status: Grossly intact.

LABORATORY DATA: Dilantin level within normal limits. All other laboratory findings were within normal limits. Preoperative chest x-ray was unremarkable.

HOSPITAL COURSE: On 9 August 1999, the patient underwent a laparoscopic Nissen fundoplication. For further details, please see operative note. The postoperative course was initially unremarkable. On the first postoperative day, the patient was started on clear liquids and was slowly advanced to a soft diet. The patient received two units of packed red blood cells postoperatively. By the third postoperative day, the patient was showering and was tolerating a soft diet. The patient's calcium was noted to be 7.2 and she received supplemental calcium. Medical consultation was obtained with Dr. Bradley during the patient's hospital stay.

On 12 August 1999 in the afternoon, the patient developed shortness of breath and had a decreased oxygen saturation on the pulse oximeter. In order to rule out a possible pulmonary embolus, we obtained a CT scan of the chest which was normal. The patient did have some atelectasis and infiltrate in the lower lobes. The patient was felt to be in some failure and was given Lasix 40 mg IV and the patient responded quite well. The patient was placed in the intensive care unit for monitoring and the patient was noted to have a severe bradycardia. Cardiology consultation was subsequently obtained and a pacemaker was recommended. The patient was noted to have sinus arrest with junctional escape rhythms.

The patient was monitored over the weekend and on 16 August 1999, the patient received a dual chamber atrioventricular pacemaker. For further details of the procedure, see the operative note. The postprocedure course was unremarkable. The patient remained in the intensive care unit for one day and then was transferred to the telemetry unit. The patient's wound remained clean and dry. On 17 August 1999, the staples were removed along the abdomen. The wounds were well healed. Overall, the patient did well and on 18 August 1999, I elected to discharge the patient home.

DISCHARGE INSTRUCTIONS:

MEDICATIONS:

Lorcet plus one tablet p.o. q.6h. p.r.n. pain.
The patient is to resume her regular p.o. medications.

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001978
PAGE 2

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0009813

ACTIVITY: Restricted. The patient has been advised to do no strenuous activity. The patient is allowed to shower.

DIET: The patient is to remain on a soft diet for the next several weeks. She has been advised not to eat any bread.

SPECIAL INSTRUCTIONS: The patient is to follow up with me in one week.

CONDITION ON DISCHARGE: Improved.

FINAL DIAGNOSES:

1. Gastroesophageal reflux disease.
2. Tachycardia-bradycardia syndrome.

THOMAS V. MINCHEFF, M.D.

3KD0623/KD/TSI

D 8/18/99

T 8/23/99

cc: Robert L. Bradley, M.D.

001979

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0019765

DATE: 12/20/99

PREOPERATIVE DIAGNOSIS:

1. Large type 4 hiatal hernia.

POSTOPERATIVE DIAGNOSIS:

1. Large type 4 hiatal hernia.

PROCEDURE PERFORMED:

1. Repair of large type 4 hiatal hernia, Hill procedure with posterior gastropexy and partial fundal plication.

SURGEON:

1. Dr. Mincheff.

FIRST ASSISTANT:

1. Dr. Bannister.

ANESTHESIA:

1. General endotracheal.

INDICATIONS FOR PROCEDURE:

is a 57-year-old white male who has been complaining of fullness in the chest associated with nausea and vomiting for several months. A barium enema was performed recently which suggested that the mid transverse colon was in the chest. A CT scan was subsequently obtained which confirmed a large type 4 hiatal hernia with the entire stomach and portion of the mid transverse colon in the chest. Since the patient is symptomatic the patient will require repair of the large type 4 hiatal hernia.

DESCRIPTION OF THE PROCEDURE: The patient was taken to the operating room and placed in a supine position upon the operating room table. Preoperative IV antibiotics were administered. Compression stockings were placed on the lower extremities. After induction of general anesthesia and endotracheal intubation the abdomen and anterior chest was shaved and then prepped with Betadine solution. Sterile towels as well as sterile drapes were applied in the usual manner. A Foley catheter was previously inserted as well as a nasogastric tube. Using a 10 blade scalpel, a midline skin incision was made from the xiphoid down to below the umbilicus. The incision was carried down to the subcutaneous layers with use of electrocautery. The abdominal cavity was entered. The abdominal cavity was explored. The spleen was then placed and is normal. The rest of the colon and small bowel were normal. The liver is normal. The patient was found to have a large hiatal hernia and the entire stomach is in the chest. The mid transverse colon was also in the chest. The stomach and mid transverse colon were reduced into the abdominal cavity. The hernia sac is carefully excised. The dissection is carried out bluntly posterior to the esophagus and a Penrose drain is placed around the esophagus and the esophagus is given inferior traction. The gastrohepatic ligament is divided with the LDS. The Balfour retractor was inserted prior to exploring the abdominal cavity and this provided better exposure. A

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001980

PAGE 1 -

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0039705

Beaver was placed along the liver and the liver was retracted cephalad. This provided better exposure to the hiatus. After the esophagus was completely freed and the sac was removed, the left and right crus were then identified. Further dissection was carried inferiorly to identify the median ligament and the preaortic fascia. The left and right crus was then reapproximated using 0 silk sutures. A 46 Maloney dilator was inserted and the hiatus was narrowed. Even after removal of the 46 French dilator, there was enough space to allow the fingertip to enter. After the hiatus was repaired, I then proceeded with a Hill procedure. The GE junction was cleared. The anterior vagus was identified. The posterior vagus was also palpated and preserved. Using 0 silk sutures, three sutures were placed seromuscular to the left and right of the anterior vagus and secured to the median ligament and preaortic fascia. The Penrose drain was removed. A good repair was obtained. The nasogastric tube was retained in the stomach. The patient was placed in reverse Trendelenburg during the case to allow for better exposure. He was then placed back into a normal supine position. The Balfour retractor was removed and then the wound was closed. The fascia was closed with a #1 Polysorb continuous suture. The skin was closed with staples. The skin was cleansed and dry. A sterile dressing was applied. The patient was later transferred to the recovery room in stable condition. Complications were none.

Material forwarded to the lab was a hernia sac.

THOMAS V. MINCHEFF, M.D.

3MB1220/MB/TST

D 12/20/99

T 12/20/99

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001981

- PAGE

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0039765

ADMITTED: 12/12/99

DISCHARGED: 12/27/99

The patient is a 57-year-old white male with a history of alcoholism. He presented with a two-week history of anorexia, nausea, vomiting, and unable to keep food down. He was felt to be clinically dehydrated and was admitted for IV fluids and evaluation.

His chest x-ray was significant for showing a very large hiatal hernia with loops of colon in the chest. With this, surgery consultation was requested and a CT of the chest and abdomen were ordered, which confirmed the hernia but also showed thrombosis of the inferior vena cava. Because of the inferior vena cava thrombosis, the patient was anticoagulated with heparin. When he was felt to be stable, he had surgical repair of his large hiatal hernia.

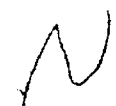
Postoperatively, he did well and had no complications.

On the day of discharge he was tolerating a regular diet well and had been converted to p.o. Coumadin for his anticoagulation.

DISPOSITION: He was discharged home with a diagnosis of dehydration, hiatal hernia, inferior vena cava thrombosis, and alcoholism.

DISCHARGE MEDICATIONS: Coumadin 2.5 mg once a day, Berocca Plus once every other day, Paxil 20 mg once a day, Valium 10 mg three times a day as needed, Lorcet Plus 1 q.4h. as needed.

He is to follow a regular diet and see Dr. Ward in a week.


TRESHA T. WARD, M.D.

1zd0108/ZD/TSI

D 1/05/00

T 1/09/00

001982

2760

CORRECTION

NAME: _____

HOSPITAL: 9945

DATE: 07/06/00

PREOPERATIVE DIAGNOSIS: Gastroesophageal reflux disease, chronic asthma.

POSTOPERATIVE DIAGNOSTIC: Gastroesophageal reflux disease, chronic asthma.

PROCEDURE PERFORMED: Laparoscopic Nissen fundoplication

SURGEON: Thomas V. Mincheff, M.D.

FIRST ASSISTANT: Arthur W. Cooley, M.D.

ANESTHESIA: General, endotracheal.

INDICATIONS FOR THE PROCEDURE: This is a 57-year-old white female who was recently hospitalized with pneumonia and recurrent asthma. The patient has been complaining of dysphagia and occasional regurgitation. This has been going on for quite some time. The patient also has gastric emptying problems as well. The patient was referred for a 24 hour pH probe which confirmed marked gastroesophageal reflux disease. She has also undergone an EGD. Barium swallow noted a large hiatal hernia. The patient has tried medical management and this has failed. We have decided to proceed with laparoscopic repair of the hiatal hernia along with a 360-degree Nissen fundoplication.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room and placed in a supine position upon the operating room table. Preoperative IV antibiotics were administered. After induction of general anesthesia and endotracheal intubation, a 16 French Foley catheter was inserted and a 16 French nasogastric tube was inserted. The entire abdomen was prepped with betadine solution. Sterile towels as well as sterile drapes were applied in the usual manner. Pneumatic compression stockings were placed on the patient prior to the prep.

Placing approximately 1 cm above the umbilicus a transverse skin incision was made just to the left with a #15 blade scalpel. Using the Hasson procedure, the abdominal cavity was entered. A 12-12 trochar was inserted. The balloon was inflated. The abdominal cavity was then inflated with 4-6 liters of air, creating a pressure of 10 mm Hg. The 10 mm trocar, 90 degrees to the right and the abdominal cavity was examined.

001983

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 5245

The gastrohepatic ligament was carefully divided. A window was found. The dissection was carried out also using the harmonic scalpel dividing the ligamentary attachments. The peritoneum was incised anterior to the esophagus with the use of the harmonic scalpel. The right crus was first identified and later the left crus of the diaphragm is identified. The large hiatal hernia was reduced into the abdominal cavity. Fatty tissue was carefully freed. The posterior vagus as well as anterior vagus were clearly identified and preserved. A window was then developed behind the esophagus.

The dissection was carried out to the left of the esophagus freeing up the lateral attachments. A vessel loop was then placed around the esophagus and this provided traction. The Babcock clamp which was placed on the stomach prior to that was removed. After the distal esophagus has been freed circumferentially, I then proceeded with taking down the short gastrics. A 10-12 cm segment was freed. Using the harmonic scalpel, the short gastrics are divided. Dissection is carried all the way up to the apex or cardia of the stomach. The foreoesophageal attachments were divided.

After good length had been accomplished along the fundus, I then proceeded with closure of the esophageal hiatus. A 36 French Bougie was inserted after the nasogastric tube was removed. The Bougie was carefully passed into the distal esophagus and then stomach under direct vision.

The left and right crus were then reapproximated with several 0 Surgidek sutures using the endostitch device. Clips were placed above the knot and then suture was divided. After partial closure of the hiatus, I then proceed with the 360 degree wrap. During the dissection, posterior to the esophagus and laterally, the 30 degree scope was used. With the partial closure of the hiatus, I then proceeded with the 360 wrap as stated above and a Babcock clamp was placed posterior to the esophagus. The fundus was brought up and brought behind the esophagus and a 360 degree wrap was obtained. The 36 French Bougie was passed down in order to provide a floppy wrap. Sutures were placed circumscular using 0 Surgidek or nonabsorbable suture and using the endostitch device by Autocuture encompassing the anterior portion of the esophagus with each stitch. Extracorporeal knot tying was performed and the knot was slid down toward to the esophagus. All secured. After the knots had been tied, a clip was placed and the suture was cut. The Babcock clamp was released.

The 36 French Bougie was removed. It was replaced with the 36 French tube. Then proceed the wrap to the right laterally, I then proceed with the 360 degree wrap. The 30 degree scope was used. The 360 degree wrap was obtained. The fundus was brought up and brought behind the esophagus and a 360 degree wrap was obtained. The 36 French Bougie was passed down in order to provide a floppy wrap. Sutures were placed circumscular using 0 Surgidek or nonabsorbable suture and using the endostitch device by Autocuture encompassing the anterior portion of the esophagus with each stitch. Extracorporeal knot tying was performed and the knot was slid down toward to the esophagus. All secured. After the knots had been tied, a clip was placed and the suture was cut. The Babcock clamp was released.

001984

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 5245

was closed with 0 Polysorb interrupted sutures. The puncture sites were closed with staples. The skin was cleansed and dried. Sterile dressings were applied. After extubation, the patient was transferred to the recovery room in stable condition.

COMPLICATIONS: None. The patient tolerated the procedure well.

THOMAS V. MINLHAPP, M.D.

SKD0707/KD/TSE

D. 7/06/00

T. 7/07/00

cc: W. Ryan Dixon, M.D.

Allen C. Smith, M.D.

001985

EAST LUNA PINAS REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0005248

ADMITTED: 07/06/00

DISCHARGED: 07/08/00

ADMITTING DIAGNOSIS: Gastroesophageal reflux disease.

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESSES

is a 59-year-old white female who has recently been diagnosed with gastroesophageal reflux disease. She has also had pulmonary problems, including asthma and pneumonia as a result of her reflux problems. She has been on medical management for quite some time. However, conservative management has been unsuccessful. The patient is now scheduled for definitive care. She is scheduled for a laparoscopic Nissen fundoplication.

PAST HISTORY: Significant for gastroesophageal reflux disease, asthma, and arthritis.

OPERATIONS: Appendectomy, tonsillectomy, jaw surgery, C6 & C7 fusion.

ALLERGIES: Penicillin and Solu-Medrol.

CURRENT MEDICATIONS: Asthma inhalers, Pravastatin, Eplerenone, Celecoxib, arthritis medications, and sleeping medications.

FAMILY HISTORY: Father had diabetes. Parents, heart disease.

INVENTORY BY SYSTEMS: Noncontributory.

SOCIAL HISTORY: Alcohol: None. Drugs: None. Tobacco: None. The patient lives with her family.

PHYSICAL EXAMINATION: Essentially unremarkable except for some mild inspiratory wheezes.

LABORATORY FINDINGS: Within normal limits.

HOSPITAL COURSE

The patient was admitted on July 6, 2000. She underwent a laparoscopic Nissen fundoplication. Preoperative and postoperative IV steroids were administered. On the first postoperative day, the nasogastric tube was removed and the patient was started on clear liquids which was slowly advanced to a soft diet. Wounds remained clean and dry. Analgesics were administered on a prn basis. On July 8, 2000, the patient was discharged on a diet and a solid diet was started. The patient was instructed to follow up with her primary care physician.

001986

CAROLINA LINCOLN REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0004245

SPECIAL INSTRUCTIONS: The patient is to follow up with me in 1 week for staple removal. The patient is allowed to shower.

CONDITION ON DISCHARGE: Good.

FINAL DIAGNOSIS: Gastroesophageal reflux disease.

THOMAS V. MINCHEFF, M.D.

4789717/5D/TSE

D 7/13/00

T 7/17/00

CC: W. Fion Dixon, M.D.

001987

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 13723

ADMITTED: 02/16/01

DISCHARGED: 03/22/01

DISCHARGE DIAGNOSES:

1. Persistent nausea and vomiting.
2. Recurrent pancreatitis.
3. Chronic alcohol abuse.
4. Large fixed hiatal hernia with gastroesophageal reflux disease.
5. Status post exploratory laparotomy with closure of the crura of the diaphragm and closure of perforation of esophagus with a Tahl stomach patch. Status post feeding gastrostomy.
6. Helicobacter pylori gastritis.
7. Distal esophageal stricture.
8. Postbulbar duodenitis.
9. Gastroparesis of undetermined etiology.
10. Polychromal gamma globinopathy (IGA, IGM).
11. Chronic hypotension with systolic about 100.
12. Medical noncompliance.

DISCHARGE MEDICATIONS: The patient was discharged home on TPN. The patient was placed on a clear liquid diet only and he had some Flonase for some allergic rhinitis. Other medications included; Zantac drip and his TPN. This will be monitored by home health for daily tube feedings. No additional medications were given on discharge.

HISTORY AND PHYSICAL: This patient's history and physical is as per the medical record, see the chart for full clinical details.

CLINICAL COURSE: This patient when admitted to this institution had been recently discharged two weeks prior. He has a known history of recurrent nausea, vomiting, chronic pancreatitis, chronic ethanol abuse, and medical noncompliance. This has put off surgery on his chronic reflux for several months to years refusing surgical intervention secondary to significant fear of surgery. However, the patient's symptoms progressively worsened and the patient finally agreed to surgical intervention.

The patient was taken to surgery for a fundoplication. He was found to have a very friable esophagus and perforation was noted and ~~closed~~ *repaired*. With the above, the patient had a G-tube placed for feeding supplementation. However, when the feeding tube was used, high residual was noted and the feeding tube was held. Therefore, the patient had to be started on peripheral TPN for nutritional supplement. The patient was tried on a clear liquid diet and then advanced and the patient still had recurrence of nausea and vomiting.

A gastrografen study and referral to GI was done via Dr. Bright Williamson in Florence. This revealed that he had an esophageal stricture which is the site of his esophageal repair which explains his recurrence of nausea and vomiting. In addition, it was noted that the patient had gastroparesis. He had no emptying of the stomach.

001988

- PAGE 1 -

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 13723

Initially it was thought that the patient had a duodenal stricture, but it was found that he had some postbulbar duodenitis along with gastroparesis. Therefore, the patient's stomach was not emptying and therefore made his G-tube ineffective. There was a consideration about whether the patient was a candidate for a J-tube placement, however, the patient refused.

With the above interventions, the patient had a prolonged stay with a waxing and waning course. He was deconditioned secondary to prolonged bed rest. Physical therapy was ordered. The patient became ambulatory and felt somewhat stronger. The patient had some intermittent joint pains which were treated symptomatically. However, he continued to have persistent nausea and vomiting with poor gastric emptying. This became problematic as how to treat the patient.

The patient's distal esophageal stricture was status post surgery and it needed at least 6-8 weeks of healing before dilatation could be commenced, however, the exact etiology of his postbulbar duodenitis is unclear. The patient has been on *Helicobacter pylori* therapy while hospitalized and consideration of this could be secondary to *Helicobacter pylori* infection as the patient has been treated with this in the past with no significant improvement.

It was decided that this patient will be managed as an outpatient. A Hickman catheter was placed for TPN. He was to continue on the above peripheral feedings for the next three weeks and then be reseen back in the GI clinic with Dr. Bright Williams and followup with Dr. Bannister, Dr. Cooler and Dr. Mincheff for additional intervention. This patient is to take all medications as directed and follow up as scheduled.

Bradley
ROBERT L. BRADLEY, M.D.

1KD0410/KD/TSI

D 4/08/01

T 4/10/01

001989

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 00000444687

DATE: 12/16/02

PREOPERATIVE DIAGNOSIS: Gastroesophageal reflux disease.

POSTOPERATIVE DIAGNOSIS: Gastroesophageal reflux disease.

PROCEDURE PERFORMED: Laparoscopic Nissen fundoplication.

SURGEON: Thomas V. Mincheff, M.D.

FIRST ASSISTANT: C. Brooks Bannister, M.D.

ANESTHESIA: General endotracheal.

INDICATIONS FOR THE PROCEDURE:

a 31-year-old Vietnamese male who has had severe reflux symptoms. The patient has undergone an EGD, a 24-hour pH probe and esophageal manometry studies which indicates severe gastroesophageal reflux disease. The patient has been treated aggressively with medications. However, the patient persists to have severe symptoms. After careful discussion with the patient, we elected to proceed with a reflux procedure. As discussed, we will perform a laparoscopic Nissen fundoplication. The risks and complications of the procedure have been thoroughly reviewed with the patient and the patient wishes to proceed.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room and initially placed in the supine position upon the operating room table. Pneumatic sequential compression stockings were placed on the lower extremities. Preoperative IV antibiotics were administered. After induction of general anesthesia and endotracheal intubation, a 16 French Foley catheter was inserted and an 18 French nasogastric tube was inserted. The patient was then repositioned in the lithotomy position upon the operating room table with both legs in stirrups. The entire abdomen was prepped with betadine solution and sterile towels as well as sterile drapes were applied in the usual manner.

Initially five trocars were used. An incision was made 4 cm above and to the left of the umbilicus. Using a Hasson open approach, the abdominal cavity was entered. An origin 10 mm trocar was inserted and secured. The abdominal cavity was inflated with 4-6 liters of CO2 reaching a pressure of 15 mm of Hg. A 10 mm 0 degree camera was then inserted and then in the right upper quadrant or right subcostal area. 10 mm trocar was inserted under direct vision. To the right of the xiphoid, through a separate stab wound a 10 mm trocar was inserted again under direct vision in the left subcostal area through a separate stab wound a 10 mm trocar was inserted, again under direct vision. The fifth 10 mm trocar was inserted.

The patient was then repositioned in a reverse Trendelenburg position. I elected to work from the right side. A Babcock clamp was placed on the stomach and the stomach was retracted inferiorly. The gastrohepatic ligament was carefully opened and a small window was

001990

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 00000444887

developed and the dissection was carried superiorly. The peritoneal attachments across the esophagus were carefully freed and divided with the use of the harmonic scalpel. The phrenoesophageal attachments were carefully divided with the harmonic scalpel. The zero degree camera was changed over to a 30 degree scope and dissection was carried up into the mediastinum. The esophagus was freed circumferentially. The posterior vagus is identified and later kept within the wrap. The left and right crux are carefully dissected free and clearly identified.

After a complete window has been provided through careful dissection posterior to the esophagus, I then proceeded in taking down the short gastric vessels. This will provide less tension on the wrap. The short gastric were divided using a harmonic scalpel. Careful dissection was provided and hemostasis was obtained.

After we had dissected around the esophagus prior to taking down the short gastric, a vessel loop was placed around the esophagus and this was used as traction. After completion of taking down the short gastric, we were ready for the wrap. First the right and left crux were approximated and the hiatus was narrowed with placement of two 0 nonabsorbable rated sutures.

An endostitch was used to place the sutures. Extracorporeal knot tying was performed. A clip was placed across the suture and the sutures were cut. After the hiatus was narrowed down, a Babcock clamp was passed behind the esophagus and the stomach was grasped and brought around the esophagus in a 360 degree wrap. The wrap was placed high on the esophagus and a 2 cm wrap was performed. The wrap was performed over a Bougie. I used an 18 French nasogastric tube and a 40 French Bougie which equals 58 French. A loose wrap was thereby obtained. The first muscular suture was placed on the fundus and then a suture was placed into the muscle of the esophagus and through the seromuscular layer on the right side. An endostitch was used and the suture was tied using endocorporeal knot tying.

Several other sutures were placed in a similar manner again using a nonabsorbable graded suture. A tension-free wrap was completed. The area was checked for hemostasis and the area was dry. The Bougie had been previously removed. The nasogastric tube was retained. The individual cannulas were then removed under direct vision. The two sites above the umbilicus were closed. The one to the right was closed with an endoclose suture using 0 Vicryl and the one on the left was closed after deflation of the abdomen and the fascia was closed with interrupted 0 Vicryl sutures.

The other sites were later closed with staples. During the procedure, I used a sixth port which was a 5 mm trocar which helped to advance the camera. This was also later closed with staples. The patient was taken out Trendelenburg. The abdomen was cleansed and dried and sterile dressings were applied. The patient was later extubated and transferred to the recovery room in stable condition.

001991

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 00000444887

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: 100 cc.

FLUIDS: 3700 cc of crystalloid.

DRAINS: None.

INTRAOPERATIVE FINDINGS: A significant amount of reaction was noted around the esophagus.

THOMAS V. MINCHEFF, M.D., F.A.C.S.

1kd1227/KD/TSI
D 12/16/02
T 12/17/02

001992

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0000044687

ADMITTED: 12/16/02

DISCHARGED: 12/18/02

ADMITTING DIAGNOSIS: Gastroesophageal reflux disease.

BRIEF HISTORY AND HOSPITAL COURSE: a 31-year-old Vietnamese male who has documented severe gastroesophageal reflux disease and symptoms. The patient has undergone an EGD, a 24-hour pH probe and esophageal manometry studies which indicate severe gastroesophageal reflux disease. The patient has been treated aggressively with medications. However, the patient persists to have severe symptoms. After careful discussion with the patient, we elected to proceed with an anti-reflux procedure.

On the 16th of December, 2002, the patient underwent a laparotomy Nissen fundoplication. For further details, please see operative note.

The postoperative course was essentially uneventful. The patient received postoperative analgesics on a p.r.n. basis. On postoperative day #1, the nasogastric tube was removed and the patient was started on clear liquids. By the second postoperative day, the patient was on a soft diet.

Postoperative day #2, the patient was doing remarkably well, tolerating his diet. His wounds remained clean and dry. He was ambulating well. We elected to discharge the patient home on the 18th of December 2002.

DISCHARGE MEDICATIONS: Lorcet 1-2 tablets p.o. q.6h.

DIET: Soft.

The patient has been advised to eat no bread foods.

ACTIVITIES: The patient is to convalesce at home.

SPECIAL INSTRUCTIONS: The patient is to followup with me towards the end of the week for a wound check.

001993

PAGE 1

CAROLINA PINES REGIONAL MEDICAL CENTER

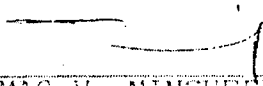
DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0000044627

CONDITION ON DISCHARGE: Improved.

FINAL DIAGNOSIS: Gastroesophageal reflux disease.


THOMAS V. MINCHEFF, M.D., F.A.C.S.

Sod1228/OD/TSI
D 12/26/02
T 12/28/02

001994

PAGE 2

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 000002-152

DATE: 5/12/05

PREOPERATIVE DIAGNOSIS: Type 3 paraesophageal hernia.

POSTOPERATIVE DIAGNOSIS: Type 3 paraesophageal hernia.

PROCEDURE PERFORMED: Paraesophageal hernia repair.

SURGEON: Thomas V. Mincheff, M.D.

FIRST ASSISTANT: Arthur W. Cooler, M.D.

ANESTHESIA: General endotracheal.

INDICATIONS FOR THE PROCEDURE: is a 79-year-old white female who has been complaining of severe dysphagia and chest pain for quite sometime. She has been unable to eat. A CT scan and upper GI were performed which revealed a large hiatal hernia. On careful evaluation, the patient was noted to have a type 3 paraesophageal hernia which will require repair. Medical and cardiology consultation were obtained and the patient was cleared for surgery. The risks and complications of the procedure have been thoroughly reviewed with the patient and her family. All aspects of the procedure have been discussed and reviewed and the patient and family wish to proceed.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room and placed in a supine position upon the operating room table. Pneumatic sequential compression stockings were placed on the lower extremities. A central line was placed via the right internal jugular vein for better access. The patient had poor peripheral access.

After induction of general anesthesia and endotracheal intubation, a Foley catheter and nasogastric tube were inserted. The entire abdomen was prepped with betadine solution. Sterile towels as well as sterile drapes were applied in the usual manner. With the using of a 10 blade scalpel, an upper midline skin incision was made from the xiphoid down to the umbilicus. The incision was carried down through the subcutaneous layers with the use of electrocautery. The incision was carried down through the abdominal wall. The abdominal cavity was entered. The patient was then placed in a reverse Trendelenburg position. Palpation of the abdominal cavity does not reveal any further pathology. Retractors were inserted. The stomach was then mobilized and reduced into the abdominal cavity. The cardia and portion of the fundus were noted to be in the chest. The patient had a type 2 paraesophageal hernia.

FILE COPY

PAGE 1

001995

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0000034392

The hernia sac was carefully freed. The esophagus was mobilized and a Penrose was placed around the esophagus. Attention was taken to preserve the posterior and anterior vagus nerves. In order to get better exposure, the short gastrics were taken down, divided between clamps and ligated using 2-0 Vicryl ties. The gastrohepatic ligament was divided between clamps and ligatures were placed using 2-0 Vicryl ties. A few of the branches of the left gastric were thereby taken. The esophagus was freed posteriorly identifying the left and right cruz. The dissection was carried down to identify the preaortic fascia staying anterior to the aorta. The median arcuate ligament was identified as part of the preaortic fascia.

The nasogastric tube was checked to make sure that now it was in the stomach. The anesthesiologist had trouble initially passing the nasogastric tube since a portion of the stomach was in the chest. With the stomach now reduced and in normal anatomic position, the nasogastric tube was carefully passed into the stomach and checked for position.

We then proceeded with closure of the esophageal hiatus. A 46 French Bougie was passed and then the left and right cruz were reapproximated with several C silk interrupted sutures. The sutures were tied and after the sutures were tied, the Bougie was removed. In order to obtain better exposure, previously the triangular ligament was taken down to fold the left lobe of the liver down. This provided better exposure to the anterior esophagus.

After the cruz was sutured, we then proceeded with the partial wrap. I elected to proceed with a Hill procedure placing 3-4 muscular sutures along the cardia fundus securing the anterior stomach to the medial arcuate ligament with interrupted 2-0 silk sutures. A good partial wrap was thereby completed securing the stomach within the abdominal cavity and recreating the normal position of the GE junction and angle within the stomach cavity. The Penrose drain was then removed. The nasogastric tube was checked once again for good position and then the patient was taken out of reverse Trendelenburg.

The abdominal wound was then closed. The fascia was closed with a running #1 Vicryl continuous suture. The wound was irrigated with normal saline. The skin was closed with staples. The skin was cleansed and dried. A sterile dressing was applied. After extubation, the patient was transferred to the recovery room in stable condition. A postprocedure chest x-ray was obtained to verify position of the central venous line.

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: Minimal.

FILE COPY

PAGE 2

001996

Report Status: TRANSCRIBED

Pat No: 1829977

Reg By: 0121 MINCHEFF, THOMAS V

Med. Rec: 0000024382

Pat. Type: 11

Type: MED Dict.: 05/06/2003 06:05 3kd06052

Physician: MINCHEFF, THOMAS V

Admit.: 05/06/2003 12:30

Discharge: 05/23/2003 16:41

Location: Unknown

Transc.: 06/06/2003 08:05

PATIENT NAME:

MEDICAL REC#: 0000024382

ACCOUNT NO.: 1829977

DICTATED BY: THOMAS V. MINCHEFF, M.D., F.A.C.S.

DATE OF ADMISSION: 5/06/2003

DATE OF DISCHARGE: 5/23/2003

ADMITTING DIAGNOSIS: Large paraesophageal hernia.

BRIEF HISTORY AND HOSPITAL COURSE:

is a 72-year-old white female who had been complaining of severe dysphagia and chest pain for quite sometime. She was unable to eat. A CT scan and upper GI were performed which revealed a large hiatal hernia. On careful evaluation, the patient was noted to have a type-3 paraesophageal hernia which will require repair.

PAST MEDICAL HISTORY: The patient's past medical history was significant for gravida 6, para 5, abortus 1, status post total abdominal hysterectomy for benign disease, status post permanent pacemaker implantation with complications in 1998, status post laparoscopic cholecystectomy in 1998. Status post excision of a benign mass from the right breast. Status post right rotator cuff repair. Status post appendectomy. Status post hemorrhoidectomy. Status post bilateral total knee replacements. Marked gastroesophageal reflux disease, depression, anxiety, status post excision of a stomach polyp in 1999, chronic hypertension, history of heel spurs, plantar fasciitis of the right foot. History of insomnia. History of esophageal stricture.

History of proctitis. Allergic rhinitis. Raynaud's disease. Osteoarthritis. Baker's cyst behind the left knee, status post transient excision of a tubulovillous adenoma of the rectum with high grade dysplasia on September 21, 2000, status post cardiac

001997

Report status: TRANSCRIBED

Pat Nbr: 1828077

Req By: 0181 MINCHEFF, THOMAS V

Med. Rec: 0000024383

Pat Type: 11

Type: MED Dict.: 06/06/2003 06:05 3436052

Physician: MINCHEFF, THOMAS V

Admit.: 05/06/2003 12:16

Discharge: 06/06/2003 12:16

Location: Unknown

Tmscd.: 06/06/2003 00:01

catheterization in August of 2000, right-sided low back pain with sciatica, iron deficiency anemia secondary to heme-positive stools in 2000, hyperlipidemia, osteopenia.

Medical and cardiology consultations were obtained and the patient was cleared for surgery. On 12 May 2003, the patient underwent repair of a large paraesophageal hernia. For further details, please see the operative note. Postoperatively, the patient developed a postoperative ileus which gradually resolved spontaneously. No further surgery was required. The patient was started on clear liquids and gradually the diet was slowly advanced. For a short period of time, the patient was on total parenteral nutrition. Physical therapy was performed. The patient's wounds remained clean and dry. There were no signs of infection. Respiratory therapy was performed.

The patient had bibasilar atelectasis. Dietary consultation was obtained. The patient later regained normal bowel activity and once the ileus resolved, was started back on p.o. intake and this was gradually increased. By 20 May 2003, the patient was on a soft diet. White count remained normal. TPN was gradually decreased and later discontinued. By 23 May 2003, the patient was tolerating solid food. On 23 May 2003, the patient was subsequently discharged home.

DISCHARGE INSTRUCTIONS: The patient is to resume the same diet at home.

ACTIVITIES: The patient has been advised to do no heavy lifting or straining.

MEDICATIONS: During the patient's hospitalization, she appeared to have developed a reaction to Lorcet. The patient was given a prescription for Darvocet. The patient is to continue on her regular medications.

SPECIAL INSTRUCTIONS: The patient is to follow up with us in our office.

CONDITION ON DISCHARGE: Was improved.

FINAL DIAGNOSIS: Large paraesophageal hernia.

001998

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0000035180

DATE: 8/15/03

PREOPERATIVE DIAGNOSIS:

1. Gastroesophageal reflux disease.
2. Reflux esophagitis.

POSTOPERATIVE DIAGNOSIS:

1. Gastroesophageal reflux disease.
2. Reflux esophagitis.

PROCEDURE PERFORMED: Nissen fundoplication.

SURGEON: Thomas V. Mincheff, M.D.

FIRST ASSISTANT: C. Brooks Bannister, M.D.

ANESTHESIA: General endotracheal anesthesia.

INDICATIONS FOR PROCEDURE:

is a 56-year-old white female who was initially referred to us by Dr. Bell. The patient has been complaining of chronic reflux symptoms. The patient has been refractory to medical management. A 24-hour pH probe and esophageal manometry studies were obtained. The patient was found to have severe reflux disease with a DeMeester score of 56. Esophageal motility was normal.

Since the patient has not responded to medical treatment, we have thoroughly reviewed the options for correction of the reflux symptoms. The patient has elected to proceed with a Nissen fundoplication. We have discussed both the open and laparoscopic approaches. As discussed with the patient, we will first attempt a laparoscopic approach. However, the patient has had previous surgery. The patient is aware of the risks and complications of the Nissen fundoplication including injury to the esophagus, stomach, spleen, and liver. All aspects have been thoroughly reviewed, and the patient wishes to proceed. The patient is also aware that, should we not be able to proceed laparoscopically, we may have to convert to an open procedure.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room and placed in a supine position upon the operating room table. Preoperative antibiotics were administered. Pneumatic sequential compression stockings were placed on the lower extremities. After induction of general anesthesia and endotracheal intubation, the patient was placed in a modified lithotomy position upon the operating room table. A Foley catheter was inserted. The nasogastric tube was inserted. An 16-French nasogastric tube was inserted. The surgical abdomen was prepped with Betadine solution, and sterile towels were applied in the usual manner.

001999

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0000027140

DESCRIPTION OF PROCEDURE, CONTINUED: Staying approximately 4 cm above and to the left of the umbilicus, a small transverse skin incision was made with the #15 blade scalpel. Using a Hasson open approach, the abdominal cavity was entered. The abdominal cavity was inflated with 4-6 liters of CO₂, reaching a pressure of 15 mmHg. The 10 mm 0-degree camera was first inserted, and the abdominal cavity was examined. The liver appears normal in size. The stomach appears normal. However, there is a large amount of fat overlying the stomach. The patient has multiple adhesions in the right upper quadrant. This is from previous surgery.

Through a separate stab wound in the left upper quadrant, a 10 mm trocar was inserted just beneath the ribs. Through a separate stab wound in the right upper quadrant, a third 10 mm trocar was inserted. In the subxiphoid area through a separate stab wound, another trocar was inserted. Four cm above and to the right of the umbilicus, the fifth trocar was inserted, again under direct vision.

The patient was then placed in a reverse Trendelenburg position. Using the fan, the liver was carefully reflected superiorly. A Babcock clamp was placed along the stomach, and the stomach was pulled down. We first attempted to approach the area laparoscopically. I first tried to take down the gastrohepatic ligament. However, due to a large amount of fat in this area, exposure was difficult. Since we could not progress, we elected then to convert to an open procedure. The individual trocars were removed. The Hasson trocar was removed and the fascia was closed with a #0 Vicryl figure-of-eight suture.

Using a #10 blade scalpel, a midline skin incision was made from the xiphoid down to the umbilicus. The incision was carried down through the subcutaneous layers with use of electrocautery. The fascia was divided with electrocautery, and the abdominal cavity was entered. Retractors were inserted. In order to get better exposure we took down the triangular ligament and folded the left lobe of the liver over. The spleen was densely attached to the left lobe, and through careful dissection, this was freed. A small superficial capsular tear was noted in the spleen. This was controlled with mere placement of surgical.

The gastrohepatic ligament was then divided, and careful dissection was carried across the esophagus, dividing the peritoneum. The left lateral attachments were then divided. The phrenoesophageal attachments were divided using careful sharp dissection. Through careful blunt dissection, testing was palpated posteriorly and freed. The posterior vagus was identified and preserved. A Penrose drain was placed around the esophagus and was placed on traction. The 3-French nasogastric tube was easily palpated within the esophagus.

002000

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 000025140

DESCRIPTION OF PROCEDURE, CONTINUED: A substantial window was then developed, dissecting the esophagus up into the mediastinum. The left and right crura were then identified. The hiatal hernias were brought down into the stomach. The left and right crura were approximated with placement of #0 silk interrupted sutures. In order to perform a 360 degree wrap, we took down several of the short gastrics approximately one-third of the way down along the greater curvature of the stomach. Short gastrics were divided between clamps, and ligatures were placed using 3-0 Vicryl ties. Also clips were applied. The other portions of the stomach were then wrapped around the esophagus without difficulty.

A floppy wrap was then developed. A 40-French bougie was then passed down through the esophagus alongside the 18-French nasogastric tube, thus providing a 58-French dilation. Then a 360-degree wrap was performed with placement of 2-0 silk seromuscular sutures placed individually. A suture was placed through the muscular layer of the esophagus as well. Three sutures were placed, thereby providing at least a 3 cm wrap on the esophagus. No kinking was noted. Each suture was placed individually and then tied. After the fundoplication was completed, the bougie was removed, leaving the nasogastric tube behind.

The wrap was checked again and found to be adequate. The spleen was checked again, and there was no bleeding. The abdomen was then irrigated with normal saline. The area was dry. The posterior vagus nerve was incorporated in our wrap. The Penrose drain was removed.

The patient was then placed back in supine position. The abdominal wound was then closed. The fascia was closed with a running #1 PDS continuous suture. The subcutaneous layer, which is quite thick, was then closed with interrupted 3-0 Vicryl sutures. The skin was closed with staples. The skin was cleansed and dried. The sterile dressing was applied. After extubation, the patient was transferred to the recovery room in stable condition.

COMPLICATIONS: None.

THOMAS V. MINCHEFF, M.D.

AGW/BJL/aw/TST
D 5/15/03
T 5/15/03

DR. L. JAMES FULLERTON, M.D.

002001

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0000025140

ADMITTED: 9/15/03

DISCHARGED: 9/20/03

HISTORY OF PRESENT ILLNESS: This is a 55-year-old Caucasian female kindly referred by Dr. James Bell with a significant gastroesophageal reflux disease. This has been documented with appropriate studies and also she showed no abnormality on her esophageal manometry. She had endoscopy and had been treated aggressively with proton pump inhibitors. Due to her ongoing symptoms, she was prepared for a possible laparoscopic cholecystectomy. She had multiple prior abdominal procedures, and it was unknown as to whether she would have to be converted to an open because of adhesive disease.

SURGERIES: Prior surgeries included a partial hysterectomy, cholecystectomy, umbilical hernia, exploration for adhesions.

MEDICATIONS: She is on multiple medications including; Celebrex, Peridium, and Protonix.

PHYSICAL EXAMINATION: Was essentially unremarkable except for multiple abdominal scars.

LABS: Any important labs will be discussed in the hospital course.

HOSPITAL COURSE: The patient was taken to the operating room on September 15, 2003, where attempted laparoscopic repair was performed. This had to be converted to an open procedure. Postoperatively on the first postoperative day, she was afebrile. She had minimal NG tube drainage and the nasogastric tube was discontinued at that time. Because of prior deep venous thrombosis, she was maintained on Lovenox prophylactically. On the second postoperative day, she was ambulatory and complaining of some headaches. She continued to slowly improve.

She was having gas pains on the third postoperative day, but had passed flatus on three different occasions. Her pulse oximetry at this time was 91% and she was placed on two liters of nasal cannula. On the nineteenth, she had stool. Her Foley catheter was discontinued at this time and her diet was advanced. On the twentieth, she was taking p.o. feedings well. She was doing quite well and she was discharged to home at that time. She was to be followed up in our office.

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0000025140

DISCHARGE MEDICATIONS: Include Lorcet plus for pain.

FINAL DIAGNOSES: Gastroesophageal reflux disease and hiatal hernia.

C. BROOKS BANNISTER, M.D.

4KD1025/KD/TSI

D 10/24/03

T 10/25/03

002003

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0000020408

DATE: 6/21/05

PREOPERATIVE DIAGNOSIS: Gastroesophageal reflux disease.

POSTOPERATIVE DIAGNOSIS: Gastroesophageal reflux disease.

PROCEDURE PERFORMED: Open Nissen fundoplication.

SURGEON: C. Brooks Bannister, MD

ASSISTANT: Thomas Mincheff, MD

ESTIMATED BLOOD LOSS: 450 cc.

INDICATIONS FOR PROCEDURE: This is a 70-year-old Caucasian male who had documented gastroesophageal reflux disease. This was both by endoscopy and with a pH probe monitoring. His esophageal manometry was normal. He was also having recurrent respiratory problems, which his referring physician felt might be secondary to his reflux. He was referred for an open Nissen fundoplication. He was kindly referred by Dr. James Bell.

DESCRIPTION OF PROCEDURE: The patient was placed in the supine position on the operating room table and under adequate general endotracheal anesthesia, the abdomen was prepped and draped in a sterile manner. A midline incision was made from xiphoid at the umbilicus and the abdomen was entered in the usual careful manner obtaining hemostasis with electrocautery. Once entering the abdomen and exploration was carried out, his preoperative hemoglobin was 9.4 gm. He had fairly significant diverticular disease in the sigmoid colon. There were no masses lesions palpable in the colon. There were no other masses felt in the abdomen. The liver appeared normal. Following this, the left triangle region of the left lobe of the liver was mobilized with Metzenbaum scissors exposing the hiatus. The peritoneum at the hiatus was incised with scissors and then the esophagus was bluntly mobilized passing a Penrose drain around the esophagus. A small amount of areolar tissue in the peritoneum and hernia sac was then lysed along the lesser curvature side of the stomach and esophagus. Following this, the area was chosen and the short gastrics were then mobilized. They were divided between Hemoclips and dividing more towards the upper pole of the spleen. The Hemoclips malfunctioned here and there was some bleeding encountered. This was controlled by isolating the bleeder carefully, clamping it, and then suture ligating with 3-0 silk suture ligature, and then ligating proximally with a free tie of 2-0 silk. Further mobilization was carried out mobilizing the entire greater curvature to the esophagus. There was a good more than two fingerbreadth window created and the stomach was very floppy and easily wrapped around the esophagus. Following this, once we had mobilized enough and had enough stomach, the NG tube was removed and then a 50-French bougie dilator passed into the stomach. Prior to performing the wrap, the crura were approximated with interrupted 0 silk sutures.

002004

CAROLINA LINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0000020456

Once the crura had been approximated to again about a two fingerbreadth hiatus, the wrap was then performed. The stomach was passed around the esophagus and the stomach was very mobile in this area and easily came around. The Nissen wrap was then performed by suturing the stomach, taking a bite in the stomach, and then through the esophagus, and then back into the stomach creating about a 3 to 4-cm wrap. This was right at the EG junction. A very good wrap was performed. It was under no tension and it was formed easily. The Penrose drain was then removed, the Bougie dilator was removed, and the nasogastric tube easily passed into the stomach. The area was then irrigated and suctioned. Hemostasis was adequate. Estimated blood loss to be about 450 cc, which sounds a little high to me; however, that was an estimate from the anesthetist. Because his hemoglobin was 9.4 preoperatively, he would be starting with a unit transfusion because of his age and the past history of coronary artery disease, (he had, had a prior CABG). Once the area was carefully inspected and no bleeding was seen, the abdominal closure was accomplished by closing the fascia with continuous running #1 PDS suture. The skin was closed with the skin staplers. The patient was then awakened, extubated, and taken to the recovery room in satisfactory condition.

C. BROOKS BANNISTER, M.D.

42M0621/ZM/TS1

D 6/21/05

T 6/21/05

cc: T. James Bell, MD

002005

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

HOSPITAL#: 0000020458

ADMITTED:

DISCHARGED: *7/28/05*

HISTORY AND HOSPITAL COURSE: The patient was admitted to the hospital with Eitka transient ischemic attack or petit mal attack. He was confused at home. He had been having similar spells. Seizure was considered, and Dr. Pan was seen in consultation. Arrhythmia was considered due to anemia, probably from esophageal blood loss from reflux esophagitis. His B12 was low, and hopefully this was the cause of some of his dementia. His gastroesophageal reflux was stable. EEG was pending. After four days in the hospital, he was stable. He was given B12, and he will need to take B12 on a daily basis for a while at dialysis or at home. It also was found he needed reflux surgery, but he was able to be discharged from the hospital to resume his home medications, takes B12 2 cc Wednesday at dialysis, and Chromogen one a day.

FINAL DIAGNOSIS:

1. Acute mental status changes.
2. Vitamin B12 deficiency with dementia, early.
3. Anemia secondary to esophageal bleed and B12 deficiency.
4. Gastroesophageal reflux disease.
5. Atherosclerotic cardiovascular disease, remote, post bypass.

TJB
T. JAMES BELL, M.D.

3SW0726/SW/TSI

D 7/24/05

T 7/26/05

002006

7366

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

MR #: 63399

ROOM #:

HOSPITAL #: 008858361

DOB: 12/23/1969

DATE: 08/02/2006

PREOPERATIVE DIAGNOSIS:

1. Morgagni congenital diaphragmatic hernia.
2. Biliary dyskinesia.

POSTOPERATIVE DIAGNOSIS:

PROCEDURE:

1. Laparoscopic repair of congenital diaphragmatic hernia with Alloderm.
2. Laparoscopic cholecystectomy.

SURGEON: Jason Richard Dameron, MD

* ASSISTANT: Thomas Mincheff, M D

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: Minimal.

DRAINS: None.

SPECIMENS: Gallbladder.

COMPLICATIONS: None.

HISTORY: The patient is a 36-year-old Caucasian male previously evaluated by Dr. Mincheff for abdominal pain. CT scan was obtained which demonstrated a diaphragmatic hernia containing what appeared to be the transverse colon in the anteromedial aspect of the right hemidiaphragm. The patient was also having postprandial abdominal pain with nausea and vomiting especially after the intake of fatty, greasy foods. A HIDA scan was obtained which demonstrated an abnormal gallbladder ejection fraction. Laparoscopic with possible conversion to an open procedure for his diaphragmatic hernia repair as well as laparoscopic and possible open cholecystectomy were discussed with the patient. After all risks and benefits and alternative therapies were discussed with the patient, he elected to proceed.

DESCRIPTION OF THE PROCEDURE: After informed consent was obtained, the patient was taken to the operating room and placed in the supine position. After general endotracheal anesthesia was administered, the abdomen was prepped and draped in sterile fashion. A transverse supraumbilical skin incision was made with a scalpel and carried down through the skin and subcutaneous tissue using cautery. The fascia was incised vertically and a stay suture of 0 Vicryl was placed on each side of the fascial incision. The perineum was grasped on opposite sides using tonsil clamps and incised with Metzenbaum scissors. The peritoneal cavity was then entered. A Hasson trocar was placed and the pneumoperitoneum was created.

Next, two 5 mm trocars were placed in the patient's right upper quadrant

002007

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:
MR #: 63399
ROOM #:

HOSPITAL #: 008868361
DOB: 12/23/1969
DATE: 08/02/2006

under direct laparoscopic visualization. A third 5 mm trocar was placed in the patient's left upper quadrant under laparoscopic visualization as well. Prior to placing the trocar, skin incisions were made with a scalpel. The patient was noted to have a large diaphragmatic defect in the anteromedial aspect of the left hemidiaphragm. The majority of the transverse colon was noted to be within the defect. Atraumatic bowel graspers were used to grasp the transverse colon and reduce it. There were no adhesions noted to the pleura. There were two adhesive bands that were incised with a Harmonic scalpel between the undersurface of the diaphragm and the colon. Once the colon had been reduced, Alloderm was reconstituted and sutured in place using 2-0 and 0 Surgidac using endo-stitch device. The most anterior aspect of the Alloderm was secured to the abdominal wall using the laparoscopic tacking device.

Next, the gallbladder was retracted cephalad. The cystic duct and cystic artery were bluntly dissected. The cystic artery and cystic duct were then clipped and divided leaving two clips each on the cystic duct remnant and the cystic artery remnant. Cautery was used to remove the gallbladder from the gallbladder fossa. The gallbladder fossa was retrieved using an endo-catch bag. Hemostasis was confirmed. The peritoneal cavity was irrigated. The endo-catch bag containing the gallbladder was removed from the peritoneal cavity and passed off as specimen. All trocars were then removed with direct laparoscopic visualization and there was noted to be no bleeding from the trocar sites. The supraumbilical fascia was closed with 0 Vicryl in a simple running fashion. The skin of all incisions was closed with staples. The patient was extubated and taken to the post anesthesia recovery room in stable condition. All needle and sponge counts are correct. The patient tolerated the procedure well.

Jason Richard Dameron, MD

cc: Thomas V Mincheff

30149 \42590574

DD: Wed Aug 02 15:35:34 2006

TD: Wed Aug 02 17:35:07 2006

002008

DICTATOR COPY for Jason Richard Dameron, MD

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:	HOSPITAL #:	008868361
MR #: 63399	DOB:	12/23/1969
ROOM #:	ADMITTED:	07/28/2006
	DISCHARGED:	08/02/2006

ADMISSION DIAGNOSES:

1. Abdominal pain.
2. Diaphragmatic hernia.

BRIEF HISTORY AND HOSPITAL COURSE:

a 36-year-old Caucasian male, a patient of Dr. Nichols who for the last several months has been complaining of abdominal discomfort. He was initially referred to me by Dr. Nichols with some right lower quadrant pain and the concern was that the patient may have a right inguinal hernia. On examination the patient was not found to have an inguinal hernia. However, I elected to send the patient for a CT scan of the abdomen and pelvis and on the CT scan the patient was noted to have a hernia of the foramen of Morgagni. There was a large intestine noted up in the chest. The patient had frequent emergency room visits and was seen by several physicians and finally the diagnosis of a hernia of the foramen of Morgagni was obtained. The patient has had increasing symptoms over the last several weeks. As discussed with the patient in my office we were planning to make arrangements to repair this on an elective basis. The patient had been given some pain medication and was advised to follow up with me the following week. Due to increased symptoms, however, the patient came back to the emergency room and was admitted. The patient's symptoms, however appeared to be more consistent with biliary tract disease and I elected to obtain biliary studies prior to the patient's planned surgery for the diaphragmatic hernia. Biliary studies revealed that the patient had biliary dyskinesia with a diminished ejection fraction. Arrangements were made to remove the gallbladder at the same time as repairing diaphragmatic hernia. On the 1st of August 2006 the patient underwent laparoscopic repair of the congenital diaphragmatic hernia with AlloDerm and also underwent laparoscopic removal of the gallbladder. For further details please see operative note. The patient's postoperative course was uneventful. The patient received preop and postop antibiotics and was started on a clear liquid diet and slowly advanced to a regular diet as tolerated. The patient received analgesics on a p.r.n. basis. The patient's wounds remained clean and dry. With the uneventful postoperative course the patient was discharged on the 2nd of August 2006 and was given a prescription for analgesics on a p.r.n. basis. The patient is to follow up with Dr. Dameron in the next week. The patient has been advised to do no heavy lifting or straining. The patient is allowed to shower.

CAROLINA PINES REGIONAL MEDICAL CENTER

DISCHARGE SUMMARY

NAME:

MR #: 63399

ROOM #:

HOSPITAL #: 008868361

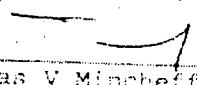
DOB: 12/23/1969

ADMITTED: 07/28/2006

DISCHARGED: 08/02/2006

CONDITION ON DISCHARGE: Improved.

FINAL DIAGNOSIS: Diaphragmatic hernia, biliary dyskinesia.


Thomas V Mincheff, MD FACS

cc: Dr. Nichols

30060 \42655720

DD: Mon Aug 28 11:24:24 2006

TD: Mon Aug 28 11:59:54 2006

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:
MR #: 34170
ROOM #: 0220 A

HOSPITAL #: 008872966
DOB: 12/08/1920
DATE:

DATE OF PROCEDURE: 09/28/2006.

PREOPERATIVE DIAGNOSIS: Type 3 para-esophageal hernia.

POSTOPERATIVE DIAGNOSIS: Type 3 paraesophageal hernia.

PROCEDURE:

1. Laparoscopic repair of type 3 paraesophageal hernia.
2. Percutaneous endoscopic gastrostomy tube placement.

SURGEON: Jason Richard Dameron, MD

ASSISTANT: Thomas V Mincheff, MD

ANESTHESIA: General endotracheal anesthesia.

ESTIMATED BLOOD LOSS: 100 mL.

DRAINS: 22 French gastrostomy tube.

SPECIMENS: None.

COMPLICATIONS: None.

HISTORY: The patient is an 85-year-old male with a history of dysphagia for solids and liquids as well as some hematemesis. An esophagogastroduodenoscopy was performed as well as an upper gastrointestinal series, which demonstrated a very large paraesophageal hernia. Repair was recommended, and all risks, benefits, and alternative therapies were discussed with the patient, he elected to proceed.

DESCRIPTION OF THE PROCEDURE: After informed consent was obtained, the patient was taken to the operating room and placed in the supine position. After adequate general endotracheal anesthesia was administered, the abdomen was prepped and draped in a sterile fashion. A 10 mm incision was made superior and just to the left of the umbilicus after the skin and subcutaneous tissues were infiltrated with local anesthetic. The incision was carried down through the skin and subcutaneous tissues using cautery. Stay sutures of 0-Vicryl were placed in the rectus fascia and the fascia was incised between the two stay sutures. The peritoneum was then entered. Digital exploration was performed. There was no evidence of adhesions. A Hasson trocar was then placed and pneumoperitoneum was created. Next the skin and subcutaneous tissues were infiltrated with local anesthetic at the site of a right upper quadrant 5 mm trocar in the anterior axillary line just inferior to the costal margin. A skin incision was made and a 5 mm trocar was placed under direct laparoscopic visualization. Next a 5 mm trocar was placed in the mid clavicular line and antecostal margin in the same manner. A 10 mm trocar was then placed in the same manner inferior and medial to the

CAROLINA PINES REGIONAL MEDICAL CENTER

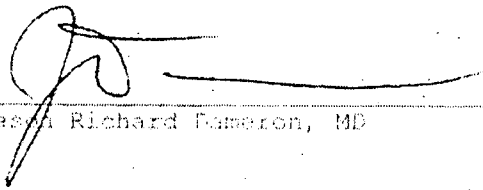
OPERATIVE NOTE

NAME:
MR #: 34170
ROOM #: 0220 A

HOSPITAL #: 002872966
DOB: 12/08/1920
DATE:

previously placed 5 mm trocar in the mid clavicular line. Next a 5 mm trocar was placed in the same fashion in the mid clavicular line, costal margin in the left upper quadrant. A liver retractor was placed and attached to the Martin arm. The patient was noted to have a very large type 3 paraesophageal hernia. The stomach was noted to be densely adherent to the mediastinum. The harmonic scalpel was used to dissect the stomach and wash the adhesions between the stomach and mediastinal structures. The stomach was eventually reduced. The gastrohepatic ligament was incised with cautery. The peritoneum overlying the right crus was incised. This was secured around circumferentially. A window was made posterior to the esophagus. The posterior aspect of the left crus was identified and dissected. The crura were then closed with interrupted 0 Surgitek sutures using the Endo stitch device. Hemostasis was confirmed. Next was gastroscope was introduced into the oropharynx and passed into the stomach and insufflated.

The abdominal wall was transilluminated. An introducer needle was placed into the abdominal wall into the stomach under endoscopic visualization. A snare was used to grasp with the guidewire that was placed through the introducer needle and was pulled through the mouth. A gastrostomy tube was then placed over the guidewire and pulled through the mouth and subsequently through the abdominal wall. The gastroscope was then placed back into the stomach and photographs were taken to confirm positioning and placement of the G tube. It was then cut to an appropriate length and secured to the abdominal wall using interrupted 3-0 Ethilon sutures. A bolster was applied for this. It was then attached to a drainage bag. The patient was extubated and taken to the post anesthesia recovery room in stable condition. All needle and sponge counts were correct. He tolerated the procedure well.


Jason Richard Cameron, MD

cc:

30059 \42746071

DD: Tue Oct 03 08:36:29 2006

TD: Wed Oct 04 10:03:37 2006

002012

PAGE 2

9799

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

MR #: 000033051

ROOM #: 0315 A

HOSPITAL #: 003045183

DOB: 07/15/1924

DATE: 10/11/2006

PREOPERATIVE DIAGNOSIS: Type 3 hiatal hernia.

POSTOPERATIVE DIAGNOSIS: Type 3 hiatal hernia.

PROCEDURES:

1. Laparoscopic repair of type 3 hiatal hernia with mesh.
2. Percutaneous endoscopic gastrostomy.

SURGEON: Jason Richard Dameron, MD

ASSISTANT: Thomas V Mincheff, MD FACS

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 100 ml.

DRAINS: 20-French gastrostomy tube.

SPECIMENS: Hernia sac.

COMPLICATIONS: None.

INDICATIONS: The patient is an 82-year-old African-American male who was having dysphagia for solids and liquids. CT and upper GI revealed a large hiatal hernia containing stomach. Surgical treatment was recommended. After all risks, benefits and alternative therapies were discussed with the patient, he elected to proceed.

DESCRIPTION OF THE PROCEDURE: After informed consent was obtained, the patient was taken to the operating room and placed in supine position. After adequate general endotracheal anesthesia was administered, the abdomen was prepped and draped in sterile fashion. The skin and subcutaneous tissue were infiltrated with local anesthetic just superior and to the left of the umbilicus. A skin incision was made with #11 scalpel blade, and carried down through skin and subcutaneous tissue using cautery. Stay sutures of 0 Vicryl were placed in the fascia. The fascia was incised and the peritoneum entered. The Hasson trocar was placed and a pneumoperitoneum created.

Again, the skin and subcutaneous tissue were infiltrated with local anesthetic at the site of a 5 mm trocar in the anterior axillary line in the right upper quadrant just beneath the costal margin. The skin incision was made, and the 5 mm trocar placed under direct laparoscopic visualization. A laparoscopic liver retractor was then placed into the peritoneal cavity, and the liver was retracted cephalad. The liver retractor was secured using a Morton arm.

POSTED

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

MR #: 000033051

ROOM #: 0315 A

HOSPITAL #: 003045183

DOB: 07/15/1924

DATE: 10/11/2006

Next, the skin and subcutaneous tissue were infiltrated with local anesthetic at the site of two right upper quadrant trocars, and the skin incisions were made. One of the 5 mm trocars was placed in the midclavicular line just beneath the costal margin. The other one was placed 4 fingerbreadths inferior and medial to the previously placed trocar. Both of these were placed under direct laparoscopic visualization. The skin and subcutaneous tissue were infiltrated with local anesthetic at the site of a left upper quadrant trocar. The skin incision was made, and the trocar was placed in the midclavicular line beneath the costal margin.

Evaluation of the diaphragm revealed a large, diaphragmatic defect with the majority of the stomach herniated up into the chest. The hernia sac was noted to be dense and adherent to the mediastinum. A combination of sharp and blunt dissection was used to dissect the hernia sac and reduce the stomach into the peritoneal cavity. The short epigastrics, halfway down the greater curvature of the stomach, were divided using the Harmonic scalpel. A window was made posterior to the esophagus to facilitate placement of AlloDerm. The esophageal hiatus was closed with two curled sutures. These were interrupted 0 Surgidac sutures, which were placed using the endo stitch device.

Next, an 8 x 12 AlloDerm was cut to the appropriate size, and placed into the peritoneal cavity. It was passed posterior to the esophagus and was used as an onlay to reinforce the esophageal hiatus. It was secured using 0 Surgidac using the Endo stitch device. Six simple interrupted sutures were used to secure the mesh in place. Hemostasis was confirmed. All trocars were removed under direct laparoscopic visualization. The laparoscopic liver retractor was also removed under direct laparoscopic visualization as well.

Next, the gastroscope was placed into the oropharynx and passed into the stomach. The abdominal wall was transilluminated. An introducer needle was placed into the stomach under endoscopic visualization. A guidewire was passed and retrieved using the gastroscope. The gastrostomy tube was placed over the guidewire, and in antegrade pull fashion was pulled through the anterior abdominal wall. It was secured using interrupted 3-0 silk sutures. It was then placed to a drainage bag after being cut to the appropriate length.

002014

DICTATOR COPY for Jason Richard Dameron, MD

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

MR #: 000033051

ROOM #: 0315 A

HOSPITAL #: 003045183

DOB: 07/15/1924

DATE: 10/11/2006

The patient was extubated and taken to the PACU in stable condition. All needle, instrument and sponge counts were correct. There were no complications. He tolerated the procedure well.

Jason Richard Dameron, MD

cc: Leon Hunt, Gary A. Barker, MD

30033 \62886430

DD: Fri Oct 13 10:53:49 2006

TD: Sat Oct 14 12:10:04 2006

002015

THE BYERLY HOSPITAL

00013379

OPERATIVE NOTE

NAME:
HOSPITAL #15399
ROOM: 340
DATE: 7-1-96

P. J. HARRIS, M.D.
291511562 50-F
112115
721 W HONE AVE
HARTSVILLE SC 29330

PREOPERATIVE DIAGNOSES: GASTROESOPHAGEAL REFLUX DISEASE.

POSTOPERATIVE DIAGNOSES: SAME.

OPERATION: LAPAROSCOPIC NISSEN FUNDOPLICATION.

SURGEON: Thomas V. Mincheff, M. D.

FIRST ASSISTANT: R. M. Harris, M. D.

ANESTHESIA: General endotracheal.

INDICATIONS FOR THE PROCEDURE:

is a 60-year-old, white female with documented gastroesophageal reflux disease. The patient has been treated for many years and has continued to be symptomatic. Recent studies, 24 hour pH probe, esophageal motility studies confirmed gastroesophageal reflux disease. The patient also has a hiatal hernia and her symptoms have not been relieved with long term medication. A Nissen fundoplication is indicated.

DESCRIPTION OF THE PROCEDURE: The patient is taken to the Operating Room and placed in the supine position upon the operating table. Sequential pneumatic compression stockings are placed on the lower extremities. After induction of general anesthesia and endotracheal intubation, a 16 French nasogastric tube was inserted into the stomach and a 16 French Foley catheter was inserted into the bladder. The entire abdomen is then prepped with Betadine solution. Sterile towels as well as sterile drapes are applied in the usual manner. Staying approximately 3 cm. above and to the left and lateral of the umbilicus, a small transverse skin incision is made into the skin with the 15 blade scalpel, the incision is carried down through the fascia. The abdominal cavity is entered using the Hasson procedure. Two fixation sutures are placed on the fascia with 2-0 Poly-Sorb. The 10-12 mm. trocar and cannula are inserted into the abdominal cavity and secured with the fixation sutures. The abdominal cavity is then inflated with 4-6 liters of CO2 reaching a pressure of 15 mm. of Mercury. The camera is then inserted and the stomach and liver appear normal. No abnormalities are seen. With use of a 15 blade scalpel, a small vertical midline incision is made just below the xiphoid. Through this small incision, a second 10-12 mm. trocar is inserted through the abdominal wall under direct vision. This trocar was placed for our liver fan retractor. A third incision is made in the right upper quadrant.

002016

PAGE 2
OPERATIVE NOTE

#15399

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701 W HOME AVE
HALLSVILLE SC 29550

beneath the costal margin with a 15 blade scalpel, a third trocar is passed through the abdominal wall under direct vision. The same is performed then on the left side staying below the costal margin and the fourth trocar is passed through the abdominal wall. A fifth trocar is placed approximately 4 cm. above and to the right of the umbilicus. The left lobe of the liver is then retracted with a liver fan retractor. A Babcock clamp is placed on the stomach and the stomach is retracted inferiorly. The dissection is initially started in the gastrohepatic ligament staying close to the hiatus. The peritoneum is incised with the electrocautery as well as using the harmonic scalpel. The esophagus is freed anteriorly and posterior through careful blunt dissection. The hiatus is exposed. The left and right crus are clearly identified. The anterior and posterior vagus are identified and preserved. After the esophagus has been freed circumferentially, a vessel loop is placed around the esophagus and later used for traction. There was a moderate of fat around the esophagus and this was carefully freed off. After the esophagus was completely exposed, the left and right crus are then reapproximated. The hiatal hernia is reduced and the hiatus is narrowed by approximating the left and right crus with several interrupted 2-0 Surgidec sutures. Extra corporal knot tying was performed. The sutures were placed using the endosuture device. After closure of the hiatus, the short gastrics are then divided approximately 10 to 12 cm. along the greater curvature along the fundus. This is done with the harmonic scalpel. Once an adequate amount of stomach has been freed for the wrap, a Babcock clamp is placed posteriorly to the esophagus and the stomach is brought around esophagus for the wrap. A 58 French Bougie is then carefully passed down the esophagus and kept in place until the sutures have been placed. Three sutures are placed for the wrap which is approximately 2 cm. in length. Extra corporal knot tying is performed and a clip is placed just above the knot and the sutures are cut individually. The suture encompasses a portion of the stomach and the anterior esophagus. After an adequate wrap has been performed, the Bougie is removed and a fourth suture is placed along the stomach and secured to the crus on the right. Again, 2-0 Surgidec suture material is used and extra corporal knot tying is performed. A clip is placed above the knot and the suture is cut. The fundoplication looks good. All sutures are secure. Bleeding was minimal. Under direct vision, all five cannulas are individually removed. The abdominal cavity is deflated. The wounds are then closed. The fascia is closed with interrupted 2-3 Poly-Sorb sutures. The skin is closed with staples. Sterile dressings are applied after the wounds have been cleaned and dried. The patient is extubated and transferred to the Recovery Room in stable condition.

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PAGE 3
OPERATIVE NOTE

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112135

701 W HOME AVE
KADISVILLE

SC 29550

COMPLICATIONS: None.

Thomas V. Minchep
THOMAS V. MINCHEP, M. D.

DATE

DD 7-1-96
ET 2-1-96

TVM:ch

002018

THE BYERLY HOSPITAL

OPERATIVE NOTE

HOSPITAL #: 14731
ROOM:

DATE: 7-6-96

PREOPERATIVE DIAGNOSES: REFLUX ESOPHAGITIS, SEVERE
GASTROESOPHAGEAL REFLUX DISEASE.

POSTOPERATIVE DIAGNOSES: SAME.

PROCEDURE: LAPAROSCOPIC NISSEN FUNDOPLICATION.

SURGEONS: THOMAS V. MINCHEFF, M. D.
FIRST ASSISTANT: DR. HARRIS.

ANESTHESIA: General endotracheal.

INDICATIONS FOR THE PROCEDURE:

35-year-old white male who has a history of gastroesophageal reflux disease since the age of 18. The patient has been maintained on medical management, however, the patient continues to have severe symptoms. Upper GI work up including an EGD, 24 hour pH probe studies, and esophageal manometry studies revealed severe gastroesophageal reflux disease. The patient is now scheduled for a laparoscopic Nissen fundoplication.

DESCRIPTION OF THE PROCEDURE: The patient is taken to the operating room and placed in a supine position upon the operating room table. Preoperative IV antibiotics were given. Sequential pneumatic compression stockings are placed on the lower extremities. After induction of general anesthesia and endotracheal intubation, a 16 French Foley catheter is inserted and a 16 French nasogastric tube is inserted. The entire abdomen and upper chest is shaved and then prepped with Betadine solution. Sterile towels as well as sterile drapes are applied in the usual manner. The first incision is made approximately 3 cm. above, and to the left of the umbilicus. Using a 15 blade scalpel, a transverse skin incision is made. The subcutaneous layers are divided with the electrocautery. The anterior rectus fascia is incised and the underlying rectus muscle is spread apart revealing the posterior rectus fascia which is also incised. The abdominal cavity is entered using the Hasson procedure. Fixation sutures are placed using 0 Polysorb. A 10-12 mm. trocar is then inserted and secured in place with the fixation sutures. The abdominal cavity is then inflated with 4-6 liters of CO₂ reaching a pressure of 15 mm. of Mercury. A 16 mm. camera is inserted into the abdominal cavity and the abdominal cavity is examined. No significant abnormalities are seen.

002019

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Through a separate stab wound, just beneath the xiphoid, a 10 mm. incision is made and the right upper quadrant, just below the subcostal margin, through a separate stab wound, a 10 mm. incision is made and the same is performed on the left side. Scaring 4-5 cm. above and the right of the umbilicus, a 10 mm. incision is made and a 10 mm. incision is passed through the abdominal wall, again under direct vision. The patient is then placed in a reverse Trendelenburg position. Through the epigastric port, a liver fan is inserted and the left lobe of the liver is retracted cephalad. A Babcock clamp is placed along the stomach and the stomach is retracted inferiorly. The gastrophrenic ligament is divided with the use of the harmonic scalpel, staying very close to the upper portions of the stomach. The patient is noted to have a significant amount of fat around the distal esophagus and to the left of the esophagus. The phrenoesophageal membrane is divided with the harmonic scalpel and the space on either side of the esophagus is carefully freed through blunt dissection. The 30 degree scope is then inserted and the retroesophageal space is developed. The right and left crus are exposed and clearly visualized. After the retroesophageal space has been freed a vessel loop is placed around the distal esophagus. Dissection is placed on the vessel loop. The short gastric vessels are then taken down, noting the harmonic scalpel. This is done along the fundus of the stomach. A length of 10 cm. is thereby freed around the esophagus, and there appears to be enough of stomach for the wrap. A 55 French bougie is then carefully inserted into the esophagus after the nasogastric tube has been removed. Careful attention is taken not to perforate the esophagus or proximal stomach. Using the dissector the esophagus on right crus are then reapproximated with placement of a surgical anastomosis using the Endositch device. Extracorporeal knot tying is conducted and just above the knot a clip is placed and the anastomosis is cut. The ptosis is thereby narrowed. The hiatus is narrowed just to allow the dissector to go through. The fundus of the stomach is brought posterior to the esophagus using a Babcock clamp and a 55 French nasogastric intubation is made with placement of 1-0 interrupted interrupted sutures, approximating the stomach anteriorly. Extracorporeal knot tying is performed, and just above the knot a clip is placed and the anastomosis are cut. The anastomosis is placed in the stomach and the anastomosis is secured with the Endositch device. Extracorporeal knot tying is placed a suture between the stomach and the crus on the right. Again using a surgical and extracorporeal knot tying was

PAGE 2
OPERATIVE NOTE

performed and placement of a clip was placed above the knot and the suture was cut. The vessel loop was later removed. The Nissen was localized over the esophagus and a 2 cm. segment was clearly made. The wrap was not tight, as we used a 58 French bougie. The area was dry. The liver fan was removed. The patient was returned to normal supine position.

Individual cannulas were removed. The umbilical wound as well as the trocar site at 4 cm. above the umbilicus was closed in layers. The fascia at the 4 cm. trocar site was closed with an endoclose suture using 0 Polysorb. The incision made at 3 cm. above the umbilicus into the left was closed in layers using 0 Polysorb. The skin was closed with staples. The abdominal cavity was deflated prior to closure. The other three incision sites were closed with staples. During the dissection, we inserted a 2 mm. trocar which facilitated in holding the stomach down so that there would not be any angulation during the insertion of the bougie. Also the 2 mm. trocar and grasper were used in holding back some of the fat close to the spleen.

After closure of the individual wounds, the skin is cleansed and dried. Sterile dressings are applied. The nasogastric tube and Foley were removed and after extubation, the patient was transferred to the recovery room in stable condition. Complications none. The patient tolerated the procedure well. Estimated blood loss 100 cc. Fluids - Crystalloids.

ADDENDUM: Posterior and anterior vagus were individually identified and preserved.


THOMAS V. MINCHESS, M. D.

TVM:lt
EST 7-6-98

cc: Dr. Robert Bullard

002021

11/11 1607-01-00A

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0013723

DATE: 02/25/81

PREOPERATIVE DIAGNOSIS: Large, fixed, hiatal hernia with gastroesophageal reflux disease.

POSTOPERATIVE DIAGNOSES: Large, fixed, hiatal hernia with gastroesophageal reflux disease and esophageal perforation.

PROCEDURE PERFORMED: Exploratory laparotomy, closure of the crura of the diaphragm, closure of the perforation of the esophagus with a Thal stomach patch over top of this, and a feeding gastrostomy tube.

SURGEON: C. Brooks Bannister, M.D.

ASSISTANTS: Arthur Cooler, M.D. and Thomas Mancheff, M.D.

INDICATIONS FOR THE SURGERY: This is a 61-year-old black male kindly referred by Dr. Robert Bradley with a large, fixed, hiatus hernia. He had approximately a third to a half of his stomach up in his chest. He had severe nausea and vomiting and reflux. He had been evaluated in the past and had been advised to have this corrected. However, due to a fear of the surgery, he had not consented to the operation. Due to profound nausea and vomiting, at this time he had reached a point that he could no longer function without having this corrected.

DESCRIPTION OF THE PROCEDURE: With the patient in a supine position on the operating room table and under adequate general endotracheal anesthesia, the abdomen was prepped and draped in a sterile manner. An incision was made from the xiphoid to the umbilicus and the abdomen entered in the usual careful manner obtaining hemostasis with the cautery.

Following this, the area was inspected. He had a large hiatus hernia with a portion of his stomach up in the chest and his GE junction was actually above the diaphragm. Following this, the left triangle of the liver was sharply taken down, exposing the hiatus. An incision was made over the hiatus and this area was then mobilized. The stomach was mobilized down out of the chest. He had a thick hernia sac anteriorly. This was bluntly and sharply mobilized. Short gastrics were then controlled by mobilizing these with a right-angle clamp and then controlling them with large Hemoclips and dividing. Once an adequate length of stomach had been exposed, continued dissection was carried along the esophagus to expose the esophagus for the wrap.

We were then inspecting, looking for the crura which were quite attenuated, when it was noted that he had what appeared to be a perforation or a leak. There had essentially been no real sharp dissection done in this area and this was felt to most likely be due to very friable esophagus from his reflux disease. This was then repaired with silk sutures in an interrupted fashion and we were then planning on performing a wrap around this to buttress it. However, the crura were then approximated under the esophagus with interrupted silk.

002022

CAROLINA PINES REGIONAL MEDICAL CENTER

OPERATIVE NOTE

NAME:

HOSPITAL#: 0112712

Again, this area was inspected, and with any mobilization or inspection of the esophagus that was so friable, it would literally fall apart and again was repaired with 3-0 silk interrupted sutures. Once the repair had been performed, an NG tube was gently passed down and guided into the stomach.

Following this, the repair was reinforced by suturing the stomach to the esophagus and around the repair with multiple 3-0 silk sutures. This essentially gave a 180 to 270 degree wrap but was not a true wrap in the sense of the word. Essentially, this amounted to a Thal patch being sutured around the repair of the esophagus to reinforce this and hopefully prevent a further leak. The wound irrigated copiously with saline and suction. The case was very difficult in that the esophagus was so friable and literally seemed to fall apart in front of our eyes.

Once the repair had been performed, it was elected to place a 10 mm Jackson-Pratt to run down in this area. Also, the stomach was checked and he certainly had adequate length that we could perform a gastrostomy tube without putting any tension on what we had already done. An incision was made in the left upper quadrant. A 20-French Nik gastrostomy tube was then brought in. The gastrostomy was performed and the tube secured into the stomach with a double roll of 3-0 pursestring silks. The stoma was then sutured to the abdominal wall and four quadrants around the tube with interrupted 3-0 silks. The tube was secured to the skin with 3-0 silks.

Following this, again it was inspected and there was found to be absolutely no tension whatsoever on the repair that had been performed around the esophagus. The peritoneum was closed with a running #1 PDS suture. The skin was closed with the skin stapler. Sterile dressings were applied. The patient was awakened, extubated, and carried to the recovery room in satisfactory condition.

C. BROOKS BANNISTER, M.D.

4EDC226/ZD/TSI

D 2/26/01

T 2/26/01

CC: Robert Bradley, M.D.

0002023

- PAGE 2 -

STATE OF SOUTH CAROLINA) THE COURT OF COMMON PLEAS
COUNTY OF DARLINGTON) FOR THE FOURTH CIRCUIT

Ruth J. Person,) Civil Action No.: 2004-CP-16-322
Plaintiff,)

v.)

**AFFIDAVIT OF
BAMBI AUSTIN PARNELL**

C. Brooks Bannister, M.D., Hartsville)
Surgical Center, and Carolina Pines)
Regional Medical Center,)
Defendants.)

1. My name is Bambi Austin Parnell and I am the Operations Supervisor for Iron Mountain Records Management in Florence, South Carolina.

2. I have worked with Iron Mountain for approximately ten years. As part of my job, since 2004, we have housed a certain portion of older medical records for Carolina Pines Regional Medical Center. As part of that account, I work often and closely with Lou Jean Gainey, the health information management director for Carolina Pines.

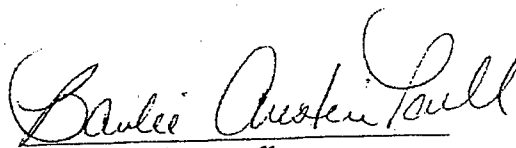
3. As described in my earlier deposition testimony in this matter, the Carolina Pines records are filed according to a system maintained by Carolina Pines Regional Medical Center. Due to changes in Carolina Pines' procedures for their medical records over the years, there are various numbers and codes that are used to track various records and patients for Carolina Pines' medical records held and stored at Iron Mountain.

4. In the above referenced case, we initially received a request for records for certain patients on October 17, 2006. Records responsive to the request were produced to Carolina Pines on October 23, 2006, according to our records.

002024

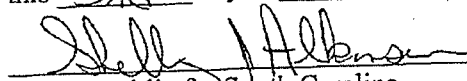
5. As is described in my earlier testimony, when records were produced for Carolina Pines there would oftentimes be subsequent conversations because the records we provided would not be the records they needed. Often times our office would send a record that we believed to be responsive for the proper patient name, but due to the filing system used by Carolina Pines, it would not be the correct date of treatment or procedure records that Carolina Pines needed. As described in my earlier testimony, Iron Mountain would then talk back and forth with Carolina Pines in an effort to get the record that was requested.

6. After the initial request on October 17, 2006, our office had subsequent interaction with Carolina Pines regarding each record requested. Brian Tapper and Gavin Brown with our office were able to produce the correct records on November 10 and 11, 2006. I have reviewed the Affidavit of Lou Jean Gainey in connection with this matter and I agree with her account of the interaction between our offices between October 17, 2006, and November 11, 2006 in searching for the requested records.


Bambi Austin Parnell

SWORN TO and subscribed before me

this 3rd day of October, 2007

 (L.S.)
Notary Public for South Carolina

My commission Expires: 3-12-14

002025

STATE OF SOUTH CAROLINA

COUNTY OF DARLINGTON

Ruth J. Person,

Plaintiff,

v.

C. Brooks Bannister, M.D., Hartsville
Surgical Center, and Carolina Pines
Regional Medical Center,

Defendants.

THE COURT OF COMMON PLEAS

FOR THE FOURTH CIRCUIT

Civil Action No.: 2004-CP-16-322

AFFIDAVIT OF
EDDIE MOORE

FILED
2007 OCT -4 AM 11:11
CLERK OF COURT/R.D.
DARLINGTON COUNTY, S.C.

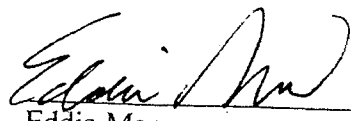
1. My name is Eddie Moore and I am the Director of the Radiology Department at Carolina Pines Regional Medical Center.

2. I have worked at Carolina Pines Regional Medical Center for the last 27 years. I have been the Director of the Radiology since 12/01/1980.

3. Regarding radiological films, our office does not have any radiological records for Ms. Ruth Person. Oftentimes, when patients are transferred from Carolina Pines to another hospital or medical care facility, the patients take their original films with them to the new facility. In this case, Ms. Person was transferred from Carolina Pines to Palmetto Richland Hospital in Columbia, South Carolina and did not return to Carolina Pines.

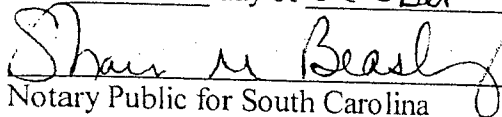
4. Information from the Department of Radiology indicate that when Ms. Person was discharged from Carolina Pines Regional Medical Center and transferred to Palmetto Richland Memorial Hospital in Columbia, South Carolina, that she or a family member took the X-rays with her for the physicians in Columbia to review. Iron Mountain Records Maintenance was never involved in storing or keeping any radiological films.

002026


Eddie Moore

SWORN TO and subscribed before me

this 1st day of October, 2007

 (L.S.)
Notary Public for South Carolina

My commission Expires: 2/19/13

002027

CERTIFICATE OF APPELLANT

The undersigned hereby certifies that this Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

RESPECTFULLY SUBMITTED



Daryl J. Corbin
Corbin Law Firm
Post Office Box 447
Florence, SC 29503
(843)667-6119
Attorney for Appellant

Florence, South Carolina

September 25, 2009

002028

IN THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM DARLINGTON COUNTY
HONORABLE J. MICHAEL BAXLEY, CIRCUIT COURT JUDGE
C/A NO. 2004-CP-16-322

Ruth J. Person,

Appellant,

vs.

Carolinas Pines Regional Medical Center,

Respondent.

PROOF OF SERVICE

I, Daryl J. Corbin, counsel for Appellant Ruth J. Person, certify that I have served a copy of the Record on Appeal and a copy of the Proof of Service on September 29, 2009, by depositing a copy of the same in the United States Mail, postage prepaid, addressed to the following:

Martin S. Driggers, Jr., Esquire
Sweeny, Wingate & Barrow
1515 Lady Street
Columbia, SC 29201

RESPECTFULLY SUBMITTED,

RECEIVED
SEP 29 2009
SC Court of Appeals

CORBIN LAW FIRM
227 West Evans Street
Post Office Box 447
Florence, South Carolina 29503-0447
(843)667-6119

BY:

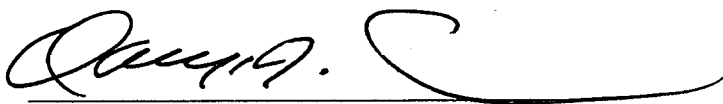


DARYL J. CORBIN
Attorney for Appellant

CERTIFICATE OF APPELLANT

The undersigned hereby certifies that this Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

RESPECTFULLY SUBMITTED



Daryl J. Corbin
Corbin Law Firm
Post Office Box 447
Florence, SC 29503
(843)667-6119
Attorney for Appellant

Florence, South Carolina

September 25, 2009

RECEIVED

OCT 01 2009

SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM DARLINGTON COUNTY
HONORABLE J. MICHAEL BAXLEY, CIRCUIT COURT JUDGE
C/A NO. 2004-CP-16-322

Ruth J. Person,

Appellant,

vs.

Carolina Pines Regional Medical Center,

Respondent.

CERTIFICATE OF APPELLANT

The undersigned hereby certifies that the Record on Appeal in the above-captioned case complies with the South Carolina Supreme Court Order dated August 13, 2007.

RESPECTFULLY SUBMITTED,

CORBIN LAW FIRM

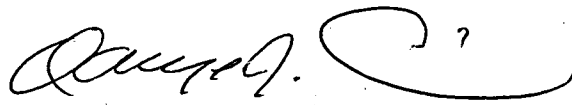
227 West Evans Street

Post Office Box 447

Florence, South Carolina 29503-0447

(843)667-6119

BY:



DARYL J. CORBIN

Attorney for Appellant

Florence, South Carolina
October 16, 2009

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OCT 19 2009

SC Court of Appeals