THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

R. Scott Sprouse, Circuit Court Judge

Case No. 2015-CP-46-00882
Appellate Case No. 2016-002008

Lorrie Dibernardo, individually and as the Personal Representative of the Estate of Anthony Dibernardo, deceased,.....Appellant,

V.

Carolina Cardiology Associates, PA and Naresh Mori, MD,.....Respondents.

RECORD ON APPEAL

Volume II of II

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All right. Mr. Bailiff, if you'll get our jury for us please, sir.

THE BAILIFF: Yes, sir.

(The jury panel enters the courtroom.)

THE COURT: Good morning, ladies and gentlemen.

JURY PANEL: Good morning (in unison.)

THE COURT: I hope everyone had a good evening. We're here for the conclusion of the trial. Before we get started let me ask our standard questions. Did any third parties attempt to talk to you about the case last night? Or did anyone conduct any independent research? Or was there any deliberation about the case?

JURY PANEL: (No response.)

THE COURT: Let the record reflect there were no positive responses. Very good. We're ready to proceed with closing arguments.

Mr. McGowan?

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

All right. Here we are. The last day, the last lawyer speeches and His Honor will tell you what the law is and what y'all are supposed to do. You know we do this because -- you know, the first court of jury trial was 2500 years ago in ancient

Greece. And before this if you killed one of mine I was supposed to kill one of yours and that would of course mean you'd go kill one of mine and I'd have to go kill one of yours. It was just a big cycle of vengeance which never -- that just didn't work so we came up with jury trials, which is what this is, to try to put a stop to things and to try to make things right in a reasonable, civilized way.

And that's why we're here. Why we're here in this case is really two reasons. One is to make things right between these parties, and the other is public safety.

Our South Carolina Supreme Court has said the reason we have law like this is public safety, that it matters what happens here and people's conduct in the future will be driven in large part by what happens with things right here.

You notice the doors have been open. We've had people come in and out all -- all week. That's because this is a public forum. This is a public courthouse, and what happens here is public. And what happens here matters because people will determine what they do in the future based upon what could happen here.

Now, let's get right into the facts of the

case. It's been more confusing, I think, than it should have been but I believe that was probably my doing some of the time. This is extraordinarily simple when you boil it down. Mr. Dibernardo had an injury to his heart muscle and that injury was caused by Dr. Mori. They want to come in and say that it matter if it was the sheath or if it was the needle, but it doesn't.

We have to prove that Dr. Mori fell below the clinical standard of care in only one way. It can be either of them. It can be the sheath. It can be both. It just has to be one or the other or both.

Y'all can agree that he injured the heart and he do so because he didn't follow the standard procedure, and some of you might think it's the needle and some of you might think it's the sheath. That's fine. That means we still have proven our case.

I think this was honestly was determined the day before yesterday when Dr. Mori was on the stand and said, if you follow the standard procedures for inserting a needle, you will not injure the heart. If you follow the standard procedure for inserting a sheath, you will not injure the heart.

And we know what the standard procedures are.

For the sheath, for instance, you keep the wire in there and you keep it where it's supposed to be and you will not have a spear tipping causing injury. That's just the truth. It's just the facts. And that's what he said because it's true. Similarly, if you insert this needle properly, it will not cause injury to the heart.

Particularly, one thing that -- remember the game of Operation? I think that came out in like 1979 or something. But if you hook your arterial clip to, which he said originally that he did, and you're inserting this needle with pressure and you feel that pop of the pericardium, you stop and you pull your fluid back and see that it's in the right spot. And that's what he said he did.

If your electrode is on there and you go too far, you can -- you touch that heart it's going to be giving you a signal. And you can touch that heart pretty firmly without causing any injury to anybody.

And if you had done this right you would have -- you would have known that you were in contact with heart tissue before you ever broke it up, abraded it and lacerated it the way they did.

Now, we don't say and don't have to prove that

this was a direct puncture of the heart because it wasn't. What the surgeon saw afterward was an area of oozing which required the cellulose material called SurgiSeal and it was packed on top of it. It's like a skinned knee or an abrasion. The problem is when that's on your heart it causes a lot of bleeding and you can die.

So based solely upon Dr. Mori's testimony, we believe we have established the legal requirements to prove this case. If you do it right, you follow the standard procedure, you will not hurt the heart in this way. So whether it was the needle that did it or whether it was the sheath that did it, it makes no difference for the purposes of rubric or the purposes of whether we've proved our case or not.

It seems pretty simple. Trial probably should have been over with but it wasn't, and the reason it wasn't is because we had a lot of different stories out of Dr. Mori. This had started in his deposition. Originally -- we went over this with him on the stand. Originally he said he put that sheath in because the blood pressure was dropping and the fluid wasn't coming out as fast as he wanted. That's when he said he swapped out the

catheter.

The data says that's just not true. He knew that wasn't true, yet he said it anyway. The blood pressure drop was well after -- this timeline establishes the fact. It's just the truth and it's in the medical records. The blood pressure dropped well after the sheath was put in and well after that pigtail catheter that's on Fluoro Number 2 that we've seen many times was removed.

The reason that happened the way it did is because once you remove that catheter you allow that blood in that boarded up area of the heart to start bleeding profusely with nothing in the way and all that blood to start coming out of that sheath.

So that was his first story: I put the sheath in because the blood pressure was dropping. Sorry, Doctor. That's just not true. It is not true. What else do you have?

Well, now he says -- then he says, well, actually it was less fluid and then there was some blood. That is never documented in the medical records. Ever. Anywhere. What he says is that he put -- that the blood pressure was dropping as blood was coming out.

So he never put in the medical records he made

within an hour that, I saw blood and therefore swapped to a sheath.

Then his experts come into court and they made something -- they just absolutely made it up on the stand. They said that he had that first catheter in -- remember Video Number 1 where it arcs around -- then he removed it, flushed it and reinserted it. That just didn't happen. Dr. Mori didn't even say that happened. It simply did not occur. The experts -- one was $400 an hour, the other was $750 -- made that up. It simply did not happen.

Then they started getting in -- then they talk about the echo. Y'all remember those echos. And Dr. Mori confidently says, I'm board-certified in echocardiography. You can trust me. Here's the deal: There was blood in that heart space before the sheath was put in. That's what he told us. He told us that. He said there's blood and it's proof positive that the blood was there before the sheath was.

The problem that he has, the wheels came off that particular argument. How do we know? If you -- and this is Dr. Foster. Remember, he was yesterday. He was the last witness yesterday. He said, if anybody is going to try to show when

something happened you got to make sure your clocks correspond. What are we going to do, synchronize our watches? You got to synchronize your watches.

And we did that on the stand with Dr. Foster and what did we prove? Proved that without a doubt the first mention of blood on echo was after the sheath was inserted. Echo Number 11 didn't show it. It was right before. Echo Number 12 did.

Why is it important? Well, because it shows that we're right and always have been, but it also shows something more fundamental. If you remember what Dr. Foster said, is that, well, every cardiologist knows that you're going to try to do this in a sequence. You're going to try to sequence things so that when something happened you have to synchronize clocks, make sure they're all on the same time.

If every cardiologist knows that, ask yourself why Dr. Mori would come in and go, ah-ha, I got the case cracked here, this echo shows blood before, without correcting for the times? Why would you do that? It seems like you would only do that if you knew you were wrong and you're trying to mix stuff up. He knows what you got to do this and yet he comes in here and says, ah-ha, blood before. Truth

is it was after. That's just the truth. It's just a fact.

Then when you hear Dr. Mori day before yesterday agree with us that if you do this right you're not going to injure the heart. That's not good news for Dr. Mori so what happens? His expert witnesses come in yesterday -- that was Dr. Foster and Dr. Story -- and they don't say they don't agree with what Dr. Mori says. That was bad news for them because if they agreed with what Dr. Mori says, that means that we're entitled to her to win the law.

Because it's actually a true statement that if you do it right you don't cause injury like this. If you see the man's heart from echo, you know the landscape, which they did. You know he has an unusual heart. Of course he did. You know what you got to do to make sure this needle doesn't hurt anybody, but you didn't do it. You know what you got to do to make sure the sheath doesn't hurt anybody, but you don't do it.

Then we had -- the last of the interesting stories so far is that in opening Dr. Mori's attorney got up and said, well, the reason EKG didn't signal is because if you touch an artery or a vein it won't signal. There's no evidence that

that's true, and in fact, it's not true. Makes no sense.

If the EKG is hooked to this the way it should it's going to signal when you touch the tissue before the injury occurs and you stop. If they were going to come up with some evidence that said otherwise, they should have but they didn't. And they didn't because they know that statement is just not true. If you do it right, it's not going to hurt anybody.

Why is it that you'd have to come up with a million different stories if you're right? A great few wouldn't. People who are correct and didn't do anything wrong, follow the standard of care don't have any reason to come up with all these sort of red herrings. And there's more we're going to talk about in a moment.

What you should do is point to real evidence, medical data, pictures, videos, true facts, and when you don't have that you start making stuff up.

So the question that you're finally going to have to decide is did our evidence, the medical records, the data, the images, the videos, the echos outweigh their stories? Respectfully, we would submit that they've done that.

One thing they've been talking about pretty consistently is that this is a bleeding complication and that somehow gives Dr. Mori free pass to not do what he's supposed to do because it's a bleeding complication.

Think of it this way: You're in your car on your way home. Somebody runs into you. You've been in a wreck. That wreck is a complication of driving, right? That doesn't explain whether that complication, the wreck was due to someone's negligence or not negligence.

For instance, if you're driving home and you get in a wreck and you learn that the driver of the other car was swerving to avoid a child and ran into you, that is not negligence and that's a complication of driving.

If, however, you learn that that other driver had their eyes closed or was texting or had just gone off a three-day alcohol bender and was drunk, that is negligence. That's below the standard of driving, and therefore the complication of driving was caused by negligence.

And they're conflating these to say that they're somehow different and that's just not true. It's just not the law and it's not the case.

Dr. Story admitted that yesterday, that if somebody gets injured by any source doctors call it a complication. They do that to try to distract and try to insulate themselves from somebody saying that you screwed us up. So they pile anything into this amorphous term called complication that therefore it can't be anybody's fault. And that's just not true. And that's what Dr. Story said, is that all injuries, caused by doctors' negligence or not, are complications. So calling it a complication is not where it starts and that's not where it ends.

In fact, it's not even relevant to this particular discussion because we're here to determine if Dr. Mori fell below the standard of care.

They've also talked about an injury alone is not evidence of malpractice. The judge will tell you that that's the law that sets the line. If all we had was Mr. Dibernardo had bleeding and nothing more, it would be right. But they're not right in this case because we know what the normal procedures are, we know how you're supposed to do it and we know that if you don't do it when you're supposed to you cause injury, and we know that that's what happened here. That's why it's not an injury alone

sort of situation.

We then started talking about consent. It's been mentioned a couple of times. Nobody consents to anybody else's negligence. And they started talking about consented to the procedure. That's a distraction from what matters here, which is, was this physician negligent? Did he fall below the standard of care? Simple questions. Consent is irrelevant because you never consent to somebody else's negligence.

I also heard some things about Mr. Dibernardo had a heart condition and if he did not undergo a pericardiocentesis that he was going to be dead within a certain amount of time. Couple issues with that. It makes no difference what his life would have been if he had not undergone a procedure.

The question is, what would his life have been if he had undergone the procedure and it had been successful like it should have been versus what would -- what was his outcome here? Well, we knew that his life expectancy was about three or four days here because he died from an injury that Dr. Mori caused.

And then they tried to say that this guy was, you know, walking dead, that he was six months to

live anyway and none of that happens to be the case. But that's why they did that. Notice the way they phrased it was, if he did not have the procedure what would he have done?

Well, we seek medical treatment all the time that if it's not done properly or it's not done at all -- say somebody has a heart attack. Well, if you have a heart attack and you don't get treatment, you're probably going to die. But that's not an excuse for a doctor if they don't treat your heart attack right to say, well, you were going to die if you never came in here.

That's just not the way it works and that's not fair. That's just not the way this works.

They talk about consent and they talk about life expectancy. Think about why that's happening. Now, even if all that was true, what does that do -- why is that relevant? Say he did -- let's assume that Mr. Dibernardo had six months to live. What gives Dr. Mori the right to kill him sooner than that? Nothing.

And in fact, we very well recognize that. In 1991 the South Carolina Department of Corrections put to death Pee Wee Gaskins and he was convicted of murdering another fellow on death row. We take it

serious when people cut people's lives short. That's just the way it is. It's -- even if they're right, it's just wrong -- wrong to do that.

Now, the judge is going to give you long instructions about what the law is and that's what His Honor does. He's also going to give you a verdict form, which is this multi-page form. I'm going to go over it with you about what we think the evidence has shown and what to do with this.

There are two cases here: One's called wrongful death and one's called survival action. Wrongful death is for the loss to Lorrie Dibernardo. That's what the law says. That's her case. Mr. Dibernardo's case -- Ant's case is called the survival action. And there are two separate causes of -- two separate lawsuits essentially being tried at one time, one for him who is not with us and one for her.

The first two questions on both are the same. And you'll have this and the foreperson will be charged with filling this out on behalf of everybody. But it says, did Dr. Mori violate generally accepted standards of medical care in his treatment of Mr. Dibernardo? Did we prove by a preponderance of the evidence that Dr. Mori fell

below the standard of care, standards of medicine?

I think -- you look at this evidence. Based on everything we know I think we've proven that, and I think we're entitled to have you say yes on that question because we know that if he had just done the basic stuff -- if he had just done it properly, the injury to the heart wouldn't have occurred.

Now, everyone is saying that even with the best of care you still get bleeding. Nobody has said that even with best of care standard of care that you get injuries to your heart like this. Nobody said that because that's not true. You might get bleeding but you don't get injuries to your heart like this. That's just what it is.

Second question is, was Dr. Mori's violation of generally accepted standards of care a proximate cause of Mr. Dibernardo's death? We propose it's yes. What does that mean? It means that but for Dr. Mori falling below the standard and injuring this man's heart he would not have died when he did.

We are all renting in the world. None of us will be here forever. We all have a life expectancy. Cutting it short is what the question asks.

The third question is, what amount of actual

damages were incurred by the statutory beneficiary as a result of the death and we talked to you about that in opening. There is no way to put a dollar value on that.

We said that we were asking for $2 million for that. It's up to you. That may be too much, may be too little but there's no -- it's your good conscience and your sort of moral compass that decides what that is. It's fundamentally totally up to you.

The second question -- the fourth question, I should say, was Dr. Mori's violation of generally accepted standards of care a result of reckless, willful, wanton, grossly negligent conduct proved to a level of clear and convincing evidence?

How bad was this? Well, if everybody knows what you're supposed to do to avoid injury like this -- he himself said he's done thousands of these. Well, then you should know better. If you know that if you don't do it right you're going to cause injury to somebody and that injury can kill people, that's reckless. That's what the law has called grossly negligent, an absence of care.

And I think the most glaring thing happened the day before yesterday with Dr. Mori where he said

that -- he told me when I took his deposition that he used the alligator clip on this man. That's what he said the first time he was under oath. When he testified here, though, he says he didn't.

Okay. So let's talk about that. If he did use it, there is no doubt that he should have not injured the heart the way he did. That would have meant he had this thing on, ignored it and he kept going anyway. That's what that would have meant.

So he knows, oh, that's not good so I need to change my story and say I didn't use it. So now he's in the position of saying, well, I didn't use that device -- well, now the problem is that you should have because you admitted you should have and you didn't, and that is grossly negligent.

So either you were grossly negligent by not doing it when you should have, or you did use it and you proceeded anyway. Either one of those under the law is gross negligence. That's all I've got to prove is one thing.

The -- I've been trying cases like this for years and it's interesting that the defense to not only gross negligence but all of it is, I wasn't negligent in putting the sheath in. I was negligent in putting the needle in. That's the defense.

That's like if this was a murder case and the defendant says, I know you say I shot the man in the hallway with a rifle but the truth is I shot him with a pistol in the kitchen. That's not a defense. That's not a defense. Either one is sufficient under the law.

The fifth question is going to be, did Dr. Mori engage in any misrepresentation related to the claim of the plaintiff? That's a yes-or-no question. Any misrepresentation. What that says is, was he not truthful and not honest? And why was he not truthful and honest?

Well, we only have to prove one misrepresentation. When he told us that he put the sheath in because the blood pressure was dropping, that's sufficient. When he told us the echo showed definitively there was a clot before the sheath was in without lining the times up, he knew that that's a misrepresentation. We only have to prove one. That's a yes-or-no question and we would ask that you check that one yes.

Number 6 is, did Carolina Cardiology -- that's the practice -- engage in any misrepresentation related to the plaintiff? And that arises from Dr. Shah -- I don't know if you remember him but he was

from the first day.

It arose from the death certificate. This is Exhibit Number 10. There are certain requirements the law places on people that sign these -- Dr. Shah is the one that signed it on behalf of the practice -- about how you put this in. All he put was, respiratory failure pericardial effusion. He skipped over the part where his partner injured the heart and there was an emergency surgery and a ventilator. That is the misrepresentation of the practice.

Why is that important? Because this death certificate is the only thing that goes to the state government to know if something happened or not. Frequently this is the only piece of paper that goes to the family as it goes through the funeral home. And if you have an estate or house or car you have to deal with, you got to go to probate court and this is the only piece of paper that ever comes out.

Now, in this case Mrs. Dibernardo looked further, asked that it be looked at further, but that does not change the fact that this is a misrepresentation of the practice related to the plaintiff. We would ask that you check that answer yes as well.

The last is, if you answer Number 4 yes about gross negligence, what amount of punitive damages should be awarded for that conduct under Number 7? That's different than the actual damages and that is a number that's wholly up to you. It is completely in your discretion about what you think is appropriate there. Those are all the questions on the wrongful death action.

The survival action is just, did he violate the standard of care; was it a proximate cause; and if yes and yes, how much for damage is fair? Same questions and we'd ask that you answer them the same way.

What's going to happen next is that Mr. Beighley is going to have a chance to speak with you and then I'll have a brief moment to reply to that. And then His Honor will charge you the law and you'll step back to make a decision. And that's where y'all have to come to an agreement, all of you together to decide what's the right thing, have we proven our case under the law?

And at that point once you're sent out that door the last time this case will be in your hands and the decision will be yours and yours alone. We thank you for your service and I'll get to speak to

you another time. Thank you.

THE COURT: All right. Mr. Beighley?

MR. BEIGHLEY: May it please the Court, Your Honor.

Mr. Foreman, Members of the Jury, on behalf of Carolina Cardiology and Dr. Mori I want to thank you for this week, for your being here every day on time and most appropriately for paying attention to everything said, everything we've done, everything that went on in this courtroom.

After the lawyers sit down the judge is going to tell you about the law and then you're going to go back and you have to apply the law to the facts.

This is my last chance to explain to you what I believe the evidence shows and I'd like to start out where I left off in my opening statement. I told you that the plaintiff's theory in this case is to tell half the story. It's my job to tell you the other half.

And as I did before, I referenced this exhibit about the blood pressure drop and how it looks like that's the end of the story. The blood pressure drop comes back up. But now we have an allegation that Dr. Mori is misrepresenting that the blood pressure drop, in fact, is why he started to have

first concern about bleeding.

You will have the record back there, and if you look at the exhibit notebook the cath lab record is in there. You will see the cath lab flow sheet if you choose to look at it.

What you will see -- and Dr. Mori testified to this -- this patient's blood pressure dropped from 116 over 65 to 95 over 57; his oxygen dropped from 97 to 65; his heart rate went up from 60 to 82. And that was noted at 10:44, shortly after the needle went in. That was a concern. That made him worry.

Counsel then says, there was no bleeding. Only bleeding occurred after the sheath. I think we've shown you in multiple ways -- and I'll talk about the ways -- that the record has shown the bleeding.

Again, going back to the cath lab records, if you look at what comes out -- got to find the page because it's important -- you've got a blood pressure drop that I talked to you about and we have aspiration of blood/fluid. We have aspiration of blood/fluid multiple times -- 2.7 liters of blood -- mostly blood -- blood/fluid came out of this man.

That is nearly -- the normal blood content depending on the size of the patient is 5 or 6 liters. That's a lot of blood coming out. That is

evidence of bleeding.

The other -- the next half story is that Dr. Mori said he put the needle in; if he followed standard procedures he shouldn't have a complication. But you still can have one. That's why it's a complication. Otherwise, anybody could do this. You wouldn't even need a doctor because there's no skill, there's no variation in the patient. Everybody is the same.

Everybody told him that even with a skillful performance of this procedure you can get a bleeding complication. And the judge will charge you that simply because a complication occurs that's not evidence that the standard of care was violated.

Argument is that the bleeding didn't occur until the sheath when I've already showed you that blood was described in the record, but for some reason nobody wants to believe Dr. Mori when he says bleeding occurred before the sheath went in.

Ask yourselves this question: Why would Dr. Mori -- he's got -- let me get my exhibit here. If he is in this pericardial effusion, which is this area here -- if he's in there going through it why in the world would he go to the step of pulling out, trying to flush that catheter and put the catheter

back in on the sheath? Why would he do that?

Because there was bleeding. There's no other reason. If everything was fine and the fluid was coming out clear, no problem, I'm happy, but that's not the case. There was bleeding and I'll tell you why there was bleeding.

There was bleeding because when the sharpest thing on the playing field, this needle right here, when that went in it was a difficult process. Took two or three attempts.

Now, Plaintiff's attorney says it shouldn't be difficult dealing with that. He's got a big effusion. I mean, anybody can see it. Now, think about this, and you heard this testimony -- even on this picture -- which is not a massive heart. This is just a regular heart. This isn't a chest that's been caved in. This is just a regular -- look at this pleural effusion. You see down here it's wide. What happens up here? What happens over here? The dimensions of that pulmonary effusion vary greatly. Just like you see here they vary greatly in this patient.

And Dr. Mori showed you on echo where the needle went in on this patient's effusion wasn't wide. It was much narrower. So you've got to keep

that in mind. When this needle goes in it's not a uniform picture.

In this illustration you see this man unfortunately has cardiac tamponade, which the plaintiff developed, but this effusion looks like it's standard size. But that's not the way it was, and that's not the way it was on Mr. Dibernardo.

All of this is by way of showing you that the rest of the story is, yes, if you're just taking a picture and drawing a little line in there it looks easy but when you're in there working on a moving, beating, extremely large heart with a chest deformity things can happen.

And that's what the law protects a physician from. When he gives his care within the standard and a complication occurs, as it did in this case, that is not malpractice.

Now, counsel says that bleeding didn't occur until the sheath was inserted. We had Dr. Mori's testimony. We had reference to it in the cath lab report and we also showed you the echo.

Now, Plaintiff tries to dismiss the echocardiograms that you saw. Those are moving pictures of a heart. Now, he had his own expert who had the same medical records that we did. Didn't

hear him talk about the echos. Didn't hear him say a word about the echos. But Dr. Mori did. Dr. Mori pointed it out to you.

So how do you come back and combat the evidence on the echo? You say, well, there's different times between the cath lab and the echo. So we had two experts on the stand, and Plaintiff's counsel said, well, let's assume that you have to synchronize this machine and the times on this machine aren't the same on that machine.

So he calculated a period of time and said, I want you to assume that this amount of time has to be adjusted. Notice we didn't have anybody from the hospital tell us that. We don't know how or when synchronization occurs, if it occurs, but we know that Plaintiff's counsel picked a number that suited him.

So he said, if you assume this difference in time, then it proves the clot occurred -- the bleeding occurred after the sheath was inserted. And what did Dr. Foster say? That's impossible. It couldn't have formed in that amount of time.

So he disproved categorically that this synchronization has anything to do with this blood clot being present. It takes time for blood to

clot.

Also, you heard the testimony of Dr. Foster and what did he say? He said, when I reviewed this my opinion was based on the fact that we got these blood pressure drops here right around the time the sheath was inserted. He said, because if the bleeding is going to affect your blood pressure, it takes time. You would have to back it up to when the needle was inserted in order to get the drop down here. It's not instantaneous.

So we've got multiple pieces of evidence in the medical record, the testimony of the experts that showed you that bleeding was present before the sheath was put in. We've got logic and common sense that tells you that if it wasn't a bleeding problem Dr. Mori wouldn't have needed to try to go to some other method to save this man's life.

Because what happened -- and you saw this on -- there's -- nobody's disputed this: This man had cardiac tamponade. You saw that on the echo. No dispute about that. His heart couldn't beat. And so the only reason that he survived that procedure is because all that blood was drawn out by Dr. Mori's efforts.

And did that -- did the catheter contact the

heart wall during that procedure? Yes, it did. But is that negligence? Was that what caused the problem in the first place? No. Did the catheter go through the heart? No. Did we skim on the edge of the heart wall and when the doctor -- the surgeon went in there he didn't even have to sew it up. He put some SurgiSeal on it and he removed what? A big blood clot.

So I submit to you the rest of the story on the bleeding needs to be considered and evaluated in this case.

Plaintiff's argument that it doesn't matter whether it was the needle or the sheath should have -- rest of the story is it can happen. It's a known potential complication. It's a risk and it can occur even when the standard of care has been followed.

Everyone in this court, even the plaintiff's experts said yes, you can have bleeding and it doesn't mean there was a violation of the standard of care. Everyone said that. You cannot eliminate all these complications.

Plaintiff's attorney said the argument is that he did an excellent initial catheterization. He should have just stopped and said, take the patient

to recovery. Well, what would have happened? This situation would have then become symptomatic while he was in the ICU, not in the cath lab where Dr. Mori could have intervened.

Yes, if you have a normal procedure, everything's going fine, that's what you would do. Not when you've got continuing bleeding. Bleeding to the point you have a massive blood clot. Bleeding to the point that you get cardiac tamponade. You've got to do something and that's what Dr. Mori did.

I want to talk at some length about misrepresentation because I think perhaps of all the issues in this case that I find the most without support in any of the allegations is that Dr. Mori somehow misrepresented anything to anyone in this case.

I would -- I'd like to start by taking a few minutes to show you just how this patient-physician relationship got started and what occurred during that relationship as far as representations.

Dr. Mori was asked to assist this patient and assessed him on the 19th, and he wrote a two-page note. He looked at the records. He examined the patient. He outlined his plan and he said, the plan

is to proceed with pericardiocentesis, possibly on Monday. After that the patient will need a left and right heart catheterization. Risks, benefits and alternatives -- risks, benefits and alternatives have been discussed with the patient. He assessed; he evaluated; he discussed the risks and the benefits.

Mr. Dibernardo acknowledges that. He acknowledges it when he comes into the hospital. This is the form he signed when he comes in that says the conditions -- this is the hospital consent form and what does it say? I understand the practice of medicine and surgery is not an exact science; diagnosis and treatment may involve risk of injury, even death. I acknowledge no guarantees have been made to me regarding the result of examination or treatment in this hospital.

That is an acknowledgment of the potential for risk generally, but it doesn't stop there because after Dr. Mori talks with him he has a separate two-page document on cardiac catheterization -- my physician has informed me of the plan of procedure, major compartments of the procedure, most common side effects, treatment, benefits, alternatives, the risk involved with each, the chances of complication

in the treatment of my condition. He acknowledges it.

Does he consent to malpractice? Of course not. Plaintiff's attorney is insinuating that somehow we're arguing he consented to malpractice. No, he doesn't consent to malpractice. But he realizes what his choices are and he realizes that if you agree to have a procedure there are some potential risks. It's not a simple walk in and walk out.

He also -- third time -- consented to having the catheterization in the event that -- the plan was to do the pericardiocentesis through the catheterization. Third time now he's acknowledging potential risks and the discussions and the understanding.

So that's -- that's part of the representations. We've got to look at this whole thing. You were asked to say there were misrepresentations. Look -- you look at those records; nobody misrepresented anything. Let's look at the medical record. Let's look at what Dr. Mori said right after this procedure was done.

In the first paragraph it says, pericardiocentesis for large pericardial effusion. Second procedure was plan left and right heart cath.

Could not be done because of a complication. This was after the pericardiocentesis. He goes on to say that fluid turned hemorrhagic. There was a suspicion of myocardial injury during the pericardiocentesis. Right femoral vein was cannulated. Blood was aspirated, given back to the patient. Emergency cardiac surgery consultation was called for.

And it's included. What does he say again? Pericardiocentesis was done with resulted complication. Now, who is -- I mean, are you hiding something here? Are you misrepresenting? You did a procedure. You had a complication. You go out and you say that. He told Mrs. Dibernardo that.

And even after now the patient has passed away Dr. Mori does his final note. I won't read the whole thing to you. Plan was to perform left and right heart cath; however, this could not be done because of complications from the pericardiocentesis. During pericardiocentesis patient had expressed hemorrhagic pericardial fluid. Likely consideration: At this time there's injury to the myocardium as a result of the needle injuring the myocardium.

How more direct and honest can you be? You put

it right out there. We had a complication and I think the needle caused it. He's not misrepresenting. He's not trying to hide anything.

They say that Dr. Shah was misrepresenting. Dr. Shah followed this patient after these complications and the surgery and his eventual death. Dr. Shah is given a form to fill out as the cause of death which he correctly noted was respiratory failure and precipitated by the pericardial effusion.

Now, could he have gone through there and listed every step? Could he have made it a two-page note? Sure, he could have, but why would he when everything is in the medical record? He's just giving you a recap of what was the cause of death? Respiratory arrest. What was the -- lead up to it? Pericardial effusion.

He wasn't trying to misrepresent. Maybe he could have listed more steps but that's not misrepresentation when every piece of what went on in this case is right here in the medical records.

So I submit to you that there's absolutely no reason to think that the defendants misrepresented anything in this case. They've been open and honest and candid in what happened. They simply don't

admit that they committed malpractice for the reasons that you've heard from the witnesses that you've heard.

Now, I don't want to spend a whole lot of time on this but I feel it's necessary to comment on this because I have a bearing on the evidence that you heard and that is: What was the basis, condition for surgery? The facts are from the witness stand from Kelly Gregory the swelling was getting worse. He was concerned about his swelling.

Mr. Gregory -- and I thought this was interesting: Even with all the pain he was in, he helped you out. Swelling was getting worse. Breathing was getting worse.

Mrs. Dibernardo: Swelling getting worse, right side had more problems.

But then we come to the final care with Dr. Wooten and the testimony is that Dr. Wooten said if they put him back on the respirator he was only going to live two days. Did you hear Dr. Wooten say that in her deposition? She testified in this courtroom by way of deposition. Anything in there that said that? No.

Dr. Wooten testified that when she met with the family to recommend reintubating family told her the

following things: They were extremely hesitant to put him back on the ventilator; he's been unable to do anything; he has not been able to get out of bed by himself without help; absolutely do not want him to go to a nursing home; do not want him to go to rehab. After much discussion and attempts to encourage them to reintubate the family refused. And the plaintiff says none of that matters.

Now, one thing I want you to understand, I am not criticizing this lady for her family's decision. None of us would want to be put in that situation. Nobody would want to do that. But I do think the circumstances surrounding need to be presented candidly.

Because we're talking here about a request for damages for a lengthy period of time for the rest of this man's life, and you have a right to know what, in fact, the circumstances were. I think it's important to bring that out.

Dr. Story said he's got class four congestive heart failure, 50 percent five-year survival rate. Nobody knows, except the one person, when the end will be for a given patient and -- so nobody can say but what we can do is bring you people with training that have information that we as laypeople don't

have just to give you an idea. It's a 50 percent five-year survival rate with congestive heart failure.

Now, I want to conclude by looking at the testimony of the defendant's witnesses. Dr. Mori was criticized and accused of being misleading, misrepresenting. I thought it was just the opposite. I thought that he embraced his opportunity to be in front of you, that he tried to be as candid as he could. He knew this was his one chance to be in court, his only chance to talk to you personally. And he went through with you what he did and why he did it.

It still comes back to the basics. Bleeding is a known complication. He had difficult anatomy with a huge heart, a caved-in chest. Needle is the sharpest thing in there. It's a known potential complication. It was managed appropriately. No deception. No evidence to conceal or deny.

Dr. Story, 30 years practicing cardiology. He's not in a program or an institution. He's just a doctor that's out there practicing cardiology, been doing it for 30 years. Not a professional witness. He hasn't done this multiple times. He doesn't do it routinely or regularly.

But he came in on this case. He reviewed it. He believed that Dr. Mori deserved a defense, believed Dr. Mori's care met the standard. What did he say? You could do it right and still have a bleeding complication. He said Dr. Mori followed the standard of care. He showed you on echo a blood clot appears before the sheath goes in.

And we've talked about the fact that even with this synchronization issue there wouldn't have been enough time for the blood clot that you saw to have formed from the moment the sheath was inserted.

Finally, Dr. Foster, 30 years in cardiology. Needle caused the injury. And he explained that you don't have to get immediately returned blood. That was a big issue, wasn't it? You've got this sharp object. You stick it in the heart and what's going to happen? You're going to get blood back. But like I showed you earlier, there's a bunch of vessels around this heart. There's other structures. You heard about that yesterday.

Needle comes here, goes by one of these, comes to rest. You pull back. Unless you're just going up into the vessel you're not going to get blood right away. It's going to take a while for it to run out. So the fact that blood didn't come back on

return does not disprove an injury occurred with that. It's entirely consistent.

Dr. Foster, I thought, brought up a very interesting approach when he told you that what led him to the most support for his conclusions of the needle injury was the fact that the needle goes in here and the blood pressure is markedly dropped down here. Because that is about the time it would take for the bleeding to affect blood pressure.

And finally, what did Dr. Foster say? Even if you assume the time difference that the plaintiff's counsel suggests, between the cath lab notes and the echocardiograph it's still not enough time to achieve and cause blood clot. It takes more time than that for the blood to form. Said it would be impossible to have a blood clot in that time period.

I've probably talked too long but, ladies and gentlemen, it's my only chance. I can't go back in the room with you now. Dr. Mori can't go back. Plaintiff's counsel can't. We have to leave this in your hands. But I have to sit down now and I have to rest and be reassured because you've paid attention to every word I've said.

And I want to tell you I've done this 40 years. I can't remember a time when somebody didn't doze

off, glaze over or tune out. That has not happened in this case. We've had a jury who was content and engaged and took their job very seriously.

After you go back and hear the law the judge is going to ask you for a verdict. The word verdict comes from the Latin veredictum, speak the truth. I believe when you return your verdict in there it will speak the truth. I believe after all the evidence, testimony, argument, you hearing the law as the judge gives it you will agree with me that a true verdict and a just verdict in this case is a verdict in favor of the defendants. Thank you.

THE COURT: Mr. McGowan?

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

Holy cow, y'all. Now we have stories nine and ten. Dr. Mori got up -- just got up -- I say not Mr. Beighley because that's the lawyer and lawyers do what the clients want. That's how lawyers work. Dr. Mori just got up and told you that he did this H&P with Mr. Dibernardo and went over all these risks and benefits and all this other stuff. That's another story and it ain't true.

H&P performed by Richard -- right here -- Richard Boulware, PA. That's a physician's

assistant. Richard Boulware did it, who is not even a doctor. Not even a doctor. If you look at the back of this record, which is in evidence, it was dictated by Mr. Boulware and later signed by Dr. Mori.

So to come in and say that Dr. Mori met with this patient, went over all this stuff when it's so easy to demonstrate that "performed by Mr. Boulware" is just insane frankly.

Next we have the story about -- here's what they want you to believe -- and it doesn't even really matter because if it's the needle he's still responsible. But this is sort of what we've been dealing with. It's sort of like going to a magic show. Look over here. Now look over here.

This is Echo Number 12. It's on these little disks. Probably no one can actually see them but you've seen them already. This is the echo that every one of their experts -- Dr. Mori -- said this is clot. Ha, clot. Echo Number 12. What does that tell you? There were 11 echos leading up to it.

This is Echo Number 11. See that there? Nada. Nothing. The only thing that happened between 11 and 12 was the sheath. I don't know what to tell you. That's just a fact.

Yet, Dr. Mori is still getting up, and now he says that this fellow lost 2.7 liters of blood, half of his blood volume. And he did nothing about it for 16 minutes and recalls another 20 or 30 minutes to do it.

There's no explanation for this echo, the difference between Echo 11 and Echo 12 other than this was the sheath. We know it's the sheath. We see it on the videos. You see it and you know it. But again, it doesn't matter.

Not a single witness got on that stand and said that if you injure the heart you -- or if you follow standard procedures you'll injure the heart. They've been very careful and very delicate about how they phrased the question and that is, all of them say that even if you do this perfectly, you can still get a bleeding complication.

Fine. Not a single person has said that if you put this needle in properly you will injure the heart, and they haven't said it because it's not true. If you do this right, just like Dr. Mori said, you will not injure the heart. Period.

The whole business about times on these echos, listen, that was math. That was done with Dr. Foster. It's not my assumptions. It's just

true. It's just a fact. And there's another denial of fact between Echo 11 and Echo 12 when they start saying there's clot. That's just a fact. Again, it's been like going to a magic show.

The question is whether we've proven our basic case under the law, and respectfully I would submit that we have and would ask frankly and directly for your verdict on all counts.

THE COURT: All right. Before I begin my charge would counsel approach?

(Sidebar discussion.)

THE COURT: All right. Ladies and gentlemen, we have come to the point in this trial where I instruct you on the law. My instructions will be somewhat lengthy. They will be in three parts.

The first will be instructions on the general rules that define and control the jury's duties; second, the instructions that state the rules of law you must apply; what the plaintiff must prove to make its case; third, some rules for your deliberations.

The general rules begin with your duties as jurors. It is your duty to find the facts from all of the evidence in the case. To those facts you must apply the law as I give it to you. You shall

not be concerned with what the law should be but what it is. And you must not be influenced by any personal likes or dislikes, opinions, prejudices or undue sympathy.

That means you must decide the case solely on the evidence before you in accordance with the law, the very thing you took an oath promising to do at the beginning of the trial. It is your responsibility and yours alone to determine the facts of this case.

I would therefore charge you that if during the course of this trial or during this charge you have been given or left with the impression or feeling that I favor one side or the other or that I have a personal feeling about the facts of the case I specifically instruct you to disregard that impression. Under our Constitution I am not allowed to have an opinion as to the facts of the case.

You should not be influenced by any objections or the Court's ruling on them. You and you alone are the judges of the facts.

You determine the facts by evaluating or weighing the evidence that you've heard during the trial. What is evidence? Evidence is sworn testimony from the witness stand and any exhibits

that have been entered into evidence.

The statements of the attorneys are not evidence. What they have said in opening statements, closing arguments and at other times is intended to help you interpret the evidence but it is not evidence.

Plaintiff has the burden of proof in this case. The burden of proof in this case is by a preponderance of the evidence. A preponderance of the evidence simply means the greater weight of the evidence. It is evidence which as a whole shows the facts sought to be proved is more likely true than not true.

This can be illustrated by imagining a set of scales. When the case begins the scales are even. After all of the evidence has been presented if the scales remain even or tip even slightly in favor of the defendant, then the plaintiffs have failed to meet the burden of proof and would not be entitled to recover in this case. If, on the other hand, the scales tip even slightly in favor of the plaintiff, the plaintiff will have met the burden of proof and you should return a verdict for the plaintiff.

The preponderance of the evidence is not determined by the number of witnesses; instead, it

must be determined by the greater weight of all of the evidence. There are two types of evidence generally presented during a trial: direct evidence and circumstantial evidence.

Direct evidence is the testimony of a person who claims to have actual knowledge of a fact, such as an eyewitness. It is evidence which immediately establishes the main fact to be proved.

Circumstantial evidence is proof of a chain of facts and circumstances indicating the existence of a fact. It is evidence which immediately establishes collateral facts from which the main fact may be inferred. Circumstantial evidence is based on inference and not on personal knowledge or observation. It is proof that does not actually establish the fact in question but that asserts or describes something else from which you may either reasonably infer the truth about the fact or at least reasonably infer an increase in the probability that the fact is true.

For circumstantial evidence to be sufficient to warrant the finding of a fact the circumstances must lead to that fact with reasonable certainty. The facts and circumstances should be considered in light of ordinary experience and common sense. The

existence of a fact cannot be based on speculation, surmise or conjecture.

The law makes absolutely no distinction between the weight or value to be given to either direct or circumstantial evidence, nor is a greater degree of certainty required of circumstantial evidence than of direct evidence.

Necessarily, you must determine the credibility of the witnesses who have testified in this case. Credibility simply means believability. It becomes your duty as jurors to evaluate the evidence and determine which evidence convinces you it is true.

In determining the believability of witnesses who have testified in this case you may believe one witness over several witnesses or several witnesses over one witness. You may believe a part of the testimony of a witness and reject the remaining part of the testimony of that same witness. You may believe the testimony of a witness in its entirety or reject the testimony of a witness in its entirety. You may consider whether the witness has an interest in the result of the trial, whether the witness is prejudiced toward either the defendant or the plaintiff, the opportunity for the witness to have seen the matters and things about which the

witness may testify and the way the witness acts on the witness stand.

You have heard from several expert witnesses. The rules of evidence ordinarily do not permit witnesses to testify to opinions or conclusions. An exception to this rule exists for witnesses we call expert witnesses. A witness but who with education and experience has become an expert in some art, science or profession may give an opinion as to the subject in which the witness claims to be an expert and may also give the reasons for that opinion.

You should consider any expert opinion given by a witness and like any other evidence give it the weight you think it deserves. If you decide that an expert witness's opinion is not based on sufficient education and experience or if you decide that the reasons given in support of the opinion are not sound or that the opinion is outweighed by other evidence, you may disregard the opinion in its entirety.

An expert witness's testimony is to be given no greater weight than that of other witnesses simply because the witness is an expert. You do not have to accept an expert's opinion even though it is uncontradicted.

Testimony has been presented to you by deposition. A deposition is a document containing sworn testimony given by a witness outside of court in the presence of lawyers for each party who may ask questions of the witness. The testimony is entitled to the same consideration and is to be judged as to credibility and weighed by you in the same way as if the witness were present and gave the testimony from the witness stand. It is then for you the jury to determine the effect, value, weight and truth of the testimony given in the deposition.

This is a medical malpractice case. The plaintiff claims that the defendant committed medical malpractice, which is a form of carelessness or negligence. In order to recover from medical malpractice, the plaintiff must prove by a preponderance or greater weight of the evidence, one, the standard of care; two, a breach of the standard of care; three, proximate cause; and four, damages.

The plaintiff must prove the standard of care the defendant owed the plaintiff in treating the plaintiff. When a doctor treats a patient the law does not require perfection. The law does require that the doctor use that degree of knowledge, care

and skill ordinarily possessed and used by doctors in good standing in the doctor's field of medicine under the same or similar circumstances and that the doctor follow the generally accepted practices and procedures in the profession.

Next, the plaintiff must prove that the defendant negligently departed from the standard of care in treating the plaintiff. Negligence is the failure to do what an ordinarily careful doctor in the defendant's field of medicine would have done under the same or similar circumstances or doing of something that an ordinarily careful doctor would not have done under the same or similar circumstances.

A doctor is not an insurer of a cure or even of a positive result; therefore, the mere fact that a treatment does not benefit the patient or that it even harms the patient does not in and of itself mean that the defendant was negligent. A bad result, injury, death or failure to cure is not by itself enough to show that the defendant was negligent.

Similarly, a doctor's mistake or error in making a decision alone does not constitute negligence. If, however, a doctor fails to gather

information reasonably available which a reasonable doctor would have gathered before making a decision, the doctor fails to comply with the recognized standard of medical care which would be exercised by a similar doctor under similar circumstances.

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

Qualified doctors and experts may differ as to what constitutes the best course of treatment and these differences do not amount to malpractice. Where doctors in good standing disagree or when medical authorities are divided with regard to a specific course of treatment or care then the doctor is bound only to exercise his best judgment in determining which course on the whole is best for the patient.

Just because another doctor may have used

another course of treatment does not make the defendant negligent; however, if a doctor does not have the degree of learning and skill required or if the doctor does not use the care required it is no defense to a charge of negligence that the doctor did the best that he could.

In considering whether the defendant made a reasonable decision, you must consider the decision in relation to the facts as they existed at the time and not in light of what hindsight may reveal.

Finally, the plaintiff must prove that the defendant's negligence proximately caused the plaintiff's damages. Proximate cause is something that produces a natural chain of events which in the end brings about the injury. It is a direct cause of the injury.

To prove that the defendant's negligence proximately caused the plaintiff's injury the plaintiff must first prove causation in fact. This is proven by showing that the injury would not have occurred but for the defendant's negligence.

The plaintiff must also prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This means that the injury occurred as a natural and probable consequence of the

defendant's negligence. The plaintiff must prove that some injury from the defendant's negligence was foreseeable but does not have to prove that the particular injury that occurred was foreseeable. However, the defendant cannot be held responsible for something which could not be expected to happen.

Proximate cause does not mean the only cause. There may be more than one proximate cause. The defendant's act can be a proximate cause of the plaintiff's injury if it was at least one of the direct concurring causes of the injury.

The defendant claims that the plaintiff had a preexisting injury or condition prior to the date that the plaintiff claims that the defendant injured him. If you find that the plaintiff received an injury as a result of the negligence of the defendant and is entitled to recover for that injury, the fact that the plaintiff had a preexisting injury or condition would not prevent the plaintiff from recovering.

The defendant is responsible for all ill effects which considering the plaintiff's condition of health when the plaintiff was injured naturally and necessarily followed the injury. The defendant takes the plaintiff as the plaintiff is found,

whether the plaintiff is in perfect health, in poor health or somewhere in between.

A defendant's liability is in no way lessened or affected because of the fact that the injury would not have resulted in or would not have been as serious or severe had the plaintiff been in good health or that the injuries were aggravated and rendered more difficult to cure by reason that the plaintiff was not in good health.

In other words, if the presence of a preexisting injury or condition aggravates and prolongs the injury and increases the damages, the plaintiff should be compensated for the increased or added damages. A person with a preexisting injury or condition is not, however, entitled to any compensation for the preexisting injury or condition itself.

In addition, if the problems are the result of the natural progression or worsening of a preexisting injury or condition, then the plaintiff would not be entitled to be compensated for those problems.

If the opinions of medical experts are relied on to establish probable cause, the expert must state with reasonable certainty his or her

professional opinion the plaintiff's injuries most probably resulted from the negligence of the defendant.

It is not necessary that the expert use the words "most probably." It is enough for the expert to state that in the expert's professional opinion that the defendant's negligence was the most likely upon the possible causes of the plaintiff's injuries.

In this wrongful death and survival action Plaintiff as personal representative of the deceased's estate claims that the deceased wrongfully died as a result of the negligent acts or omissions of the defendant.

Whenever the death of a person is proximately caused by the wrongful act or neglect of another and the act or neglect is one which would have entitled the deceased to recover damages if the deceased had not died, the personal representative of the estate may bring an action for wrongful death. The personal representative has a right to recover compensatory damages for the wrongful death.

It is not necessary to show the money value of the deceased's life since the direct proof of the value of human life is not possible. What is

reasonable compensation is left to your sound discretion and judgment.

The damages in an action for wrongful death include mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship, loss of the use and comfort of the deceased's society including the loss of the deceased's experience, knowledge and judgment in managing the affairs of the deceased and his beneficiaries.

It is not necessary to show the exact amount of damages suffered by the beneficiaries or that the beneficiaries suffered a monetary loss. In addition, the person for whose benefit the action is brought does not have to be dependent on the deceased for support.

If you decide that the plaintiff is entitled to a verdict, you need to decide how much money the defendant should be required to pay. Actual damages are to compensate the plaintiff for the plaintiff's injury or loss and to put the plaintiff as near as possible in the same position the plaintiff was in before the incident occurred. In other words, actual damages would be to actual losses and expenses the plaintiff has suffered because of the defendant's negligence.

Loss of enjoyment of life compensates the plaintiff for limitations on the plaintiff's ability to participate in and derive pleasure from the normal activities of daily life.

Pain and suffering compensates the plaintiff for physical discomfort and emotional response to the sensation of pain caused by the injury itself. There is no definite standard by which to compensate the plaintiff for pain and suffering.

You have the authority to determine the amount, if any, to be allowed for pain and suffering using calm and reasonable judgment to ensure that the damages are just and reasonable in light of the testimony and evidence presented in this case.

Mental suffering, apprehension, shock, fright, emotional upset, humiliation, anxiety either present or expected in the future can properly be considered as an element of damages. The amount of damages for mental suffering cannot be exactly measured.

Gross negligence is the failure to exercise a slight degree of care. A person who is so indifferent to the consequences of his conduct as to not give a slight care as to what he is doing acts with gross negligence.

Recklessness is the knowing failure to exercise

reasonable care under all of the surrounding circumstances. An act is reckless if it is committed in a manner and under circumstances which a person of ordinary reason and prudence would know would invade the rights of the injured person.

Misrepresentation is defined as any manifestation by words or other conduct by one person to another that under the circumstances amounts to an assertion not in accordance with the facts. An untrue statement of fact. An incorrect or false representation, that which if accepted leads the mind to an apprehension of a condition other and different from that which exists. Colloquially it is understood to mean a statement made to deceive or mislead.

If you award actual damages you may also consider an award of punitive damages. Punitive damages are intended to punish the defendant for extraordinary and outrageous conduct and to prevent the defendant and others from committing similar acts in the future.

Punitive damages can only be awarded where conduct of the defendant has been something more than mere negligence. The evidence must establish the defendant's acts were reckless, willful, wanton,

meaning there was a conscious failure to exercise due care or conscious indifference to the rights and safety of others or a reckless disregard thereof.

If you find that the defendant's conduct is willful, wanton or reckless, you may award the plaintiff punitive damages. To support an award of punitive damages the plaintiff must prove by clear and convincing evidence that the conduct complained of included a consciousness of wrongdoing at the time of the conduct.

Clear and convincing is more than just a preponderance or greater weight of the evidence, which requires only proof which persuades you that a party's claim is more likely true than not true. Clear and convincing proof, on the other hand, is not as high a standard as the burden of proof in criminal cases which is proof beyond a reasonable doubt.

Clear and convincing proof leaves no substantial doubt in your mind. It means that evidence is not ambiguous, doubtful, equivocal or contradictory. Convincing means persuading by proof or argument causing one to believe in the truth of what is asserted. Clear and convincing proof establishes in your mind not only that the fact is

probable but that it is highly probable.

Before awarding punitive damages you must consider and weigh four elements which may be pertinent to the facts of the case. You must first consider the relationship between any punitive damage award and the harm caused. Any penalty imposed should take into account the reprehensibility of the conduct, the harm caused, the defendant's awareness of the conduct's wrongfulness, the duration of the conduct and any concealment.

Thus, any penalty imposed should bear a relationship to the nature and extent of the conduct and the harm caused, including the compensatory damage award made by you.

Secondly, any penalty imposed should take into account as a mitigated factor any other penalty which may have been imposed or which may be imposed from conduct involved including any criminal or civil penalty or other punitive damages award arising out of the same conduct.

Next, you should consider whether the award of an amount of any punitive damages award may deprive the defendant of any profits derived from improper conduct and whether the ill-gotten profits should be

properly awarded to the plaintiff.

Finally, any award of punitive must be limited to punishment and must not effect economic bankruptcy. To this end the defendant's ability to pay any punitive damage award should be considered. However, the economic bankruptcy factor is not an absolute bar to an award of punitive damages.

Ladies and gentlemen, we're almost to the point where I send you to the jury room to begin your deliberations. This has been a long instruction on the law but I'll leave you with some final thoughts. You were chosen as jurors because both sides believed that you could be fair and impartial in deciding this case.

I instruct you to make use of your life experiences, your good common sense and your sense of logic and reason in evaluating the evidence in this case. You are not partisans or advocates for either side. You have no friends to reward, nor any enemies to punish. You are the judges of the facts. Your sole interest is to find the truth from the evidence presented.

Be courteous with one another. Listen to the views of your fellow jurors. Take the amount of time necessary to thoroughly evaluate the evidence.

This case is important to both sides as this is their only day in court.

Now, Mr. Foreman, I'm going to go over the verdict form with you. The verdict form consists of three pages. The first question, Did Dr. Mori violate generally accepted standards of medical care in his treatment of Mr. Dibernardo? There are two choices, no and yes. Now, place no significance on the order that the choices fall on the page. One simply had to go before the other.

If you answer no to that question, then you'll proceed no further. You'll sign the end of the form. If you answer yes, you go to Question 2, Was Dr. Mori's violation of generally accepted standards of care a proximate cause of Mr. Dibernardo's death? If you answer no to that question, you go no further. You go to the end and sign the document.

If you answer yes, then you proceed. The third question, What amount of actual damages were incurred by the statutory beneficiaries as a result of the death? That -- whatever the jury finds is the appropriate amount, if you get to that, you will fill it in on that blank.

Then on page 2 you have Question 4, Was Dr. Mori's violation of generally accepted standards

of care the result of reckless, willful, wanton or grossly negligent conduct proven to a level of clear and convincing evidence? Keep in mind the different standard for punitive damages versus actual damages that I just explained to you. You have two choices there. Again, if you -- if you answer no, you go down to the end and sign it.

If you answer yes, you go further. Number 5, Did Dr. Mori engage in a misrepresentation related to the claim of the plaintiff? And then you would check whatever choice that you come to there.

And Question 6, Did Carolina Cardiology Associates engage in misrepresentation related to the claim of the plaintiff? And then you would check whatever appropriate choice -- whatever decision that you make as a jury.

And then the last question, What amount of punitive damages should be awarded for the reckless, willful, wanton, grossly negligent conduct proven to a level of clear and convincing evidence? And again, it's a clear and convincing standard and it's a blank that you as a jury would fill in if you find that that's appropriate.

The last page is to the survival action and it mirrors the questions on the first page. The first

one, Did Dr. Mori violate generally accepted standards of medical care in his treatment of Mr. Dibernardo? And you have the two choices just like on the first page.

And Number 2 is an identical question from the first page: Was Dr. Mori's departure from the generally accepted standards of care a proximate cause of pain and suffering to Mr. Dibernardo before death?

And then if you answer that in the affirmative you go to Number 3. Keep in mind if you answer the first question or the second in the negative, then you just sign the form. You would not proceed to Number 3.

So that is the jury form. What will happen now, I am going to send you to the jury room. I'm going to meet with the attorneys to see if either attorney has any additions they would like made to the jury charges, and we also are going to make sure all the exhibits are here. You are not to begin your deliberations until I send the exhibits and the verdict form back to you.

Now, the one thing that you must consider is that your verdict must be unanimous. So when you reach a verdict, a unanimous verdict, Mr. Foreman

you would knock on the door, inform the bailiff that you have reached a verdict.

So at this point, Mr. Bailiff, would you take the jury to the jury room?

(The jury panel exits the courtroom.)

THE COURT: Okay. Any exceptions from the plaintiff?

MR. MCGOWAN: Yes, sir, Your Honor. I respectfully would take exception to the Court's failure to charge on Request Number 29 regarding control of the instrumentality and would just like to make sure that a copy of our written request is being made a part of the record in the case.

THE COURT: All right. Let me find that real quick.

MR. MCGOWAN: Yes, sir. Would you like me to hand another one up?

THE COURT: If you've got another copy that would expedite this.

MR. MCGOWAN: Yes, sir.

THE COURT: Okay. Plaintiff's Request to Charge Number 29 states: When a thing which causes injury is shown to be under the management of the defendant and the accident is such as under the ordinary course of things does not happen if those

who have management but use proper care it affords a reasonable evidence in the absence of explanation by the defendant that the accident arose from a want of care.

Mr. McGowan, this will be made a part of the record. I will note for the record we have had conference in chambers. I am declining to issue this charge. I feel it establishes a different standard, a different burden of proof that is not in accordance with our medical malpractice burden of proof that the plaintiff has.

MR. MCGOWAN: Yes, sir.

THE COURT: But that -- let's make this a Court's exhibit. Or you want Plaintiff's exhibit? It will have to be a Court's exhibit. Make that a Court's exhibit.

(Court's Exhibit No. 3 was marked.)

THE COURT: That will be Number 3.

MR. MCGOWAN: Thank you, Your Honor. That would be our only exception.

THE COURT: All right. Any exceptions?

MR. BEIGHLEY: Your Honor, just to remove -- exception to the charge of punitive damages and misrepresentation on the grounds that no evidence in the record taken in the light most favorable to the

plaintiff exists to support those jury charges.

THE COURT: Thank you, Mr. Beighley. I continue to deny that motion but it's noted for the record.

All right. I would like each attorney to come forward, look at the exhibits, make sure that they're all there and then that's confirmed we'll then send that back with the verdict form for the jury.

(Discussion off the record.)

MR. MCGOWAN: Your Honor, the exhibits are in order from the plaintiff's perspective.

MR. BEIGHLEY: Form and exhibits going back.

THE COURT: All right. Well, let's send the -- Mr. Bailiff, if you'll take the exhibits and the verdict form back to the jury, instruct them that they can begin their deliberations and send the alternate back to the courtroom.

THE BAILIFF: Yes, sir.

THE COURT: Mr. Alternate, you do not get to take part in the deliberations since none of your colleagues failed to make it through the trial, so we appreciate your service. I've got good news for you. The clerk has ordered you lunch in addition to the rest of them so you get to be fed too. You're

welcome to stay.

Just tell him where to go to get his lunch.

You can't go back in the jury room but you're welcome to hang around and get your lunch. If you want to stay and see how it turns out, you're welcome to do that too, but we appreciate your service.

We'll now go into recess.

(Court is in recess.)

THE COURT: Let's go on the record.

All right. Gentlemen, we have a question from the jury and the question says, Was there a device attached to the needle before the chest puncture?

Now, when I receive questions like this on the facts my standard instruction is that the Court cannot comment on the facts and they're to base their decision on the evidence now before them. Is there any objection to that standard --

MR. BEIGHLEY: I think that's what you have to say. I agree with that.

MR. MCGOWAN: I agree with you, Judge.

THE COURT: Okay. All right. Somebody can get the jury please.

(The jury panel enters the courtroom.)

THE COURT: Mr. Foreman, I have received your

question. This is a question about the facts of the case. The Court cannot comment on the facts of the case. You will have to base your decision based on the evidence before you now.

So with that instruction, I'm going to send you back to the jury room to continue your deliberations.

(The jury panel exits the courtroom.)

THE COURT: We'll go off the record in recess.

(Court is in recess.)

THE COURT: Okay. Gentlemen, I have been informed by the bailiff the jury has knocked on the door and has a verdict.

Tell the bailiff to bring the jury in.

(The jury panel enters the courtroom.)

THE COURT: All right. Mr. Foreman, I've been informed that you have reached a verdict?

MR. FOREMAN: Yes, sir.

THE COURT: All right. Would you hand that to the bailiff please, sir?

MR. FOREMAN: (Complies.)

THE COURT: Madam Clerk, would you publish the verdict?

THE CLERK: Yes, sir.

In the State of South Carolina, County of York,

Civil Action Number 2015-CP-46882, in the matter of Lorrie Dibernardo, Individually and Personal Representative of the Estate of Anthony Dibernardo versus Carolina Cardiology Associates, PA and Naresh Mori, MD. As to the allegations of wrongful death, did Dr. Mori violate generally accepted standards of medical care in his treatment of Mr. Dibernardo, the answer to this is no. Signed this day September 15, 2016, Foreperson Kevin Cabrera.

Ladies and gentlemen of the jury, if this is your verdict please indicate by raising your right hand.

Let the record reflect all hands are raised. Thank you.

THE COURT: Anything further before I dismiss the jury from the plaintiff?

MR. MCGOWAN: No, sir.

THE COURT: Anything from the defense?

MR. BEIGHLEY: No, Your Honor.

THE COURT: Ladies and gentlemen of the jury, as I told you Monday, jury duty is very important for our system of civil justice. Our system couldn't function without our citizens being willing to serve as jurors. I thank you for your service. I know it's been a long week for you but your

service is greatly appreciated. You're now dismissed and this ends your duty for the week.

(The jury panel exits the courtroom.)

THE COURT: Okay. Anything further from the plaintiff?

MR. MCGOWAN: Can you give me ten days to think about post-trial motions?

THE COURT: All right. I'll reserve the right for either party to file post-trial motions within ten days.

MR. MCGOWAN: Thank you.

THE COURT: We'll close the record.

(Court's Exhibit No. 4 was marked and entered into evidence.)

(The trial was concluded at 1:57 p.m.)

CERTIFICATE OF REPORTER

STATE OF SOUTH CAROLINA)

COUNTY OF YORK)

I, DANA NEW, Official Court Reporter for the Thirteenth Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and the evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas for York County, South Carolina, starting on the 12th of September, 2016.

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

January 7, 2017

/S/ Dana New

Dana New

Official Court Reporter

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

History and Physical Reports

Document Name:	History & Physical (Auth (Verified))
Performed By:	SHAH MD, J K 07/19/2013 10:21:32 EDT
Signed By:	SHAH MD, J K 07/23/2013 06:09:26 EDT
Authenticated By:	SHAH MD, J K 07/23/2013 06:09:26 EDT

History and Physical
Patient Name: DIBERNARDO, ANTHONY R
DOB: 12/26/1962
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

HISTORY OF PRESENT ILLNESS: Mr. Dibernardo is a 50-year-old gentleman, who presented to the office because of the ascites and significant 4+ edema that has been lately increased compared to before. Patient has a history of congestive heart failure. Also, has chronic atrial fibrillation, history of cardiomyopathy.

Because of the history of cardiomyopathy and previous echocardiogram, it was felt that patient needs further evaluation. Previous echocardiogram did show large pericardial effusion without any pericardial tamponade. I have sent this patient to Dr. Savage for possible pericardial tap; however, he wanted to wait.

MEDICATIONS: Coreg 6.25 mg twice a day, Coumadin 6 mg every day except on a Sunday takes 3 mg, Lanoxin 0.25 mg once a day, Feosol 3 times a day, Lasix 40 mg twice a day and Synthroid 0.1 mg a day.

SOCIAL HISTORY: No history of smoking, alcohol or drug abuse.

REVIEW OF SYSTEMS: Shortness of breathing, ankle edema and abdominal swelling.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 112/72, pulse is 66. Weight 138 pounds.
LUNGS: Clear. There are no rales.
HEART: First and second normal without fourth sound. There is a soft systolic murmur; however, the heart sounds are very distant.
ABDOMEN: Distended and has a finding of ascites.
EXTREMITIES: Legs 4+ edema.

IMPRESSION:
1. Probably large pericardial effusion, rule out pericardial tamponade.
2. Cardiomyopathy.
3. History of chronic atrial fibrillation.
4. History of heart failure in the past.
5. History of prolapsed mitral valve.
6. History of cerebrovascular accident in the past.

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

History and Physical Reports

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Signed By: SHAH MD, J K 07/23/2013 06:09:26 EDT
Authenticated By: SHAH MD, J K 07/23/2013 06:09:26 EDT

7. Liver biopsy, which was done on 3/13/13 was benign.
8. Echocardiogram on 6/18/13 did show pericardial effusion without pericardial tamponade, which was large, moderately severe pulmonary hypertension, increased dynamic left ventricular outflow tract gradient with a peak gradient 61 with Valsalva maneuver and has a resting peak gradient of 39 on 6/18/13, probably patient has idiopathic hypertrophic subaortic stenosis.
9. Patient also has high creatinine, which is 3.4; potassium was very high; also hemoglobin was low.

PLAN: Patient will be admitted to CV tele. We will discontinue Coumadin. We will start the heparin and then further workup will be decided. Patient has multisystem involvement, will require other consultants to see this patient also.

Dictated by: J K. SHAH, MD, FACC, FSCAI
TR:JKS/IN
DD:07/19/2013 09:06 EDT
DT:07/19/2013 10:20 EDT
JOB:9807491/4117785
HP-**-History and Physical-**-20130719102051
Electronically Signed on 07/23/2013 06:09 EDT

SHAH MD, J K

Consultation Reports

Document Name: Consultation Reports (Auth (Verified))
Performed By: WOOTEN MD, SALLY M 07/22/2013 23:17:23 EDT
Signed By: WOOTEN MD, SALLY M 07/23/2013 08:46:22 EDT
Authenticated By: WOOTEN MD, SALLY M 07/23/2013 08:46:22 EDT

Consultation

Patient Name: DIBERNARDO, ANTHONY R
DOB: 12/26/1962
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF CONSULTATION: 7/22/2013

History and Physical Reports

Document Name: History & Physical (Auth (Verified))
Performed By: BOULWARE PA, RICHARD B 07/19/2013 15:16:36 EDT
Signed By: per contribution per contribution
Authenticated By: MORI MD, NARESH A 07/23/2013 12:50:33 EDT

Signed By: MORI MD, NARESH A (07/23/2013 12:50:33 EDT); BOULWARE PA, RICHARD B (07/22/2013 08:31:21 EDT)

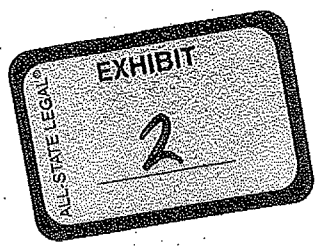
History and Physical
Patient Name: DIBERNARDO, ANTHONY R
DOB: 12/26/1962
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

AGE: 50

CARDIOLOGIST: J. K. Shah, M.D.

PROBLEM LIST:
1. Chronic atrial fibrillation.
2. Chronic anemia.
3. Hypothyroidism.
4. History of congenital cardiomyopathy, possibly a parachute mitral valve.
5. Chronic pericardial effusion without tamponade.

HISTORY OF PRESENT ILLNESS: Mr. Dibernardo is a very pleasant 50-year-old white male followed by Dr. J. Shah. The patient has a known large circumferential pericardial effusion without tamponade due to a history of mitral valve stenosis, possibly a parachute mitral valve. This has been noted to be present on echocardiogram, going back to 2009, but has normal EF. Reportedly, the patient has a history of cardiomyopathy due to congenital defect. The patient has previously been maintained on spironolactone, this was discontinued secondary to hyperkalemia. The patient has been maintained on Lasix as well, but recently within the past 1-2 weeks has had increasing shortness of breath, increasing lower extremity edema. The patient's most recent echocardiogram was done 6/18/2013, showing normal systolic function, EF of 55%, but noted to have severe biatrial enlargement, large circumferential pericardial effusion without tamponade. Also, has noted increased dynamic left ventricular outflow tract gradient with a peak gradient of 61 mmHg with Valsalva and peak gradient of 39 resting. The patient is maintained on Coreg and Coumadin given history of atrial fibrillation. INR was checked today, was 2.1. The patient denies that he has any chest pain, but has significant edema and effort intolerance and shortness of breath.



CURRENT MEDICATIONS: Include: Coreg 6.25 mg b.i.d.; Coumadin 6 mg all days with the exception of Sunday, which is 3 mg; digoxin 250 mcg daily, Lasix 40 mg 1 p.o. b.i.d., lisinopril 5 mg daily, Synthroid 100 mcg daily, Feosol 325 t.i.d.

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

History and Physical Reports

Document Name: History & Physical (Auth (Verified))
Performed By: BOULWARE PA, RICHARD B 07/19/2013 15:16:36 EDT
Signed By: per contribution per contribution
Authenticated By: MORI MD, NARESH A 07/23/2013 12:50:33 EDT

Signed By: MORI MD, NARESH A (07/23/2013 12:50:33 EDT); BOULWARE PA, RICHARD B (07/22/2013 08:31:21 EDT)

ALLERGIES: He has no known drug allergies.

PAST SURGICAL HISTORY: Unremarkable.

FAMILY HISTORY: Unremarkable.

SOCIAL HISTORY: Negative alcohol or tobacco use. Married, lives with his wife.

REVIEW OF SYSTEMS: Per HPI.

PHYSICAL EXAMINATION:
VITAL SIGNS: BP 118/68, pulse is 78.
GENERAL: This is a diminutive statured white male, appears to be in no acute distress.
HEENT: Normocephalic. There is significant exophthalmus noted. Oropharynx is clear.
NECK: Supple without bruits.
CARDIOVASCULAR: He has an irregularly irregular rate with an audible systolic murmur.
LUNGS: Clear.
ABDOMEN: Markedly distended with positive shifting dullness to percussion.
EXTREMITIES: Have 1-2+ pitting edema bilaterally.

LABORATORY DATA: All labs are currently pending. Most recent labs from 6/17 showed a hemoglobin of 8.9 with a hematocrit of 28.3, MCV of 66.4, MCH 20.9. The sodium at that time was 133 and the potassium was 6.7, BUN was 94 and creatinine is 3:1. EKG has not yet been performed.

ASSESSMENT AND PLAN: Large pericardial effusion, now with worsening lower extremity edema and possibly ascites. A STAT 2D echocardiogram has been ordered and will be repeated. We will repeat labs including a BMP, CBC, D-dimer, TSH, T3 and T4. We will hold Coumadin and start the patient on heparin drip, follow PT and INR. Plan is to proceed with a pericardiocentesis possibly on Monday. After that, the patient will need a right and left heart catheterization. Risks, benefits and alternatives have been discussed with the patient. Given the elevation of serum creatinine, we will consult nephrology to see the patient, though this is likely all passive hepatic congestion and renal insufficiency due to right ventricular strain. Further recommendations will be made accordingly.

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

History and Physical Reports

Document Name:	History & Physical (Auth (Verified))
Performed By:	BOULWARE PA, RICHARD B 07/19/2013 15:16:36 EDT
Signed By:	per contribution per contribution
Authenticated By:	MORI MD, NARESH A 07/23/2013 12:50:33 EDT

Signed By: MORI MD, NARESH A (07/23/2013 12:50:33 EDT); BOULWARE PA, RICHARD B (07/22/2013 08:31:21 EDT)

Dictated by: RICHARD B. BOULWARE, PA
TR:RBB/AN
DD:07/19/2013 12:15 EDT
DT:07/19/2013 12:50 EDT
JOB:9809196/4118771
HP-**-History and Physical-**-20130719125009
Electronically Signed on 07/22/2013 08:31 EDT

BOULWARE PA, RICHARD B

Electronically Signed on 07/23/2013 12:50 EDT

MORI MD, NARESH A

EKG/Rhythm

Document Name: EKG (Auth (Verified))
Performed By: Contributor_system, PMC_MUSE 07/21/2013 05:59:44 EDT
Signed By:
Authenticated By:

Electrocardiogram 12 Lead
Ventricular Rate - 65 BPM
Atrial Rate - 66 BPM
QRS Duration - 88 ms
Q-T Interval - 412 ms
QTC Calculation(Bezet) - 428 ms
Calculated R Axis - 161 degrees
Calculated T Axis - 37 degrees
Diagnosis - Atrial fibrillation with premature ventricular or aberrantly conducted complexes
Diagnosis - Right ventricular hypertrophy
Diagnosis - Anterolateral infarct , age undetermined
Diagnosis - Abnormal ECG
Diagnosis - Confirmed by EKG NOT READ, : (1705), editor Armstrong, Bailey (31) on 7/22/2013 10:32:27 AM

Cath Lab

Document Name: Cardiac Catherization Report (Auth (Verified))
Performed By: MORI MD, NARESH A 07/22/2013 13:11:32 EDT
Signed By: MORI MD, NARESH A 07/23/2013 12:50:35 EDT
Authenticated By: MORI MD, NARESH A 07/23/2013 12:50:35 EDT

Cardiac Catheterization Report
Patient Name: DIBERNARDO, ANTHONY R
DOB: 12/26/1962
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

PROCEDURES PERFORMED:
1. Pericardiocentesis for large pericardial effusion.
2. Left and right heart catheterization, which was to be done to evaluate for constrictive physiology, could not be done because of complications after pericardiocentesis.

BRIEF HISTORY: A 50-year-old gentleman with history of Noonan syndrome, had a history of large pericardial effusion and came for left and right heart catheterization and also pericardiocentesis.

DESCRIPTION OF PROCEDURE: We started out with pericardiocentesis. The area under _____ sternum was prepped and draped. Next, the pericardial space was entered using a large-bore needle. Next, initially more than 1 L of pericardial fluid was drained; however, later on the fluid turned hemorrhagic with the blood pressure also going down. This raised the suspicion of

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Cath Lab

Document Name:	Cardiac Catherization Report (Auth (Verified))
Performed By:	MORI MD, NARESH A 07/22/2013 13:11:32 EDT
Signed By:	MORI MD, NARESH A 07/23/2013 12:50:35 EDT
Authenticated By:	MORI MD, NARESH A 07/23/2013 12:50:35 EDT

myocardial injury during pericardiocentesis and hence, the right femoral vein was cannulated, lots of blood was aspirated from the pericardial space and then eventually given back to the patient. Emergency cardiac surgery evaluation was called for, the pericardial window placement and also repair of myocardial injury.

CONCLUSIONS: Pericardiocentesis was done with resultant complication of hemodynamic instability and probable injury to the myocardium during pericardiocentesis. Patient went for emergency surgery for pericardial window and also pericardial biopsy and repair of myocardial injury.

Dictated by: NARESH MORI, MD
TR:NM/IN
DD:07/22/2013 12:28 EDT
DT:07/22/2013 13:11 EDT
JOB:9828434/4040572
CA-**-Cardiac Catheterization Report-**-20130722131125
Electronically Signed on 07/23/2013 12:50 EDT

MORI MD, NARESH A

MRN: 342675
Patient Name: DIBERNARDO, ANTHONY R

EXHIBIT 4

Facility: PMC
FIN: 100407386

Piedmont M cal Center

EZ-8502 CC POS PRO R04/13

CARDIAC CATH – POST-PROCEDURE NOTE

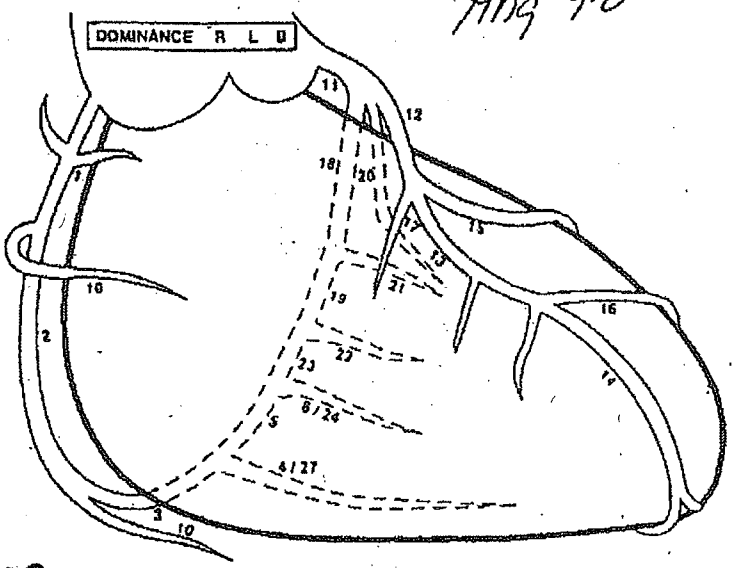
Physician: N. Mori

Pre-Procedure Diagnosis:

Post-Procedure Diagnosis:

HTN 9.0

Right Coronary Artery
1. Prox RCA
2. Mid RCA
3. Dist. RCA
4. RPDA
5. RPLS
6. 1st RPL
10. AC Marg.



Left Coronary Artery
11. LMCA
12. Prox LAD
13. Mid :LAD
14. Dist LAD
15. 1st Diag
16. 2nd Diag
17. 1st Septa
18. Prox CX
19. Dist CX
20. 1st Ob Ma
21. 2nd Ob Ma
22. 3rd Ob Ma
23. LAV
24. 1st LPL
27. LPDA

Access
RFA 5 Fr
LFA ____ Fr
RFV 7 Fr
LFV ____ Fr
Rt. Radial Art. ____ Fr
Lt. Radial Art. ____ Fr

Rhythm: AFIB **HR** 90 **EF** ____

LHC Aorta ____/____ Mean ____
LV ____ LVEDP ____

RHC RA ____ A ____ V ____
RV ____/____ RVEDP ____
PA ____/____ Mean ____
PCWP ____ A ____ V ____

ACT: ____ **Sedation/Anesthesia:** ____

O_2SAT IVC ____ RV ____ FA ____
SVC ____ PA ____ AO ____
RA ____ LV ____

PROCEDURE: Pericardiocentesis ~~RHC~~

Complications:

SPECIMEN: N/A **ESTIMATED BLOOD LOSS:** ☐ minimal or ☐ ____ ml

FINDINGS/ PLAN: pericardiocentesis done.
Dx'd heart cath could not be done
because of hemodynamic instability by

Immediate post-procedure pt.condition:

PHYSICIAN SIGNATURE: ____ **Time:** ____ **Date:** 7/22/13

PHYSICIAN NAME: (Printed) N. MORI

DICTATION # ____

Cardiac Cath-
Post-Procedure Note

4/3/2013 11:38:00 AM EZ-8502

ACCT#100407386 MR # 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J K 07/19/2013
PIEDMONT MEDICAL CENTER
DOB:12/26/1962

Cardiac Cath Lab Report

Patient Information			
Patient Name	DIBERNARDO, ANTHONY R	**Date of Birth**	12/26/1962
		Age	50 Years
		Gender	Male
Study Date	7/22/2013	**Race**	Caucasian
MRN	000342675	**Height**	154 cm (5'1")
Study Number		**Weight**	63.60 kg (140 lbs)
Account Number	100407386	**BSA**	1.62 m^2

Staff

Duty	Name	IN	OUT
Diagnostic Cardiologist	Naresh Mori, MD	7:26 AM	
Circulator	Gary Miller, RN (GM)	7:27 AM	
Ordering Physician	Arun Kundra, MD	8:02 AM	
RN - HOLDING AREA	Crystal McDaniel, RN (CMcD)	8:02 AM	9:23 AM
Scrub	Joseph Santana, CVT11	9:36 AM	
Monitor	Thompson Lundstrom, CVT 11	9:37 AM	

Cath Lab Assessment

Mode of Arrivial:	Stretcher
Accompanied by:	WIFE-LORI
Phone number for above:	IN WAITING ROOM
Person(s) Oriented to enviorment	Patient
Valuables given to:	NONE
Valuables kept by patient- Verballzes at his/ her own risk- hospitial not responsible:	N/A
Patients emotional state:	Anxious
Education provided to:	Patient
Education Provided:	Procedure
Education Provided:	Pain Scale
Education Provided:	Equipment
Education Provided:	Pre/ Post Care
Education Provided:	Effect of Medications
Education Provided:	Teaching Re-enforced
Barriers To Learning	None
Time Assessed	8:22:00 AM

OutPatient Assessment
System Assessment 1
System Assessment 2
Patient's Plan of Care

Nursing Diagnosis: Potiential for Knowledge deficit regarding the intended procedure and/ or sedation to be used:	High Priority

Interverntion: Ensure that informed consent is obtained for the procedure	Met Outcome
Intervention: Ensure that patient understands sedation to be used, and possible side effects	Met Outcome
Nursing Diagnosis: Potential for aspiration due to sedation and impairment of consciousness	High Priority
Intervention: Patient NPO for 8 hours after heavy meal and 6 hours after light meal	Met Outcome
Intervention: Medication may be given with a sip of water	Met Outcome
Intervention: Patency of upper airway and respiratory effort maintained	Met Outcome
Verified By:	CMCD
Time:	8:36:03 AM
Nursing Diagnosis: Alteration in oxygenation to tissue secondary to respiratory depression/ effects of medication administered	High Priority
Intervention: Patient evaluated by physician for appropriateness for sedation immediately prior to administration of sedation	Met Outcome
Intervention: Baseline established for BP, HR, O2 Sat, EKG, & continually monitored during procedure & recovery period	Not Met Outcome
Intervention: Patient is continually observed for changes in mental status	Met Outcome
Intervention: Emergency equipment & reversal agents immediately available	Met Outcome
Intervention: IV access is obtained & immediately available	Met Outcome
Intervention: Medication administration/ monitoring only performed by nurse trained in ACLS or PALS	Met Outcome
Verified By :	GM
Recorded by:	GM
Time:	9:22:53 AM

Patient's Plan of Care #2

Provide anticipatory instruction on pain causes, appropriate prevention, and relief measures	YES
Explain procedure and medications	YES
Verified by:	GM
Time	9:23:11 AM

Procedures

Time	Procedure	Code 1	Code 2	Code 3	Code 4	Comment
12:19 PM	Pericardiocentesis	46130100				
12:19 PM	QR - Art Access - R femoral artery*					

12:19 PM	QR - Ven Access - R femoral vein					

Radiology Summary

	Diagnostic	Interventional	Total
Fluoro Time (minutes)	6.3		6.3

Contrast

Time	Contrast	Amount (ml)	Comment
12:17 PM	Omnipaque	20	
12:17 PM	Wasted Contrast	130	

FFR

Time	Pa (mmHg)	Pd (mmHg)	FFR	Coronary Artery Segment

Complications

Time	Complication	Comment
12:19 PM	Emergency vascular surgery	

Pressures Used in Calculation (mmHg)

Baseline

Time	Site	Sys	Dias	End	Mean	A Wave	V Wave	Max dp/dt	HR (BPM)
11:13 AM	VEN				6				80
12:11 PM	ART	117	57		76				72

Medication Events-M

Pre-Case - Arun Kundra

Start	Stop	Medication	Amount	Ordered by	Given by	Comment
9:56 AM		0.9 NS IV	30 ml per hr	Naresh Mori MD	Gary Miller RN (GM)	
10:31 AM		Versed IV	0.5 mg	Naresh Mori MD	Gary Miller RN (GM)	
10:31 AM		Fentanyl IV	50 mcg	Naresh Mori MD	Gary Miller RN (GM)	

Other - Naresh Mori

Start	Stop	Medication	Amount	Ordered by	Given by	Comment
10:35 AM		1% Lidocaine Hydrochloride Subcut	18 ml	Naresh Mori MD	Naresh Mori MD	
10:35 AM		Fentanyl IV	50 mcg	Naresh Mori MD	Gary Miller RN (GM)	
10:36 AM		Versed IV	1 mg	Naresh Mori MD	Gary Miller RN (GM)	
10:45 AM	11:01 AM	Oxygen Nasal cannula	3 l per	Naresh Mori	Gary Miller	

			min	MD	RN (GM)	
11:27 AM		0.9 NS IV	200 ml per hr	Naresh Mori MD	Gary Miller RN (GM)	
11:32 AM		1% Lidocaine Hydrochloride Subcut	15 ml	Naresh Mori MD	Naresh Mori MD	
11:34 AM	11:56 AM	Dopamine IV	20 mcg per kg per min	Naresh Mori MD	Gary Miller RN (GM)	
11:41 AM	11:48 AM	Levophed IV	2 mcg per min	Naresh Mori MD	Gary Miller RN (GM)	
11:48 AM		Levophed IV	1 mcg per min	Naresh Mori MD	Gary Miller RN (GM)	
11:56 AM	12:00 PM	Dopamine IV	10 mcg per kg per min	Naresh Mori MD	Gary Miller RN (GM)	
12:00 PM	12:02 PM	Dopamine IV	5 mcg per kg per min	Naresh Mori MD	Gary Miller RN (GM)	

Vital Signs

Time	SpO2	HR	BP	RR	Ramsey Scale / Pain / Comment
8:21 AM	100	66	114/54/75	18	
9:39 AM	99	78	109/69/85	15	R1, NO PAIN
9:44 AM	100	48	110/62/78	15	R1, NO PAIN
9:49 AM	100	65	124/61/87	34	R1, NO PAIN
9:54 AM	99	60	105/61/81	30	R1, NO PAIN
9:59 AM	99	73	101/62/78	15	R1, NO PAIN
10:04 AM	98	98	111/65/77	21	R1, NO PAIN
10:09 AM	97	58	96/60/77	21	R1, NO PAIN
10:13 AM	95	55	101/58/71	20	R1, NO PAIN
10:19 AM	92	68	102/60/88	21	R1, NO PAIN
10:23 AM	93	75	104/67/79	21	R1, NO PAIN
10:29 AM	93	65	104/62/74	23	R1, NO PAIN
10:34 AM	96	58	113/60/82	25	R1, NO PAIN
10:39 AM	97	60	116/65/79	15	R1, NO PAIN
10:44 AM	65	82	95/57/72	15	R1, NO PAIN
10:49 AM	99	65	94/57/80	19	R1, NO PAIN
10:54 AM	100	74	99/51/69	18	R1, NO PAIN
10:59 AM	100	56	104/55/82	21	R1, NO PAIN
11:06 AM	99	61	95/64/78	20	R1, NO PAIN
11:09 AM	100	70	99/56/74	20	R1, NO PAIN
11:14 AM	100	58	92/54/70	21	R1, NO PAIN
11:19 AM	99	77	95/61/73	21	R1, NO PAIN
11:24 AM	97	76	87/51/71	27	R1, NO PAIN
11:26 AM	84	76	71/54/59	21	R2, NO PAIN
11:29 AM	95	53	43/32/38	36	R2, NO PAIN
11:32 AM	100	44	41/26/33	24	R2, NO PAIN

11:33 AM		41	48/28/35	23	R2, NO PAIN
11:34 AM		65	44/31/36	35	R2, NO PAIN
11:35 AM	97	74	47/30/41	51	R2, NO PAIN
11:36 AM	95	109	66/54/60	73	R2, NO PAIN
11:37 AM	99	102	65/43/52	19	R2, NO PAIN
11:38 AM	98	105	80/50/62	20	R2, NO PAIN
11:40 AM	98	104	75/50/66	19	R2, NO PAIN
11:41 AM	97	94	90/44/66	20	R2, NO PAIN
11:42 AM	98	110	71/59/64	19	R2, NO PAIN
11:44 AM	97	96	72/46/57	24	R2, NO PAIN
11:45 AM	86	112	75/53/58	30	R2, NO PAIN
11:46 AM	100	119	69/57/62	21	R2, NO PAIN
11:47 AM	99	94	78/50/64	20	R2, NO PAIN
11:48 AM	99	100	80/49/61	20	R2, NO PAIN
11:49 AM	99	53	104/44/58	22	R2, NO PAIN
11:51 AM	100	119	83/50/62	19	R2, NO PAIN
11:56 AM	100	84	109/53/79	12	R2, NO PAIN
12:01 PM	100	90	124/71/97	15	R2, NO PAIN
12:06 PM	94	74	111/52/71	18	R2, NO PAIN
12:11 PM	75	113	105/51/71	27	R2, NO PAIN

Intervention Summary

Conscious Sedation

Pre-Study Conscious Sedation Assessments	
Activity	2 - Able to move 4 extremities voluntarily or on command
Respirations	2 - Able to breathe deeply and cough freely
Circulation	2 - BP +/- 20% of pre-anesthetic level
Consciousness	2 - Fully Awake
O2 Saturation	2 - Able to maintain O2 saturation greater than 92% on room air
Pre-study Totals	10
Pre-study Assessment Statement	
Post-Study Conscious Sedation Assessments	
Activity	
Respirations	
Circulation	
Consciousness	
O2 Saturation	
Post-study Totals	
Post-study Assessment Statement	

Recovery Aldrete Score

Pre Procedure Pulses

Time Pulses Checked	8:32:15 AM
RDP:	Strong
LDP:	Strong
R Radial:	Strong
L Radial:	Strong

Post Procedure Pulses
Transfer/Discharge Form
Event Log

Time	Summary	Comment
8:01:25 AM	Phase: Baseline	
8:01:57 AM		Pre Case Documentation
8:02:12 AM		Lab Results Checked MD notified
8:17:29 AM		Patient Arrives
8:17:30 AM		Report From: Mary Montroy,RN
8:17:31 AM		Report Given To: CMCD
8:17:44 AM		Scheduled Procedure: RIGHT AND LEFT HEART CATH, POSSIBLE PERICARDIOCENTESIS
8:21:15 AM	SpO2 100%; HR 66 bpm; 114/54/75 NBP; LOC 2; RR 18/min Temp 37.1 °C	
8:21:24 AM		Initial verification of patient identification using
8:21:24 AM		two patient identifiers.
8:21:24 AM		Armband Checked & On Patient
8:21:26 AM		Patient set up with monitor for EKG,BP and Pulse Ox
8:21:26 AM	Case Event Type:Pre-Case,Physician:Kundra,Arun	
8:21:39 AM		Patient origin: CVTELE
8:21:43 AM		HIPPA option in (YES)
8:21:44 AM		Pre-procedure Teaching Performed
8:21:45 AM		Patient Verbalized Understanding of Procedure
8:21:46 AM		Accurately completed and signed consent form which is
8:21:46 AM		consistent with the history and physical and the
8:21:46 AM		procedure schedule
8:21:46 AM		Relevant documentation is present, to include but not limited to
8:21:46 AM		history and physical, nursing assessment, images and/or test
8:21:46 AM		results, and pre-anesthesia assessment.
8:21:46 AM		----------
8:21:47 AM		Availability of blood products required
8:21:48 AM		for the procedure.
8:21:48 AM		----------
8:21:48 AM		Procedure physician and another member of

		the team check
8:21:49 AM		relevant data to confirmthe site (imaging studies,
8:21:49 AM		radiology films,consultation notes, etc.)
8:21:49 AM		----------
8:21:49 AM		NPO since: 7/21/13 1800
8:21:58 AM		No Known Drug Allergies
8:21:59 AM		Pre Procedure Form
8:23:18 AM		Pt. /Family describes procedure prep and anticipated events
8:23:18 AM		Verbalized awareness and acceptance of current emotional state
8:23:20 AM		No further questions
8:23:20 AM		States criteria for discharge
8:23:20 AM		Name/Relationship to patient:
8:23:21 AM		Patient voided--time: 7/22/13 0800
8:25:22 AM		Call light within reach
8:25:22 AM		Siderall elevated x 2
8:25:23 AM		Pre-Meds reviewed
8:25:26 AM		Is patient experiencing pain? No
8:25:30 AM		IV Site: RIGHT WRIST
8:25:31 AM		IV size: 22 GA
8:25:31 AM		IV's Infusing: LASIX DRIP @ 15ML/HR
8:32:06 AM		Pre-Case: Moderate Sedation Assessment
8:32:15 AM		Pre-Procedure Pulses Checked
8:36:03 AM		Patient's Plan of Care
8:36:18 AM		POSITIVE/NORMAL MODIFIED ALLEN'S TEST TO RIGHT WRIST
9:22:52 AM		Patient identified by name/birthdate by procedure room staff
9:22:53 AM		Armband Checked & On Patient
9:22:53 AM		Patient's Plan of Care
9:36:16 AM		Patient on Table
9:38:22 AM		Lab #1
9:38:24 AM		Safety Concerns addressed with patient
9:38:24 AM		Emergency Supplies Available
9:38:24 AM		Radiation Sheilding Used
9:38:25 AM		Baseline 7 lead ECG
9:39:24 AM	SpO2 99%; HR 78 bpm; 109/69/85 NBP; RR 15/min	R1, NO PAIN
9:41:55 AM		--------- R & L 2 - Transducers--------
9:42:04 AM		100ml Bottle of Contrast in Injector
9:42:06 AM		150ml Bottle of Contrast at Table
9:42:08 AM		500ml Heparinized flush on table
9:42:10 AM		Additional 500ml Heparinized flush on table
9:42:33 AM		Transducer connected to heparinized 500ml flush bag times two
9:44:10 AM	SpO2 100%; HR 48 bpm; 110/62/78 NBP; RR 15/min	R1, NO PAIN
9:47:57 AM	Transducer	

9:47:58 AM	Transducer	
9:48:00 AM	Cath Tray Pack	
9:48:03 AM	Manifold set up (3 or 4 port)	
9:48:04 AM	Angio Injector Syringe 150ml	
9:48:05 AM	Bag Decanter	
9:48:06 AM	02 Nasal Cannula	
9:48:07 AM	Extention Tubing (any size)	
9:48:11 AM	IV Extension Tubing (Swartzman)	
9:48:12 AM	Tegaderm Dressing	
9:49:06 AM	SpO2 100%; HR 65 bpm; 124/61/87 NBP; RR 34/min	R1, NO PAIN
9:49:22 AM	J Wire .035 wire	
9:49:56 AM	5Fr. FL4 Catheter	
9:49:57 AM	5Fr. Pigtail 145 (Angled) Catheter	
9:50:06 AM	5Fr. Williams Rt Post. Catheter	
9:50:09 AM	5Fr. MPA 2 Catheter	
9:50:57 AM	7Fr. Hi - Shore Swan	
9:51:30 AM	Evacuation Container	
9:54:09 AM	SpO2 99%; HR 60 bpm; 105/61/81 NBP; RR 30/min	R1, NO PAIN
9:54:36 AM	Wholey wire	
9:56:54 AM	0.9 NS IV 30 ml per hr	
9:58:25 AM		ARRIVED ON LASIX DRIP 15mg/HR
9:59:12 AM	SpO2 99%; HR 73 bpm; 101/62/78 NBP; RR 15/min	R1, NO PAIN
10:04:05 AM	SpO2 98%; HR 98 bpm; 111/65/77 NBP; RR 21/min	R1, NO PAIN
10:09:32 AM	SpO2 97%; HR 58 bpm; 96/60/77 NBP; RR 21/min	R1, NO PAIN,
10:13:53 AM	SpO2 95%; HR 55 bpm; 101/58/71 NBP; RR 20/min	R1, NO PAIN
10:17:45 AM		Physician Called
10:19:11 AM	SpO2 92%; HR 68 bpm; 102/60/88 NBP; RR 21/min	R1, NO PAIN
10:23:55 AM	SpO2 93%; HR 75 bpm; 104/67/79 NBP; RR 21/min	R1, NO PAIN
10:29:05 AM	SpO2 93%; HR 65 bpm; 104/62/74 NBP; RR 23/min	R1, NO PAIN
10:31:37 AM	Versed IV 0.5 mg	
10:31:54 AM	Fentanyl IV 50 mcg	
10:32:27 AM		Physician Arrived
10:32:27 AM		Patient Prepped & Draped in Usual Manner
10:32:29 AM		----------Pericardiocentesis ----------
10:32:38 AM		Procedural Time Out Process: The Primary care provider or
10:32:38 AM		circulating staff member calls for all activity in the procedure
10:32:39 AM		room to STOP and ALL team members to
10:32:39 AM		participate in the Time Out Procedure.
10:32:39 AM		The correct patient identification (using two

10:32:39 AM		patient identifiers).
10:32:39 AM		Confirmation of correct side
10:32:39 AM		Presence of accurate consent form confirming
10:32:39 AM		the correct procedure to be done.
10:32:39 AM		Correct patient position.
10:32:39 AM		Relevant images and results are labeled and
10:32:39 AM		appropriately displayed
10:32:39 AM		Safety precautions based on the patient's history are addressed.
10:32:39 AM		All members of the procedure team have verbally acknowledged
10:32:39 AM		agreement to all the previous components.
10:32:43 AM		All Procedural Staff Wearing Radation Dosimeter
10:32:43 AM		Two Dosimeters for Approved Personnel
10:32:43 AM		Procedural staff initials: DB, TL, GM, JS, NM
10:32:43 AM		----------
10:33:24 AM		Case Start
10:33:24 AM	Case Event Type:Other,Physician:Mori,Naresh	
10:34:08 AM	SpO2 96%; HR 58 bpm; 113/60/82 NBP; RR 25/min	R1, NO PAIN
10:35:43 AM		1% Lidocaine Administered to Chest
10:35:52 AM	1% Lidocaine Hydrochloride Subcut 18 ml	
10:35:59 AM	Fentanyl IV 50 mcg	
10:36:54 AM	Versed IV 1 mg	
10:39:12 AM	SpO2 97%; HR 60 bpm; 116/65/79 NBP; RR 15/min	R1, NO PAIN
10:40:42 AM		ECHO TECH ARRIVED TO CASE
10:42:52 AM		Percutanous puncture to chest wall
10:43:50 AM		Catheter Inserted over Guidewire
10:44:03 AM	Pericardiocentesis Kit	
10:44:37 AM	SpO2 65%; HR 82 bpm; 95/57/72 NBP; RR 15/min	R1, NO PAIN
10:44:56 AM		Aspiration of blood/ fluid
10:45:46 AM	Oxygen Nasal cannula 3 l per min	
10:49:22 AM	SpO2 99%; HR 65 bpm; 94/57/80 NBP; RR 19/min	R1, NO PAIN
10:50:17 AM		CONTRAST INJECTED INTO PERCARDIUM
10:50:58 AM		Tubing connected
10:51:01 AM		Vacutainer connected
10:54:24 AM	SpO2 100%; HR 74 bpm; 99/51/69 NBP; RR 18/min	R1, NO PAIN
10:59:41 AM	SpO2 100%; HR 56 bpm; 104/55/82 NBP; RR 21/min	R1, NO PAIN
11:00:14 AM	6Fr. Long Sheath	
11:06:10 AM	SpO2 99%; HR 61 bpm; 95/64/78 NBP; RR 20/min	R1, NO PAIN
11:07:55 AM		Aspiration of blood/ fluid

11:09:00 AM		Vacutainer connected
11:09:43 AM	SpO2 100%; HR 70 bpm; 99/56/74 NBP; RR 20/min	R1, NO PAIN
11:10:58 AM		Tubing sutured with 2.0 Silk
11:11:16 AM		POST ASPIRATION CONTRAST INJECTION
11:11:24 AM		Total Volume out : 1240ml
11:13:33 AM	VEN : 6, HR = 80, II	PERICARDIAL PRESSURE
11:13:33 AM	Snapshot: VEN : 6, HR = 80	
11:14:08 AM	SpO2 100%; HR 58 bpm; 92/54/70 NBP; RR 21/min	R1, NO PAIN
11:15:28 AM		PIGTAIL CATHETER REMOVED FROM PERICARDIUM
11:16:39 AM		--------- R & L 2 - Transducers---------
11:19:10 AM	SpO2 99%; HR 77 bpm; 95/61/73 NBP; RR 21/min	R1, NO PAIN
11:19:23 AM	SAT: AO 98.0%	
11:24:08 AM	SpO2 97%; HR 76 bpm; 87/51/71 NBP; RR 27/min	R1, NO PAIN
11:26:37 AM	SpO2 84%; HR 76 bpm; 71/54/59 NBP; RR 21/min	R2, NO PAIN
11:27:09 AM		200ml FLUID BOLUS
11:27:35 AM	0.9 NS IV 200 ml per hr	
11:29:39 AM	SpO2 95%; HR 53 bpm; 43/32/38 NBP; RR 36/min	R2, NO PAIN
11:30:43 AM		SURGEON Called
11:31:44 AM		BLOOD SENT FOR TYPE AND CROSS
11:32:07 AM	SpO2 100%; HR 44 bpm; 41/26/33 NBP; RR 24/min	R2, NO PAIN
11:32:28 AM		----------Rt Groin----------
11:32:29 AM		1% Lidocaine Administered to Rt. Groin
11:32:34 AM	1% Lidocaine Hydrochloride Subcut 15 ml	
11:32:50 AM		Percutaneous Puncture to RFV
11:32:55 AM		Sheath Inserted Into RFV
11:33:24 AM	7Fr. Short Sheath	
11:33:26 AM	HR 41 bpm; 48/28/35 NBP; RR 23/min	R2, NO PAIN
11:33:37 AM		----------Rt Groin----------
11:33:43 AM		Percutaneous Puncture to RFA
11:33:47 AM		Sheath Inserted Into RFA
11:34:06 AM	5 Fr. Short Sheath	
11:34:40 AM	HR 65 bpm; 44/31/36 NBP; RR 35/min	R2, NO PAIN
11:34:48 AM	Dopamine IV 20 mcg per kg per min	
11:35:46 AM	SpO2 97%; HR 74 bpm; 47/30/41 NBP; RR 51/min	R2, NO PAIN
11:36:57 AM	SpO2 95%; HR 109 bpm; 66/54/60 NBP; RR 73/min	R2, NO PAIN
11:37:57 AM	SpO2 99%; HR 102 bpm; 65/43/52 NBP; RR 19/min	R2, NO PAIN
11:38:53 AM	SpO2 98%; HR 105 bpm; 80/50/62 NBP; RR 20/min	R2, NO PAIN

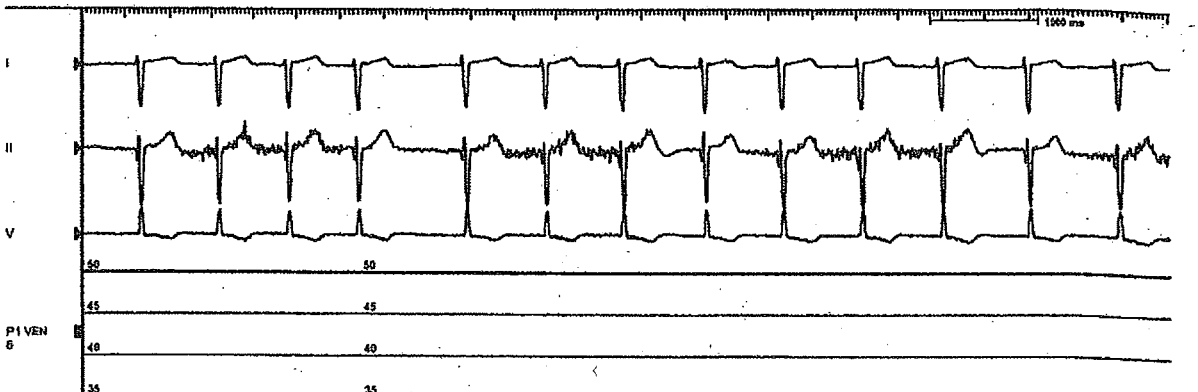
11:40:00 AM	SpO2 98%; HR 104 bpm; 75/50/66 NBP; RR 19/min	R2, NO PAIN
11:41:46 AM	Levophed IV 2 mcg per min	
11:41:52 AM	SpO2 97%; HR 94 bpm; 90/44/66 NBP; RR 20/min	R2, NO PAIN
11:42:59 AM	SpO2 98%; HR 110 bpm; 71/59/64 NBP; RR 19/min	R2, NO PAIN
11:43:18 AM		1475ml BLOOD/FLUID OUT
11:44:05 AM	SpO2 97%; HR 96 bpm; 72/46/57 NBP; RR 24/min	R2, NO PAIN
11:45:09 AM	SpO2 86%; HR 112 bpm; 75/53/58 NBP; RR 30/min	R2, NO PAIN
11:46:23 AM	SpO2 100%; HR 119 bpm; 69/57/62 NBP; RR 21/min	R2, NO PAIN
11:47:23 AM	SpO2 99%; HR 94 bpm; 78/50/64 NBP; RR 20/min	R2, NO PAIN
11:48:22 AM	SpO2 99%; HR 100 bpm; 80/49/61 NBP; RR 20/min	R2, NO PAIN
11:48:32 AM	Levophed IV 1 mcg per min	
11:49:06 AM		PATIENT BEING AUTO-TRANSFUSED WITH PERICARDIAL EFFUSATE
11:49:55 AM	SpO2 99%; HR 53 bpm; 104/44/58 NBP; RR 22/min	R2, NO PAIN
11:51:04 AM	SpO2 100%; HR 119 bpm; 83/50/62 NBP; RR 19/min	R2, NO PAIN
11:54:30 AM		LASIX DRIP OFF
11:56:04 AM	SpO2 100%; HR 84 bpm; 109/53/79 NBP; RR 12/min	R2, NO PAIN
11:56:40 AM	Dopamine IV 10 mcg per kg per min	
12:00:05 PM	Dopamine IV 5 mcg per kg per min	
12:01:05 PM	SpO2 100%; HR 90 bpm; 124/71/97 NBP; RR 15/min	R2, NO PAIN
12:05:57 PM		LAB PERSONNEL ARRIVED FOR TYPE AND CROSS
12:06:21 PM		SURGEON AND ANESTHESIOLOGIST ARRIVED TO CASE
12:06:30 PM	SpO2 94%; HR 74 bpm; 111/52/71 NBP; RR 18/min	R2, NO PAIN
12:10:52 PM		Physician Procedure End
12:11:21 PM	ART : 117/57/76, HR = 72, II	
12:11:21 PM	Snapshot: ART : 117/57/76	
12:11:23 PM	SpO2 75%; HR 113 bpm; 105/51/71 NBP; RR 27/min	R2, NO PAIN
12:12:39 PM		Hematoma present? No
12:14:30 PM		Patient Transferred to SURGERY
12:15:03 PM		Family notified of case end
12:19:32 PM	Procedure: Pericardiocentesis	
12:19:45 PM	Procedure: QR - Art Access - R femoral artery*	
12:19:52 PM	Procedure: QR - Ven Access - R femoral vein	

Supplies Summary

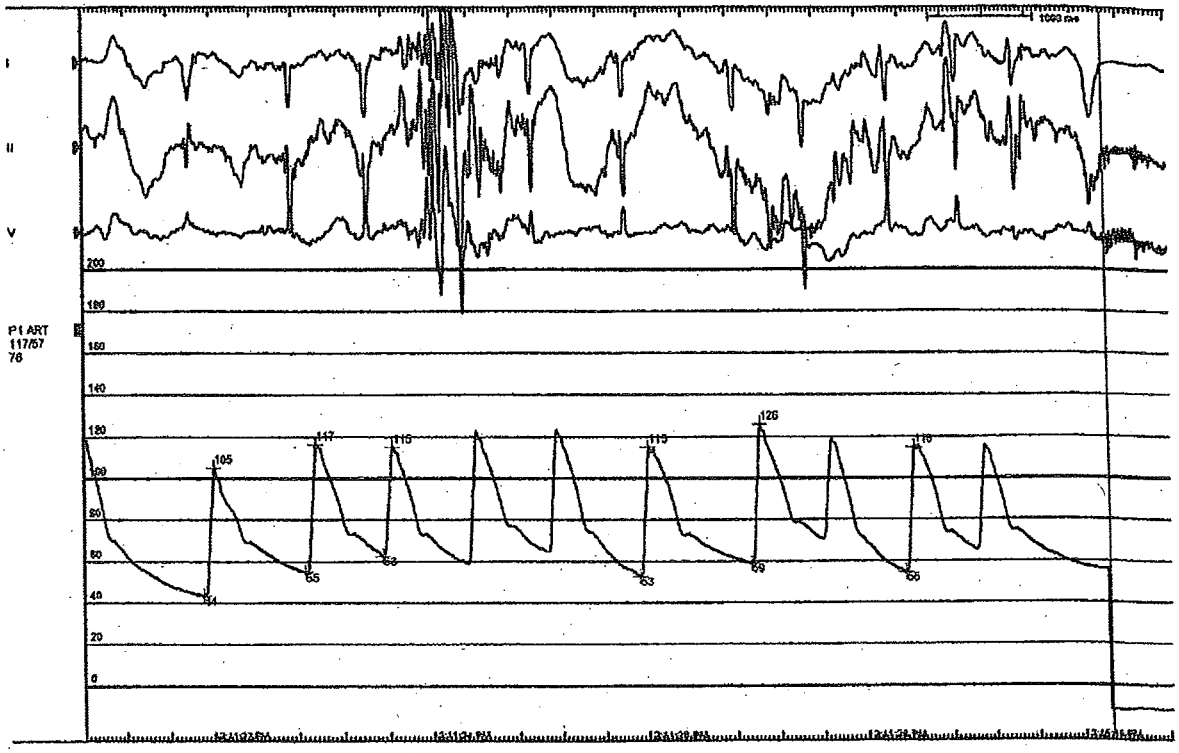
Time	Size	Manufacturer	Item Name (Model)	Lot Number	Comment
9:47 AM			Transducer		
9:47 AM			Transducer		
9:48 AM			Cath Tray Pack		
9:48 AM			Manifold set up (3 or 4 port)		
9:48 AM			Angio Injector Syringe 150ml		
9:48 AM			Bag Decanter		
9:48 AM			02 Nasal Cannula		
9:48 AM			Extention Tubing (any size)		
9:48 AM			IV Extension Tubing (Swartzman)		
9:48 AM			Tegaderm Dressing		
9:49 AM			J Wire .035 wire		
9:49 AM			5Fr. FL4 Catheter		
9:49 AM			5Fr. Pigtail 145 (Angled) Catheter		
9:50 AM			5Fr. Williams Rt Post. Catheter		
9:50 AM			5Fr. MPA 2 Catheter		
9:50 AM			7Fr. Hi - Shore Swan		
9:51 AM			Evacuation Container		
9:54 AM			Wholey wire		
10:44 AM			Pericardiocentesis Kit		
11:00 AM			6Fr. Long Sheath		
11:33 AM			7Fr. Short Sheath		
11:34 AM			5 Fr. Short Sheath		

Snapshots

Snapshot: VEN : 6, HR = 80



Snapshot: ART : 117/57/76



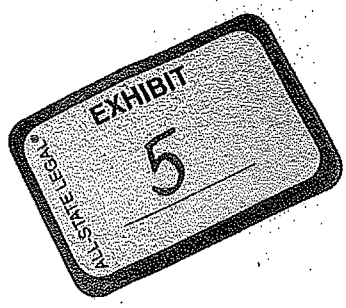
Contrast Form # 1

Previous reaction to contrast media? (except nausea/vomiting, heat/flushing pain) Within past 10 years?	No
History of asthma or allergy to multiple agents ?	NO
Diabetic?	NO
Diabetic and on Glucophage(or medications containing Metformin-ex. Glucophage, Glucovance, Avandamet, MetaGlip)?	NO
Pregnant or Nursing?	NO
Severe renal dysfunction (Creatinine > than 2.5 mg/dl)?	NO
Significant cardiac dysfuncation: (e.g. unstable angina. congestive failure, uncontrolled arryhthmias, myocardial	YES
Sickle Cell disease ?	NO
Organ transplant ?	NO
Undergoing Chemotherapy ?	NO
Do you have Multiple Myeloma ?	NO
Allergy to Barium Sulfate ?	NO

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Physician Progress Notes

Document Name: Physician Progress Notes (Auth (Verified))
Performed By: WOOTEN MD, SALLY M 07/23/2013 16:12:20 EDT
Signed By: WOOTEN MD, SALLY M 07/31/2013 19:19:29 EDT
Authenticated By: WOOTEN MD, SALLY M 07/31/2013 19:19:29 EDT



Dictated by: SALLY M. WOOTEN, MD
TR:SMW/IN
DD:07/23/2013 15:38 EDT
DT:07/23/2013 16:11 EDT
JOB:9839421/4135577
PN-**-Progress Note-**-20130723161127
Electronically Signed on 07/31/2013 19:19 EDT

WOOTEN MD, SALLY M

Operative/Procedure Reports

Document Name: Operative Report (Auth (Verified))
Performed By: SAVAGE MD, DAVID H 07/22/2013 14:15:04 EDT
Signed By: SAVAGE MD, DAVID H 07/26/2013 16:05:46 EDT
Authenticated By: SAVAGE MD, DAVID H 07/26/2013 16:05:46 EDT

Procedure Note
Patient Name: DIBERNARDO, ANTHONY R
DOB: 12/26/1962
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF PROCEDURE: 7/22/2013

PREOPERATIVE DIAGNOSES: Cardiac tamponade status post pericardial drainage.

POSTOPERATIVE DIAGNOSES: Cardiac tamponade status post pericardial drainage.

PROCEDURE: Emergency subxiphoid pericardial window.

SURGEON: David Savage, M.D.

ASSISTANT: Judy Carlton.

ANESTHESIA: General by Dr. Richter.

BIOPSY: Pericardial tissue to pathology.

COMPLICATIONS: None.

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Operative/Procedure Reports

Document Name:	Operative Report (Auth (Verified))
Performed By:	SAVAGE MD, DAVID H 07/22/2013 14:15:04 EDT
Signed By:	SAVAGE MD, DAVID H 07/26/2013 16:05:46 EDT
Authenticated By:	SAVAGE MD, DAVID H 07/26/2013 16:05:46 EDT

DRAINS: A 28 chest drainage. Patient remains in critical condition.

PROCEDURAL DETAILS: I was called stat to the cath lab out of a previous case, which I was in the middle of. There was a left side perixiphoid pigtail drain placed in the cancer. The patient was on inotropes and pressors. The windows of echo were quite poor, but showed a new fibrinous dense area of blood. Dr. _____ was clearly aspirating blood from the pericardium and putting it back in the vein. The patient was clearly unstable. Therefore, he was also known to be on blood thinners, though his INR was less than 1.5 pre the procedure. Because of the patient's critical state, and the odds of hemodynamic compromise of ongoing bleeding, we took the patient to surgery. A gram of Ancef was given. A Foley and SCDs were placed. A subxiphoid incision was made. The xiphoid bone was removed. The pericardium was entered. A quarter size area was sent for biopsy. The large clot was evacuated. The heart was not pumping well, though it was my impression that patient was acidotic. I communicated with anesthesia. I saw the point of ingress of the catheter in the fascia. It looked like it went across the acute margin of the RV. There was some mild oozing, but no significant ongoing bleeding. I placed a piece of Surgicel just in case, and after evacuating the clot with ring forceps, closed in layers with Vicryl and staples.

Dictated by: DAVID SAVAGE, MD
TR:DS/IN
DD:07/22/2013 13:26 EDT
DT:07/22/2013 14:14 EDT
JOB:9829047/4040838
OP-**-Procedure Note-**-20130722141440
Electronically Signed on 07/26/2013 16:05 EDT

SAVAGE MD, DAVID H

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Operative/Procedure Reports

Document Name: Procedure Report (Auth (Verified))
Performed By: CPDI Document 07/26/2013 13:42:35 EDT
Signed By:
Authenticated By:

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Consultation Reports

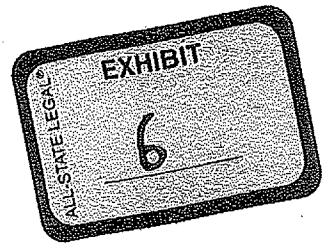
Document Name:	Consultation Reports (Auth (Verified))
Performed By:	WOOTEN MD, SALLY M 07/22/2013 23:17:23 EDT
Signed By:	WOOTEN MD, SALLY M 07/23/2013 08:46:22 EDT
Authenticated By:	WOOTEN MD, SALLY M 07/23/2013 08:46:22 EDT

REFERRING PHYSICIAN: David Savage, M.D.

REASON FOR CONSULTATION: Critical care management.

HISTORY OF PRESENT ILLNESS: Mr. Dibernardo is a 50-year-old who has Noonan syndrome with a congenital cardiomyopathy. The patient has been followed by cardiology and most recently was found to have a large pericardial effusion based upon echo. The patient presented with 1- to 2-week history of increasing shortness of breath as well as increasing edema. The patient had been on spironolactone but it was discontinued due to hyperkalemia. He was maintained on Lasix. The patient was admitted, workup was undertaken. The patient on the day of the consult underwent pericardiocentesis, which was complicated by bleeding. The patient was emergently taken to the OR, pericardial window was placed. He returned to the ICU on the ventilator. When he arrived in the ICU, he was on 3 mcg/minute of Levophed. He was also sedated with Diprivan at 50 mcg/minute. Blood pressure was in the 70s-80s. Diprivan was discontinued and has been switched to Versed. Patient is also getting p.r.n. morphine. His chart and his records have been reviewed.

PAST MEDICAL HISTORY:
1. Congenital cardiomyopathy.
2. Chronic pericardial effusion.
3. Hypothyroidism.
4. Chronic atrial fibrillation.
5. Chronic anticoagulation.
6. Chronic anemia.
7. Mitral stenosis.
8. Anemia.
9. Remote history of a CVA.
10. Noonan syndrome.



PAST SURGICAL HISTORY: Positive for the current pericardial window.

ALLERGIES: None.

FAMILY HISTORY: Noncontributory to the current illness.

SOCIAL HISTORY: The patient is married, lives with his wife. Denies alcohol or cigarette use.

REVIEW OF SYSTEMS: Unobtainable due to his condition.

PHYSICAL EXAMINATION:

Patient:	DIBERNARDO, ANTHONY R		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Consultation Reports

Document Name:	Consultation Reports (Auth (Verified))
Performed By:	WOOTEN MD, SALLY M 07/22/2013 23:17:23 EDT
Signed By: ,	WOOTEN MD, SALLY M 07/23/2013 08:46:22 EDT
Authenticated By:	WOOTEN MD, SALLY M 07/23/2013 08:46:22 EDT

VITAL SIGNS: His blood pressure is 102/49, pulse is 72, his O2 sats are 100%. He is currently off of Levophed, on normal saline at 100 and Versed at 4 mg an hour. His current vent settings are assist control of 16, tidal volume 500, FiO2 of 50% and PEEP of 5.
HEENT: He has evidence for exophthalmos. Both of his sclerae are erythematous and appear to be dry. His pupils do react. He is orally intubated.
NECK: Thick neck. I do not appreciate any thyroidomegaly.
CHEST: His breath sounds are equal although diminished. There are a few rales, no rhonchi, no wheezing.
HEART: Slightly irregular. Heart sounds are distant. There is a systolic murmur.
ABDOMEN: Distended and rotund. There is evidence for ascites. I do not appreciate any hepatosplenomegaly.
EXTREMITIES: He has brawny changes bilaterally, left more so than right. Left is more edematous than the right with 2+ piting edema.
NEUROLOGIC: The patient is currently sedated, although he is moving extremities.

LABORATORY DATA: His chest x-ray shows massive cardiomegaly, the ET tube is above the carina, I do not see any infiltrate, but his lung fields are extremely small. Blood gas on assist control of 20, tidal volume 550, FiO2 of 100%, PEEP of 5: pH was 7.64, pCO2 of 33, pO2 of 346. His labs are pending. His INR today was 1.3 with a PT of 15. Yesterday, his sodium was 130, potassium 3.6, chloride 92, bicarbonate 32, BUN of 26, creatinine 0.9 and blood sugar of 112. Cholesterol was 90, triglycerides were 74. His BNP was 2820.

IMPRESSION: The patient is a 50-year-old with the following:
1. Acute respiratory failure, which is multifactorial, predominantly due to the postoperative state but he does have underlying pulmonary hypertension and an abnormal chest wall due to pectus excavatum.
2. Pericardial tamponade following pericardiocentesis requiring surgical intervention.
3. Noonan syndrome.
4. Chronic atrial fibrillation with controlled ventricular rate.
5. Pulmonary hypertension with evidence of right heart failure despite the right ventricular systolic pressure estimated at 27.
6. Mild hyponatremia.
7. Anemia, which is chronic.
8. Chronic anticoagulation.
9. Hypothyroidism.
10. Exophthalmos.

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Consultation Reports

Document Name:	Consultation Reports (Auth (Verified))
Performed By:	WOOTEN MD, SALLY M 07/22/2013 23:17:23 EDT
Signed By:	WOOTEN MD, SALLY M 07/23/2013 08:46:22 EDT
Authenticated By:	WOOTEN MD, SALLY M 07/23/2013 08:46:22 EDT

RECOMMENDATIONS:
1. Continue vent support.
2. Sedation with Versed.
3. Morphine for pain as planned.
4. Check labs.
5. Monitor blood gases.
6. Ventilator settings have been readjusted.
7. Further evaluation and treatment depend upon the response and the findings.

Critical care time has been 45 minutes.

Dictated by: SALLY M. WOOTEN, MD
TR:SMW/BN
DD:07/22/2013 15:07 EDT
DT:07/22/2013 17:53 EDT
JOB:9830144/4041274
CO-**-Consultation-**-20130722175359

Electronically Signed on 07/23/2013 08:46 EDT

WOOTEN MD, SALLY M

Consultation Reports

Document Name: Consultation Reports (Auth (Verified))
Performed By: ERB MD, BRIAN C 07/19/2013 16:38:18 EDT
Signed By: ERB MD, BRIAN C 08/16/2013 20:14:36 EDT
Authenticated By: ERB MD, BRIAN C 08/16/2013 20:14:36 EDT

Consultation
Patient Name: DIBERNARDO, ANTHONY R
DOB: 12/26/1962
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF CONSULTATION: 7/19

TIME: 3:45 p.m.

REFERRING PHYSICIAN: J. Shah, M.D., FACC, FSCAI

REASON FOR ADMISSION: Edema, hypokalemia and possible history of acute kidney injury.

HISTORY OF PRESENT ILLNESS: A very pleasant 50-year-old Caucasian male who has been followed for his cardiac condition for quite some time. He has had a chronic pericardial effusion; chronic atrial fibrillation, on anticoagulation; suspected congenital heart disease with mitral valve stenosis and report of increased serum creatinine of 3.1 on 6/17 (I do not have these records available to me at this time). The patient denies any prior history of renal disease. He has had no renal calculi or abnormal urine studies in the past to his knowledge. He has chronic lower extremity edema, managed with diuretic therapy and also underwent evaluation for possible liver disease within the past 6 months. This included a liver biopsy, which he states was normal.

PAST MEDICAL HISTORY:
1. Congenital heart disease with mitral valve stenosis as above.
2. Chronic edema.
3. Chronic atrial fibrillation, on Coumadin.
4. Chronic pericardial effusion.
5. Hypothyroidism.
6. Anemia.
7. No known prior history of renal disease, but there is a report from Richard Boulware's dictation that his serum creatinine was 3.1 on 6/17 of this year.

REVIEW OF SYSTEMS: Negative except for that in history of present illness.

SOCIAL HISTORY: No alcohol or tobacco.

FAMILY HISTORY: Denies family history of renal disease.

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Consultation Reports

Document Name:	Consultation Reports (Auth (Verified))
Performed By:	ERB MD, BRIAN C 07/19/2013 16:38:18 EDT
Signed By:	ERB MD, BRIAN C 08/16/2013 20:14:36 EDT
Authenticated By:	ERB MD, BRIAN C 08/16/2013 20:14:36 EDT

PHYSICAL EXAMINATION:
GENERAL: Alert, thin male in no distress. He has no dyspnea.
VITAL SIGNS: Blood pressure is 118/68, heart rate is irregular at 78 beats per minute. He is afebrile. He has exophthalmos.
HEENT: Mucous membranes are moist.
NECK: Supple.
LUNGS: Clear anteriorly, has pectus excavatum.
ABDOMEN: Soft, nontender.
EXTREMITIES: He has 2+ chronic lower extremity edema.

IMPRESSION AND PLAN: A 50-year-old Caucasian male with chronic lower extremity edema, likely on the basis of his cardiac disease. He has been maintained on diuretic therapy with Aldactone and furosemide in the past. He has hypokalemia with serum potassium of 3.2, likely on the basis of diuretic therapy. His serum creatinine is 1.0, and I will send urine for urinalysis to make sure there is no proteinuria. He may undergo intravenous contrast administration with cardiac catheterization and would be at risk for contrast nephropathy since he is in somewhat prerenal state with his cardiac condition and diuresis. We will continue to follow with you.

Thank you for asking us to see Mr. Dibernardo.

Dictated by: BRIAN C. ERB, MD
TR:BCE/BN
DD:07/19/2013 16:07 EDT
DT:07/19/2013 16:37 EDT
JOB:9811581/4120125
CO-**-Consultation-**-20130719163714
Electronically Signed on 08/16/2013 20:14 EDT

ERB MD, BRIAN C

Piedmont Medical Center

EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
7/24/13 1750	Critical Care - 2nd note 4141633
7/24/13 1745	DEATH Note Pt's pulse spont respirations No carotid pulse, pronounced deced @ 1745

Piedmont Medical Center

EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
7-24-13	(0428) Resp Care notes AM ABG on vent 14/ 4.70/ +5/ 40% —
	7.42/ 35/ 129/ 23/ -1/ 99% [signature]
	Card
7/24/13	Still on vent
	Awake. low grade fever (Sepsis vs [illegible])
	Stable vitals
	good urine output.
	decreased output from tube — Na = 141; K = 3.5
	Echo: good LV — CR: 1.2
	EF: 55% (+) [signature] — BUN: 24
	EHSS — Mg: 1.5
	gl.: 98
	HB: 7.4 / 23.1
	WBC = 11c
	Imp: Improving. — Plat = 71.500
7/24/13	ABG on CPAP+5 / PS+10 [signature]
1030	40% as follows:
	pH 7.39 / PCO2 36.2 / PO2 107 / HCO3 22.3 / BD-1 / Sat 98%
	Dr. Wooten called with results — L. Kyle RRT
7/24/13	
	7.37 / 40.9 / 98 50% BiPAP 14/7

PROGRESS NOTES

07/19/2013
ACCT#:100407386 MR#:000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J K DOB:12/26/1962

7/23/2013 8:09:00 AM   EZ-2050

Piedmont Medical Center

EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
July 23, 13 0447	AM ABG drawn with patient on AC 14/500/40/+5. Results:
	pH 7.496
	CO_2 32.4
	PO_2 84
	HCO_3 25.1
	BE 2
	SO_2 97% — J. Braughton RRT
7/23/13	CCA
1130	for breathing trial today. S/p pericardiac window
	SBP 116 P 70 Idic: A[illegible]B
	S/p pericardiocentesis c pericardial tamponade well [illegible].
	[signature] J K Shah
7/23/13	Echo Completed by Cesar Deleon, RDCS
1220	Cardiology [illegible]
7/23/13 4:50 pm	case d/w pts parents. Explained procedure & complications, - prognosis guarded N. Mora

PROGRESS NOTES

7/17/2013 7:08:00 AM EZ-2050

DOB:12/20/1962
ACCT#100407386 MR# 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J K 07/19/2013
PIEDMONT MEDICAL CENTER

Piedmont Medical Center

EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
7/23/13	ICU on call
0135	pt evaluated in cross coverage
	issues: 1) acute [illegible] resp failure
	2) [illegible]
	3) [illegible] pericardial drainage for
	pericardial tamponade
	4) pulm HTN ; RVSP 37 mm Hg ; LVEF 55-60%
	5) [illegible] CHF v. noncardiogenic pulm edema
	6) Noonan syndrome
	7) acute oliguric renal failure
	8) [illegible]
	9) ascites / [illegible] LE edema
	10) Noonan's syndrome
	rec: a) full vent support ; [illegible]
	b) [illegible]
	c) [illegible]
	d) ? need for [illegible] also
	[illegible] (note 7/19/13
	e) lasix drip to convert to nonoliguric
	f) renal [illegible] for CVVHD
	g) F/u labs
	h) [illegible]
	[illegible]
	CVP 16, ⊕ [illegible] ⊖ [illegible]
	⊕ [illegible] / LE edema
	⊖ [illegible]
	[illegible] Dr. V. Patel for CCM
	[signature]

PROGRESS NOTES

7/17/2013 7:08:00 AM EZ-2050

DOB:12/26/1962
ACCT#100407386 MR # 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J K 07/19/2013
PIEDMONT MEDICAL CENTER

Piedmont Medical Center

EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
7.22.13	Venous Duplex complete.
16:35	) Negative DVT B/L lower extremities.
	EC Q D
	PRELIMINARY FINDINGS Final Report to follow

07/19/2013

PROGRESS NOTES

ACCT#:100407386 MR#:000342676
DIBERNARDO, ANTHONY R 50Y M
SHAH J K DOB:12/26/1962

7/22/2013 3:08:00 PM EZ-2050

Piedmont Medical Center

EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
7/22/13	Critical Care
1485	50 yo male c̄ following
	1) Acute Respiratory failure
	2) Pericardial Tamponade
	3) Noonan Syndrome
	4) Chronic atrial fibrillation
	5) Pulm HTN / Right Heart failure
	6) Mild Hyponatremia
	7) Anemia
	8) Chr. anticoagulation
	Consult dictated
	4041274 [signature]
	[illegible]
7/23/13	[illegible] on [illegible] [illegible] very [illegible]
	[illegible]
HB: 8.0	[illegible] [illegible] - [illegible] D [illegible] [illegible]
[illegible] 176	
WBC: 17	[illegible] [illegible] [illegible] [illegible]
CR: 1.2	[signature]

PROGRESS NOTES

07/19/2013
ACCT#:100407386 MR#:000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J K DOB:12/26/1962

7/22/2013 1:02:00 PM EZ-2050

Progress Note - Printed

Piedmont Medical Center

Printed: Sunday, JUL 21, 2013 11:07 by KUNDRA MD, ARUN

DIBERNARDO, ANTHONY R | RM: 2807, PMC – CT | 50 Y (DOB:12/26/1962) | M | ACCT#: 100407386

Attending: SHAH MD, J K
Service: 42 – IP – Telemetry
Allergies: NKA
Diagnosis: No diagnoses recorded
Isolation: None Specified

Code Status: None Specified
MRN: 342675

Reason for Admission: PERICADIAL EFFUSION CHF

Vitals	Temp	BP	Pulse	RR	SpO2	FIO2
07/21 08:44	98.2	101/64	84	20	98	—
07/21 04:10	98.3	116/68	69	20	93	—
07/20 23:45	98.2	111/58	59	18	99	—

24 Hr Tmax: 98.4 at 07/20 16:19
48 Hr Tmax: 98.4 at 07/20 16:19

	Date	kg	lb
Current Wt	07/21	60.9	134
Previous Wt	07/21	60.9	134
Admit Wt	07/19	62.6	138
BMI	07/21	26	

	Recorded	Input	Output	Balance
07/21	07:00–11:07	690	200	490
07/20	7a – 3p	560	550	10
	3p – 11p	80	600	–520
	11p – 7a	50	400	–350
	24Hr Total	690	1550	–860

24hr Lab Data – *Please see flowsheet for differential result, if ordered*

07/21 03:20											
PT	15.7	H	Chloride Lvl	92	L	Glucose Level	112.0		GFR Non African Am	>60	
INR	1.3	L	CO2	32.0		BUN/Creat	29	H	07/21 03:10		
Sodium Lvl	130.0	L	Calcium Lvl	8.20	L	Osmolality Calc	257	L	PT	15.2	H
Potassium Lvl	3.60		BUN	26		AGAP	6.0	L	INR	1.3	L
			Creatinine Lvl	0.9		GFR African Am	>60				

Reviewed Personally: [] Radiology [] Tele-findings [] Path [] PT note [] OT note [] ST note [] Other: _____

Case discussed with: _____ Time Spent: _____

SOAP Note

Rate controlled A. fib.
BP DTC & Comfortable.
Still tense ascites. Edema (+).

Planned: L+R HCath ± Pericardio
centesis in AM.

Will ↑ Lasix to 15 mg/hr.
replace K+.

Active Inpatient Medications:
aspirin (Ecotrin) 325mg = 1tab Oral Daily ✓
carvedilol (Coreg) 6.25mg = 2tab Oral Q12hr ✓
digoxin (Lanoxin) 0.25mg = 1tab Oral Daily ✓
ferrous sulfate (Feosol) 325mg = 1tab Oral BID
levothyroxine (Synthroid) 0.1mg = 1tab Oral Daily
sodium chloride (NS flush) 10mL Flush Q8hr

Active PRN Medications:
Al hydroxide/Mg hydroxide/simethicone (Mylanta (with simethicone) II Maximum Strength) 30mL
acetaminophen (Tylenol) 650mg = 2tab Oral Q4hr
alprazolam (Xanax) 0.25mg = 1tab Oral Q6hr
aspirin 300mg = 1suppos Rectal Daily
bisacodyl (Dulcolax Laxative) 10mg = 2tab Oral Daily
bisacodyl (Dulcolax Laxative) 10mg = 1suppos Rectal Daily
magnesium hydroxide (Milk of Magnesia) 30mL Oral Daily
morphine 2mg = 0.5mL Injection As Directed
nalbuphine (Nubain) 5mg = 0.5mL Injection Q4hr
nitroglycerin (Nitrostat) 0.4mg = 1tab Sublingual As Directed
sodium chloride (NS flush) 10mL Flush As Directed
zolpidem (Ambien) 5mg = 1tab Oral Q Bedtime

One Time Medications in the Past 36 hours:

Continuous Infusions:
furosemide 100 mg + Sodium Chloride 0.9% 100 mL 100mL IV 10 mL/hr ✓

Provider Signature _____ Staff # _____ Date/Time 7/21/13 - 11:10AM

Pg 1

[REPORT CONT]

Piedmont Medical Center

EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
7/21/13 0855	Renal: f/u CKD
	Based on recent labs there seems no evidence of CKD (Scr x 2, 2 days apart, is ~1.0). With this, and the fact that the patient is not a diabetic, there seems little/minimal risk of contrast ATN.
	Please contact us if we can assist further.
	[signature]
	Card:
	# pericardial effusion / s/p
7/22/2013	# CM [illegible] # [illegible]
	# CAD [illegible] # [illegible]
	# CRF
	# hyperlipidemia
	feels [illegible] better
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible] [signature]

PROGRESS NOTES

DOB: 12/26/1962
ACCT#100407386 MR # 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J K 07/19/2013
PIEDMONT MEDICAL CENTER

8/30/2013 1:05:00 AM EZ-2050

Progress Note – Printed

Piedmont Medical Center

Printed: Saturday, JUL 20, 2013 11:36 by KUNDRA MD, ARUN

DIBERNARDO, ANTHONY R | RM: 2007, PMC – CT | 50 Y (DOB:12/26/1962) | M | ACCT#: 100407386

Attending: SHAH MD, J K
Service: 42 – IP – Telemetry
Allergies: NKA
Diagnosis: No diagnoses recorded
Isolation: None Specified

Code Status: None Specified
MRN: 342675

Reason for Admission: PERICADIAL EFFUSION CHF

CEA

Vitals	Temp	BP	Pulse	RR	SpO2	FIO2
07/20 08:02	98.4	106/74	67	20	97	—
07/20 04:36	98.4	123/71	67	18	97	—
07/19 23:53	98.3	97/47	66	20	98	—

24 Hr Tmax: 98.4 at 07/20 08:02
48 Hr Tmax: 98.4 at 07/20 08:02

	Date	kg	lb
Current Wt	07/20	61.0	134
Previous Wt	07/20	61.0	134
Admit Wt	07/19	62.6	138
BMI	07/20	26	

	Recorded	Input	Output	Balance
07/20	07:00–11:36	290	200	90
07/19	7a – 3p	5.3333	0	5.3333
	3p – 11p	80	1025	–945
	11p – 7a	60	450	–390
	24Hr Total	145.3333	1475	–1329.6667

24hr Lab Data – *Please see flowsheet for differential result, if ordered*

07/20 05:10			Pro-BNP	28200		Hgb	9.0	L	Creatinine Lvl	1.0	
PT	24.0	H	Total Protein	6.6		Hct	29.1	L	Glucose Level	183.0	H
INR	2.0		Albumin Lvl	3.3	L	MCV	69.7	L	BUN/Creat	30	H
Chol Trig Ratio	1		Alk Phos	104		Platelet Count	171		Osmolality Calc	272	L
Chol/HDL	5.0		ALT	11	L	D Dimer	744		AGAP	10.0	
Chol	90	L	AST	22		PT	79.6	H	CK Total	26	L
Trig Lvl	74		Bili Total	1.1		INR	6.3	C	GFR African Am	>60	
HDL	18	L	Globulin	3.3		PTT	>400.0	C	GFR Non African Am	>60	
LDL Calc	57		Bili Direct	0.3		Sodium Lvl	135.0		CKMB	0.84	
07/19 19:45			A/G Ratio	1.00	L	Potassium Lvl	3.20	L	Troponin I	0.033	
CK Total	30	L	Bili Indirect	0.8		Chloride Lvl	93	L	T4 Total	8.690	
CKMB	0.91		07/19 11:10			CO2	32.0		T3 Uptake	55.9	H
Troponin I	0.035	H	WBC	9.1		Calcium Lvl	8.90		Hgb A1c	5.7	
07/19 17:40			RBC	4.18	L	BUN	30	H			

Reviewed Personally: [] Radiology [] Tele-findings [] Path [] PT note [] OT note [] ST note [] Other: _____

Case discussed with: _____ Time Spent: _____

SOAP Note

Vitals stable. Rate controlled A. fib. on bipap @ 10 ny/hr drip.

Ass: Right heart failure, Pericardial effusion. Chr A fib..

Contin diuresis, R/L Heart cath + Pericardiocentesis monday.

Need transfer

Active Inpatient Medications:

aspirin (Ecotrin) 325mg = 1tab Oral Daily ✓
carvedilol (Coreg) 6.25mg = 2tab Oral Q12hr ✓
digoxin (Lanoxin) 0.25mg = 1tab Oral Daily ✓
ferrous sulfate (Feosol) 325mg = 1tab Oral BID
levothyroxine (Synthroid) 0.1mg = 1tab Oral Daily
sodium chloride (NS flush) 10mL Flush Q8hr

Active PRN Medications:

Al hydroxide/Mg hydroxide/simethicone (Mylanta (with simethicone) II Maximum Strength) 30mL
acetaminophen (Tylenol) 650mg = 2tab Oral Q4hr
alprazolam (Xanax) 0.25mg = 1tab Oral Q6hr
aspirin 300mg = 1suppos Rectal Daily
bisacodyl (Dulcolax Laxative) 10mg = 2tab Oral Daily
bisacodyl (Dulcolax Laxative) 10mg = 1suppos Rectal Daily
magnesium hydroxide (Milk of Magnesia) 30mL Oral Daily
morphine 2mg = 0.5mL Injection As Directed
nalbuphine (Nubain) 5mg = 0.5mL Injection Q4hr
nitroglycerin (Nitrostat) 0.4mg = 1tab

Provider Signature _____ Staff # _____ Date/Time 7/20/13 · 1150am

Pg 1

[REPORT CONT]

MRN: 342675
Patient Name: DIBERNARDO, ANTHONY R

Facility: PMC
FIN: 100407386

Piedmont Medical Center

EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
7/19/13	Cardiology
4:20 PM	50 yr old ♂ → PMH — Noonan's syndrome (according to pt) diagnosed by Pediatrician in Albany, NY
	admitted c chronic LE edema & abd distension. Dyspnea on exertion. — h/o chronic pericardial effusion
	— h/o moderate mitral stenosis by gradient on Echo.
	BP 97/43 P 68
	JVD; chest - bil insp. crackles. — h/o Intracavitary gradient on prior Echo's
	CVS - S1+S2; irregular. No Murmurs.
	Abd - distended; Ext 2+ edema (LVOT gradient of 39 mm mean on 8/15)
	CXR → Cardiomegaly. — A fib for > 30 yrs — Thyroid disease.
	Echo today
	Nl LV function c mild LVH
	Bi atrial enlargement — severe.
	- Mean gradient of 8 mm across MV, although MV appears pliable with no 2D of mitral stenosis
	large pericardial effusion No echo of tamponade.
	Labs INR 6.3; H/H 9/29; K 3.2; Bun/Cr 30/1
	Liver biopsy → s/o → sinusoidal dilatation & other morphologic changes likely d/t chronic passive congestion, may be related to underlying cardiac disease.
A&P	predominantly (R) heart failure symptoms

(1) failure symptoms c LE edema; Distended Abd.
(2) ↑↑ INR
— Diuresis
(L) & (R) heart cath to r/o constrictive physiology.
& pericardiocentesis.

N. MORI

DOB: 12/26/1962

ACCT#100407386 MR # 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J K 07/19/2013
PIEDMONT MEDICAL CENTER

6/30/2013 1:05:00 AM EZ-2050

Piedmont Medical Center

EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
7.19.13 3:45 P	Renal 4/2 0125 Initiated ① Hypokalemia sK 3.2 ② sCr 1.0 ✓ urinalysis ③ chronic A-fib ④ chronic pericardial effusion ⑤ hypothyroidism ⑥ Anemia ⑦ congenital heart dz with MV stenosis ⑧ June 19th - sCr 3.1 ✓ [illegible] ERB

DOB:12/26/1962
ACCT#100407386 MR # 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J K 07/19/2013
PIEDMONT MEDICAL CENTER

Piedmont Medical Center

EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
7/19/13	CCA
1035	HTN AKI3 Anemia Hypothyroidism hx PMV
	Hx: 50 y/o ♂ admitted c̄ large pericardial effusion.
	hx of congenital CM. Maintained on Aldactone
	D/c'd 2° to AK. Now not responding to
	Lasix
	BP 118/68 P 78
	AOX3 Hepatomegaly ... ⊕ murmur ⊝ ...
	⊕ shifting dullness 1-2+ PE
	EKG:
	Echo 5/18 EF 55% RAE
	A/P: Pericardial effusion - now c̄ worsening ...
7/19/13	Echo done at 11:10am. ...
	... repeat echo / BMP, CBC, D Dimer
	TSH, T3, T4. Start ...
	... for pericardiocentesis ...
	will need ...
	Start ... Consult nephrology.
	[signature]
	— please see next page #4118771
	[signature] N. MORI

PROGRESS NOTES

DOB:12/26/1962

ACCT#100407386 MR # 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J K 07/18/2013
PIEDMONT MEDICAL CENTER

8/30/2013 1:05:00 AM EZ-2050

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Physician Progress Notes

Document Name:	Physician Progress Notes (Auth (Verified))
Performed By:	WOOTEN MD, SALLY M 07/24/2013 18:27:08 EDT
Signed By:	WOOTEN MD, SALLY M 07/31/2013 19:19:36 EDT
Authenticated By:	WOOTEN MD, SALLY M 07/31/2013 19:19:36 EDT

Progress Note
Patient Name: DIBERNARDO, ANTHONY R
DOB: 12/26/1962
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF SECOND PROGRESS NOTE: 7/24/2013

TIME: 5:30

SUBJECTIVE: Mr. Dibernardo is a 50-year-old gentleman with Noonan syndrome.

OBJECTIVE: Today, we placed him on a breathing trial did a blood gas. Blood gases on the breathing trial showed a pH of 7.39, pCO2 of 36 and pO2 of 107. His tidal volumes were in the 300-400 range. Respiratory rate was 29. He was awake, following commands. The patient denied shortness of breath. The patient was extubated and to BiPAP. He was placed on BiPAP initially 14/7. We increased it to 18/10. The patient had a repeat blood gas. It was essentially unchanged. The patient was doing fairly well until approximately between 5:00 and 5:15 when he suddenly desaturated. I talked with his wife and recommended re-intubating him. Initially, she agreed and then while getting ready to do it, the family came and requested a family meeting. Patty Smith was witnessed to the discussion. I talked to them about re-intubating him and resting him on the ventilator from 5-7 days and then trying again to see if we can get him off the ventilator. The family was extremely hesitant to put him back on the ventilator. According to them, his quality of life has been extremely poor for the last 3-4 months. He has been unable to do anything. He has not been able to get out of bed by himself without help. They absolutely do not want him to go to a nursing home. They do not want him to go to rehab. They basically state that he has out lived his life expectancy by multiple years. After much discussion with them and attempts to encourage them to allow us to re-intubate him, the family requested that he not be reintubated, that he be kept as comfortable as possible.

ASSESSMENT AND PLAN: The patient was made a do not resuscitate. Dr. Shah was made aware of the conversation.

Dictated by: SALLY M. WOOTEN, MD
TR:SMW/6N
DD:07/24/2013 17:59 EDT
DT:07/24/2013 18:26 EDT

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Physician Progress Notes

Document Name:	Physician Progress Notes (Auth (Verified))
Performed By:	WOOTEN MD, SALLY M 07/24/2013 18:27:08 EDT
Signed By:	WOOTEN MD, SALLY M 07/31/2013 19:19:36 EDT
Authenticated By:	WOOTEN MD, SALLY M 07/31/2013 19:19:36 EDT

JOB:9850051/4141633
PN-**-Progress Note-**-20130724182648
Electronically Signed on 07/31/2013 19:19 EDT

WOOTEN MD, SALLY M

Physician Progress Notes

Document Name: Physician Progress Notes (Auth (Verified))
Performed By: WOOTEN MD, SALLY M 07/24/2013 16:39:54 EDT
Signed By: WOOTEN MD, SALLY M 07/31/2013 19:19:45 EDT
Authenticated By: WOOTEN MD, SALLY M 07/31/2013 19:19:45 EDT

Progress Note
Patient Name: DIBERNARDO, ANTHONY R
DOB: 12/26/1962
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF PROGRESS NOTE: 7/24/2013

PROBLEMS: Respiratory failure.

HISTORY OF PRESENT ILLNESS: Patient is a 50-year-old with Noonan syndrome, congenital cardiomyopathy who was initially admitted for pericardiocentesis. The patient had complications with hemopericardium that required surgical intervention _____ window. He has remained on the ventilator, today is day #3. He was placed on a breathing trial today which he tolerated, blood gases were acceptable, we elected to extubate him. The patient himself is awake, responding, following commands but generally weak. His chart and his records have been reviewed.

PHYSICAL EXAMINATION:
VITAL SIGNS: His current blood pressure is 117/54, pulse is 84. His O2 sat on the ventilator was 100%. His vent settings were assist control of 14, tidal volume 470, PEEP of 5 and FiO2 of 40%. His I's and O's; he had 5177 in, 1906 out.
HEENT: He has severe exophthalmus. He is orally intubated.
NECK: He has a webbed neck.
CHEST: His breath sounds are equal although diminished bilaterally. They are short and shallow.
HEART: Regular rhythm. He has S3, S4, systolic murmur.
ABDOMEN: Rotund, soft. Bowel sounds are positive.
EXTREMITIES: He has brawny changes.
NEUROLOGIC: He is moving all extremities.

LABORATORY DATA: His white count is 11,200; hemoglobin is 7.4; hematocrit is 23.1; platelets are 105,000. Sodium is 141, potassium is 3.5, chloride is 109, bicarbonate is 23, calcium is 8.1, BUN is 24, creatinine is 1.2, blood sugar is 98, magnesium is 2, phosphorus is 3.1. Cultures of blood preliminarily are no growth. Chest x-ray shows massive cardiomegaly. There is prominence of interstitium. ET tube is in appropriate position. KUB is unremarkable.

IMPRESSION: The patient is a 50-year-old with the following:

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Physician Progress Notes

Document Name: Physician Progress Notes (Auth (Verified))
Performed By: WOOTEN MD, SALLY M 07/24/2013 16:39:54 EDT
Signed By: WOOTEN MD, SALLY M 07/31/2013 19:19:45 EDT
Authenticated By: WOOTEN MD, SALLY M 07/31/2013 19:19:45 EDT

1. Acute respiratory failure due to the postoperative state, his cardiomyopathy, general debility. At this point, the patient has tolerated spontaneous breathing trial. He has been extubated.
2. Congenital cardiomyopathy.
3. Noonan syndrome.
4. Hemopericardium.
5. Anemia secondary to acute blood loss.
6. Hypokalemia, which is improved.
7. General debility.
8. Mild thrombocytopenia.
9. Chronic atrial fibrillation.

PLAN:
1. Aggressive bronchial hygiene.
2. Monitor labs, chest x-ray.
3. BiPAP.
4. Diet as tolerated after checking a swallowing screen.
5. Discontinue the _____.
6. Further evaluation and treatment depending upon the response and the findings.

ADDENDUM: I did speak with his family. I did explain to them that we are going to try him off the ventilator; however, if he develops worsening respiratory distress, we will place him back. In the meantime, we are going to place him on BiPAP.

Critical care time has been greater than 40 minutes.

Dictated by: SALLY M. WOOTEN, MD
TR:SMW/BN
DD:07/24/2013 13:49 EDT
DT:07/24/2013 14:29 EDT
JOB:9847327/4140118
PN-**-Progress Note-**-20130724142903
Electronically Signed on 07/31/2013 19:19 EDT

WOOTEN MD, SALLY M

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Physician Progress Notes

Document Name: Physician Progress Notes (Auth (Verified))
Performed By: WOOTEN MD, SALLY M 07/23/2013 16:12:20 EDT
Signed By: WOOTEN MD, SALLY M 07/31/2013 19:19:29 EDT
Authenticated By: WOOTEN MD, SALLY M 07/31/2013 19:19:29 EDT

Progress Note
Patient Name: DIBERNARDO, ANTHONY R
DOB: 12/26/1962
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF PROGRESS NOTE: 7/23/2013

PROBLEMS: Respiratory failure.

HISTORY OF PRESENT ILLNESS: The patient is a 50-year-old with Noonan syndrome, who had to have an emergent pericardial window due to bleeding complicating a pericardiocentesis. The patient remained on the ventilator overnight. He is moving. This morning, we tried a breathing trial, but his respiratory rate was in the 30s. He was switched back to mechanical ventilation after about 10 minutes. Otherwise, there has been issues with his urine. Last evening, he was tachycardic and briefly did require pressors. When given fluids, he does seem to increase his urinary output; however, as soon as you back down on the fluids, then he becomes more anuric. He is on a Lasix drip. I did speak with Dr. Savage as well as Dr. Shah and we reviewed his echo. His LV function is good. His right ventricle is moving. His massive cardiomegaly is not explained well by echocardiogram, but there is no effusion at the current time. His chart and his records have been reviewed. Additionally, the patient was found to be dig toxic this morning with a dig level of 2.6.

PHYSICAL EXAMINATION:
VITAL SIGNS: His current heart rate 79-82, temperature is 99.2, blood pressure currently is 123/57. His O2 sats 100%. His CVP pressure is 20. His I's and O's, he had 5022 in and 1015 out. His pericardial drain is approximately 10-20 mL per hour. His vent settings, he has assist control with FiO2 of 40%, rate is 14, tidal volume 500, PEEP is 5.
HEENT: He has severe exophthalmus. We do have his eyes patched. He is orally intubated.
NECK: Thick _____.
CHEST: His breath sounds are equal. He has got a pectus excavatum. He has rales in both bases. No wheezing.
HEART: Irregularly irregular.
ABDOMEN: Slightly distended, but soft, slightly tympanic. I don't appreciate bowel sounds.
EXTREMITIES: He has brawny changes bilaterally.
NEUROLOGIC: He is answering questions. He is moving his extremities.

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Physician Progress Notes

Document Name:	Physician Progress Notes (Auth (Verified))
Performed By:	WOOTEN MD, SALLY M 07/23/2013 16:12:20 EDT
Signed By:	WOOTEN MD, SALLY M 07/31/2013 19:19:29 EDT
Authenticated By:	WOOTEN MD, SALLY M 07/31/2013 19:19:29 EDT

LABORATORY DATA: His white count 14,006; hemoglobin 7.8; hematocrit is 25.3; platelets are 120,000. His INR is 1.4. His fibrinogen is up to 195 from 148. Sodium is 138, potassium is 3.6, chloride is 104, bicarb is 26, calcium is 7.6, BUN is 26, creatinine is 1.4, albumin is 2.6. His total bili is 1.8. AST is 42, ALT is 15. Blood sugar is 88. His lactic acid was 1.2, magnesium 2, phosphorus is 2.8. Dig level is 2.6. Cultures are pending. Chest x-ray shows cardiomegaly, which is essentially unchanged. There is blunting of the left costophrenic angle.

IMPRESSION: The patient is a 50-year-old with the following:
1. Acute respiratory failure, which is multifactorial due to chest wall deformity, cardiomegaly, postoperative state. At the current time, the patient did not tolerate a breathing trial, although it is not clear if this was anxiety related. His current blood gases on the current vent settings, pH 7.49, pCO2 of 32, pO2 of 84.
2. Status post pericardial window.
3. Massive cardiomegaly.
4. Acute renal failure in that the patient is intermittently anuric. Question is whether this is related to his fluid status.
5. Anemia secondary to acute blood loss.
6. Digoxin toxicity.
7. Chronic atrial fibrillation.
8. Chronic edema.
9. Chronic anticoagulation.
10. Noonan syndrome.
11. Leukocytosis.

PLAN:
1. Continue vent support.
2. Increase fluid hydration.
3. Decrease the Lasix drip.
4. Albumin.
5. Monitor labs.
6. GI bleed and DVT prophylaxis.
7. Discontinue digoxin.
8. Beta-blockers for heart rate control.
9. _____ Xanax.
10. Hold any heparin or anticoagulation.

Critical care time has been greater than 40 minutes.

Patient:	**DIBERNARDO, ANTHONY R**		
MRN #:	342675	**Admission Date:**	07/19/2013
Account #:	100407386	**Discharge Date:**	07/24/2013
DOB/Age/Sex:	12/26/1962/51 years/Male	**Attending Provider:**	MORI MD, NARESH A; SHAH MD, J K

Discharge Summary Reports

Document Name:	Discharge Summary (Auth (Verified))
Performed By:	MORI MD, NARESH A 11/15/2013 02:11:53 EST
Signed By:	MORI MD, NARESH A 11/21/2013 12:54:44 EST
Authenticated By:	MORI MD, NARESH A 11/21/2013 12:54:44 EST

Discharge Summary

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

Patient Name: DIBERNARDO, ANTHONY R
MRN: 342675PMC
DOB: 12/26/1962
ACCT: 100407386PMC
ADM: 07/19/2013
DIS: 07/24/2013

HOSPITAL COURSE: Mr. Anthony Dibernardo was admitted on 7/19/2013 after he was noted to have significant lower extremity edema which had worsened compared to before. Patient has known history of Noonan syndrome and history of atrial fibrillation and prior history of pericardial effusion. He was admitted to hospital for diuresis for the lower extremity edema. Patient was then taken to the cath lab for pericardiocentesis using ultrasound and fluoroscopy guidance. Plan was also to perform left and right heart catheterization with simultaneous measurements of LV and RV pressures. However, this could not be done because of complications post-pericardiocentesis. During pericardiocentesis, patient had expression of hemorrhagic pericardial fluid. Likely consideration at this time was injury to the myocardium as a result of the needle injuring the myocardium. Patient was taken for urgent surgery and pericardial window was done which stabilized the patient. The patient was thereafter monitored in the ICU _____ on 7/24, patient went into respiratory distress and the patient's family decided to make the patient DNR at that time. Patient died thereafter.

Cause of death likely was cardiopulmonary arrest.

Dictated by: NARESH MORI, MD
TR:NM/BN
DD:11/14/2013 12:15 EST
DT:11/14/2013 21:24 EST

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: 12/26/1962/51 years/Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MORI MD, NARESH A; SHAH MD, J K

Discharge Summary Reports

Document Name: Discharge Summary (Auth (Verified))
Performed By: MORI MD, NARESH A 11/15/2013 02:11:53 EST
Signed By: MORI MD, NARESH A 11/21/2013 12:54:44 EST
Authenticated By: MORI MD, NARESH A 11/21/2013 12:54:44 EST

JOB:10745132/4400456
DS-**-Discharge Summary-**-20131114212406
Electronically Signed on 11/21/2013 12:54 EST

MORI MD, NARESH A

Physician Progress Notes

Document Name: Physician Progress Notes (Auth (Verified))
Performed By: CPDI Document 07/26/2013 13:41:05 EDT
Signed By:
Authenticated By:

STATE OF SOUTH CAROLINA
CERTIFICATION OF VITAL RECORD

State of South Carolina
Department of Health and Environmental Control
CERTIFICATE OF DEATH

State Birth Number

State File Number
13 025019

NAME OF DECEDENT — Anthony Robert DiBernardo
Forms 1-22c To Be Completed/Verified By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's, if any) (First, Middle, Last): Anthony Robert DiBernardo
2. SEX: Male
3. SOCIAL SECURITY: 085-58-1479
4a. AGE-Last Birthday (Years): 50
4b. UNDER 1 YEAR Months / Days
4c. UNDER 1 DAY Hours / Minutes
5. DATE OF BIRTH (MM/DD/YYYY): 12/26/1962
6. BIRTHPLACE (City and State or Foreign Country): Albany, NY
7a. RESIDENCE-STATE: South Carolina
7b. COUNTY: York
7c. CITY OR TOWN: Clover
7d. STREET AND NUMBER: 1010 Cloniger Street
7e. APT. NO.: Lot 36
7f. ZIP CODE: 29710
7g. INSIDE CITY LIMITS? ☐ Yes ☐ No
8. EVER IN US ARMED FORCES? ☐ Yes ☒ No
9. MARITAL STATUS AT TIME OF DEATH: ☒ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown
10. SURVIVING SPOUSE'S NAME (If Wife, give name prior to first marriage): Lorrie Moss
11. FATHER'S NAME (First, Middle, Last): Anthony P DiBernardo
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Maria Dallino
13a. INFORMANT'S NAME: Lorrie DiBernardo
13b. RELATIONSHIP TO DECEDENT: Family Member
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code): 1010 Cloniger Street, Clover, South Carolina 29710
14. PLACE OF DEATH (Check only one; see instructions)
IF DEATH OCCURRED IN HOSPITAL: ☒ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival
IF DEATH OCCURRED ELSEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify)
15. FACILITY NAME (If not institution, give street and number): Piedmont Medical Center
16. CITY OR TOWN, STATE AND ZIP CODE: Rock Hill, South Carolina 29732
17. COUNTY OF DEATH: York
18. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from state ☐ Other (Specify)
19. PLACE OF DISPOSITION (Name of Cemetery, crematory, other place): Moravian Cemetery
20. LOCATION-CITY, TOWN AND STATE: Staten Island, New York
21. NAME AND ADDRESS OF FUNERAL FACILITY: Bratton Funeral Home, Inc. PO Box 340 York, SC 29745
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT: Kenneth L Bratton (Electronically Verified)
23. LICENSE NUMBER (Of Licensee): 1900
23a. EMBALMER (Signature): J Henry Owen III
23b. EMBALMER LICENSE NUMBER: 3311
23c. LICENSE NUMBER (Of Facility): 602

Items 24-49 To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH
24. DATE PRONOUNCED DEAD (MM/DD/YYYY): 7/24/2013
25. TIME PRONOUNCED DEAD: 1745
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)
27. LICENSE NUMBER
28. DATE SIGNED (mm/dd/yyyy)
29. ACTUAL OR PRESUMED DATE OF DEATH (Spell Month): July 24 2013
30. ACTUAL OR PRESUMED TIME OF DEATH: 1745
31. WAS CORONER OR MEDICAL EXAMINER CONTACTED? ☐ Yes ☒ No

CAUSE OF DEATH (See instructions and examples)
32. PART I. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.
IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Respiratory failure — Due to (or as a consequence of):
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST: b. Pericardial effusion — Due to (or as a consequence of): c. — Due to (or as a consequence of): d. — Due to (or as a consequence of):
Approximate Interval Onset to death

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.
33. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No
35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown
36. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to one year before death ☐ Unknown if pregnant within the past year
37. MANNER OF DEATH: ☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined
38. DATE OF INJURY (Spell Month)
39. TIME OF INJURY
40. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)
41. INJURY AT WORK? ☐ Yes ☐ No
42. LOCATION OF INJURY: State: City or Town: County: Street & Number: Apartment Number: Zip Code:
43. DESCRIBE HOW INJURY OCCURRED:
44. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)
45. CERTIFIER (Check only one)
☐ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing and Certifying physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Coroner/Medical Examiner-On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
Signature of certifier:
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32): Jugal Kishor Shah 196 Cardiology Dr. Rock Hill SC 29732
46a. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER
47. TITLE OF CERTIFIER: MD
48. LICENSE NUMBER: 10867
49. DATE CERTIFIED (MM/DD/YYYY): 8/13/13
50. FOR REGISTRAR ONLY - DATE FILED (MM/DD/YYYY): August 13, 2013

EXHIBIT 10

SC03007679

ISSUED AUG 13 2013

This is a true certification of the facts on file in the Division of Vital Records, SC Department of Health and Environmental Control.

Catherine Templeton
Catherine Templeton
Director and State Registrar

Guang Zhao
Guang Zhao
Assistant State Registrar

This copy is not valid unless prepared on an engraved border displaying the state seal and issuing agency logo.

Revision Date: 03/21/2012

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

DHEC
PROMOTE PROTECT PROSPER
South Carolina Department of Health and Environmental Control

Exhibit 11—Fluoroscopy Readings

Please see flash drive

Exhibit 13—Pictures of:

Dilator, Introducer, Sheath and J. Wire

Please see flash drive

Request to Charge # ~~28~~ 29
Control of the instrumentality- Childers

"When a thing which causes injury is shown to be under the management of the defendant, and the accident is such as in the ordinary course of things does not happen if those who have management use proper care, it affords a reasonable evidence, in the absence of explanation by the defendant, that the accident arose from a want of care."
Childers v. Gas Lines, Inc., 248 S.E.2d 316 at 323-324.

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~~J~~une___, 2016
Rock Hill, SC