

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
The Court of Common Pleas for the Ninth Judicial Circuit

Hon. J. C. Nicholson, Jr., Circuit Court Judge

Appellate Case No. 2016-001986

Shon Turner, as Personal Representative
of the Estate of Charles Mikell, deceased, ... Appellant

v.

The Medical University of South Carolina Respondent

RECORD ON APPEAL - VOLUME II OF IV

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SC Court of Appeals

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STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)
-----) IN THE COURT OF
 COMMON PLEAS
 2012-CP-10-7275

SHON TURNER, as Personal)
Representative of the)
Estate of CHARLES MIKELL,)
Deceased,)
 Plaintiff) TRANSCRIPT OF RECORD
 vs.)
)
THE MEDICAL UNIVERSITY OF)
SOUTH CAROLINA,)
 Defendant)
-----)

APRIL 18, 19, 20, 21, 22, 25, 26, 2016
CHARLESTON, SOUTH CAROLINA

B E F O R E:

THE HONORABLE J.C. NICHOLSON, JR.

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INDEX

WITNESSES	DIRECT	CROSS	REDIR	RECROSS
DR. DANIELLE SCHEURER				
BY MR. RANSOM	135		145	
BY MR. COOKE		140		
DR. MARK PAYNE				
BY MR. RANSOM	146			
BY MS. FLEMING		157		
DR. GEORGE GULDAN				
BY MR. RANSOM	170		215	
BY MS. FLEMING		190		
SHEILA SCARBROUGH				
BY MR. RANSOM	224		259	
BY MS. FLEMING		231		
DR. JOHN HUGGINS				
BY MR. RANSOM	262		337	
BY MS. FLEMING		332		
DR. WILLIAM A. KOFKE				
BY MR. RANSOM	340		472	
BY MR. COOKE		407		
DONNA EMBREY				
BY MR. RANSOM	502		656	
BY MR. COOKE		585		662
MARK FIELDING				
BY MR. APOSTOLOU	660			
ANDRE SCOTT				
BY MR. APOSTOLOU	680			
BY MR. COOKE		689		
LOUANN ARTHUR				
BY MR. APOSTOLOU	690			

WITNESESS	DIRECT	CROSS	REDIR	RECROSS
DADRIAN MIKELL BY MR. APOSTOLOU	709			
MADISON MIKELL BY MR. APOSTOLOU	719			
DR. SCOTT REEVES BY MR. RANSOM BY MR. COOKE	729	746	757	759
DR. ADRIAN VAN BAKEL BY MS. FLEMING BY MR. RANSOM	786	808	812	
DR. MICHAEL ZILE BY MS. FLEMING BY MR. RANSOM	813	865		
JOHN FISHER BY MS. FLEMING BY MR. RANSOM	886	902		
DR. ERIC NELSON BY MR. COOKE BY MR. RANSOM	911	958	988	
DR. JAMES BERRY BY MS. FLEMING BY MR. COOKE	1007	1040		

PLAINTIFF'S EXHIBITS:	PAGE:
1. ANESTHESIA RECORD MUSC 502	584
2. ANESTHESIA RECORD MUSC 604	182
3. ANESTHESIA RECORD MUSC 494	478
4. ANESTHESIA RECORD MUSC 492	478
5. ANESTHESIA RECORD ONE MINUTE	478
6. ANESTHESIA RECORD TEN SECOND	478
7. REAL TIME GRAPHS	478
8. ANESTHESIA POLICES & BASIC STAND	584
9. EMERGENCY MEDICAL RESPONSE POLICY	209
10. EVENT AUDIT TRAIL	584
11. PATIENT AUDIT TRAIL	584
12. TEXT MESSAGES	361
14. COLONOSCOPY REPORT	157
15. DIAGNOSIS AND PROCEDURE SUMMARY	265
16. HIPAA REQUEST AND IOD INVOICE	762
17. INDUCED HYPOTHERMIA PHY. ORDERS	265
18. INDUCED HYPOTHERMIA NEUROLOGIC ASS.	265
19. AUDIT INPATIENT HISTORY	265
20. AUDIT VENTILATOR FLOW SHEET	265
21. 10/12/10 OPERATIVE NOTE TRACH	265
22. 10/15/10 PROCEDURE NOTE PICC	265
23. 10/16/10 CENTRAL VENOUS CATH NOTE	265
24. 10/17/10 OCCUPATIONAL THERAPY EVL.	265
25. 10/25/10 RIGHT INTERNAL JUGULAR	265
26. 10/26/10 CRITICAL CARE PROGRESS N.	265
27. 10/26/10 2010 TRANSFER FORM	265
28. HEMODIALYSES TREATMENT RECORDS	265
29. 10/26/10 2010 HOSPITAL DISCHARGE	265
30. 10/26/10 KINDRED HOS. HISTORY	265
31. 11/19/10 KINDRED HOS. TRANSFERS	265
37. 4/30/10 CARDIOLOGY OFFICE NOTE	867
39. 7/27/10 CARDIOLOGY OFFICE NOTE	382
40. 12/14/10 CARDIOLOGY OFFICE NOTE	382
45. PHOTOGRAPHS CHUCK MIKELL	698
46. PHOTOGRAPH OF DDC PROCEDURE ROOM	362
47. SUMMARY OF MEDICAL EXPENSES	762
51. SIGNATURE PAGE EMBREY	531

DEFENDANTS EXHIBITS:

PAGE:

1. NURSE'S NOTE	162
2. MAYDAY FORM	251/ 254
3. CPA EVENT DOC. INFO	ID. 236
4. ECHO REPORT	334
5. CT SCAN	334
6. ONE MINUTE CHART	432/ 599
7. MEDICAL RECORDS	793/ 867/ 871
8. MEDICAL RECORDS	815/ 869/ 1234

COURT'S EXHIBITS:

PAGE:

1. DEPO OF DR. KOFKE	482
2. DEPO OF EMBREY 8/26/14	583
3. DEPO OF EMBREY 2/22/14	583
4. REQUEST FOR ADMISSIONS	725
5. DEFENDANT MEMO	1084
6. DEPO JEWEL MIKELL	599
7. DEFENDANT CHARGE REQUEST	1234
8. JURY NOTE	
9. JURY NOTE	
10. JURY NOTE	
11. JURY NOTE	
12. TRANSCRIPT PAGE 32	

* * * Monday, April 18, 2016 * * *

THE COURT: Do we have everybody?

THE BAILIFF: We're waiting on one.

(Pause.)

(WHEREUPON, the jury panel enters the courtroom at approximately 12:08 p.m.)

THE COURT: Okay. All right. Ladies and gentlemen of the jury panel, we're getting ready to start the trial of Shon Mikell, as a Personal Representative of the Estate of Charles Mikell, vs. Medical University of South Carolina, which is commonly referred to locally as MUSC. And I'm going ask you a series of questions, and ask you to stand if the question is appropriate to you.

The first thing I'm going to do is call out a list of names. I'm going to ask you the same question about each individual. I'm going to ask you do you know the individual, are you related by blood or marriage, or have you been treated by the individual since some of the witnesses are medical doctors here in the local area.

The first name is Shon Turner. Is anybody related by blood or marriage, or does anybody know Shon Turner? It's S-h-o-n. If so, please stand.

1 (There was no response.)

2 THE COURT: The next name is Louann Arthur.
3 Does anybody know or is related by blood or marriage to
4 Louann Arthur? If so, please stand.

5 (There was no response.)

6 THE COURT: Next name is Dadrian Mikell. Is
7 anybody related by blood or marriage, or does anybody
8 know Mr. Mikell? If so, please stand.

9 (There was no response.)

10 THE COURT: The next name is Madison Mikell. Is
11 anybody related by blood or marriage or does anybody
12 Madison Mikell?

13 (There was no response.)

14 THE COURT: The next name is Marvin Lowery.
15 Does anybody know Marvin Lowery, or is anybody related
16 by blood or marriage to Mr. Lowery? If so, please
17 stand.

18 (There was no response.)

19 THE COURT: The next name is Mark Fielding.
20 Does anybody know Mark Fielding, is anybody related by
21 blood or marriage to Mark Fielding? If so, please
22 stand.

23 (There was no response.)

24 THE COURT: The next name is Andre Scott. Does
25 anybody know Andre Scott? Is anybody related by blood

1 or marriage? If so, please stand.

2 (There was no response.)

3 THE COURT: The next name is Donna Embrey.
4 She's a nurse anesthetist at MUSC. Is there anybody
5 related by blood or marriage to Donna Embrey, or does
6 anybody know Donna Embrey, or ever been treated by
7 Donna Embrey? If so, please stand.

8 (There was no response.)

9 THE COURT: The next name is Eric Nelson. He's
10 a doctor anesthesiologist at MUSC. Is anybody related
11 by blood or marriage to Dr. Eric Nelson, or does
12 anybody know Dr. Nelson, or been treated by Dr. Nelson?
13 If so, please stand.

14 (There was no response.)

15 THE COURT: The next name is Dr. Mark Payne,
16 gastroenterology at MUSC. Is anybody related by blood
17 or marriage, or has anybody been treated by Dr. Payne?
18 If so, please stand. Yes, ma'am, your name?

19 POTENTIAL JUROR: Nancy Holbach.

20 THE COURT: Do you know your number?

21 POTENTIAL JUROR: One thirty-five.

22 THE COURT: One thirty-five. Yes, ma'am. How
23 do you know Dr. Payne?

24 POTENTIAL JUROR: He did a colonoscopy probably
25 about ten years ago on me.

1 THE COURT: About two years ago?

2 POTENTIAL JUROR: Ten. Ten.

3 THE COURT: Oh, ten years ago. Okay. Have you
4 seen him in the last ten years?

5 POTENTIAL JUROR: No.

6 THE COURT: Okay. Do you have any bias or
7 prejudice toward Dr. Payne as a result of the
8 procedure?

9 POTENTIAL JUROR: No.

10 THE COURT: Can you be fair and impartial in
11 this case?

12 POTENTIAL JUROR: I guess I could. I am an
13 employee of MUSC.

14 THE COURT: Pardon?

15 POTENTIAL JUROR: I said, I'm an employee of
16 MUSC, but...

17 THE COURT: Okay. I haven't asked that question
18 but, we'll get to it.

19 POTENTIAL JUROR: Okay.

20 THE COURT: It's down the list a little bit.
21 Okay.

22 POTENTIAL JUROR: Okay.

23 THE COURT: You -- stand up if you would, and
24 we'll cover it while you are there. What do you do at
25 MUSC?

1 POTENTIAL JUROR: I'm a social worker in heart
2 and lung and L bad (ph) department.

3 THE COURT: All right. How long have you worked
4 at MUSC?

5 POTENTIAL JUROR: Off and on for eight years.
6 I've also been in the liver department, liver
7 transplant department.

8 THE COURT: Okay. Just have a seat. We'll talk
9 a little bit more when I get down to the question about
10 employee. Okay. Thank you very much. The next name
11 is Scott Reeves, a doctor in anesthesiology at MUSC.
12 Is anybody related by blood or marriage, or does
13 anybody know Dr. Reeves, or been treated by Dr. Reeves?
14 If so, please stand.

15 (There was no response.)

16 THE COURT: The next name is Dr. George J. --

17 MR. RANSOM: Guldán.

18 THE COURT: Guldán?

19 MR. RANSOM: Guldán.

20 THE COURT: Gundán?

21 MR. RANSOM: Yes, sir.

22 THE COURT: Dr. George J. Guldán, III,
23 anesthesiologist at MUSC. Has anybody been treated by
24 Dr. Guldán, or know Dr. Guldán, or related by blood or
25 marriage? If so, please stand.

1 (There was no response.)

2 THE COURT: The next name is J. Terrill Huggins,
3 doctor, Critical Care at MUSC. Is anybody related by
4 blood or marriage, or does anybody know Dr. Huggins, or
5 been treated by Dr. Huggins? If so, please stand.

6 (There was no response.)

7 THE COURT: The next name is Dr. Adrian Van
8 Bakel, a cardiologist pharmaceutical at MUSC. Anybody
9 related by blood or marriage to Dr. Bakel, or does
10 anybody know by Dr. Bakel, or been treated by Dr.
11 Bakel? If so, please stand.

12 POTENTIAL JUROR: I know Dr. Bakel.

13 (Juror 135.)

14 THE COURT: How do you know him?

15 POTENTIAL JUROR: He is one of the cardiologists
16 that work with the heart transplant patients that I do
17 psycho-socials on.

18 THE COURT: Okay. How long -- I think you
19 said -- that was where you work in the liver
20 transplant?

21 POTENTIAL JUROR: I have been in the heart
22 transplant department for two years, so I've known Dr.
23 Van Bakel for two years.

24 THE COURT: Do you ever see him on a social
25 basis?

1 MR. RANSOM: At a party once or twice a year --
2 once a year.

3 THE COURT: A MUSC party?

4 POTENTIAL JUROR: At Christmas, yes.

5 THE COURT: Do you ever see him outside of a
6 work type setting?

7 POTENTIAL JUROR: No, sir.

8 THE COURT: Can you be fair and impartial, both
9 to the State and the defendant -- excuse me, the
10 plaintiff and the defendant?

11 POTENTIAL JUROR: I don't know. I kind of side
12 on -- for doctors because I work for doctors.

13 THE COURT: I understand that. Okay. We'll
14 discuss that in private very shortly. Okay?

15 POTENTIAL JUROR: Okay.

16 THE COURT: Well, why don't you just come on up
17 and let's do it right now. Y'all can join me up here.

18 (The following side bar was reported.)

19 THE COURT: All right. Come right over here so
20 the court reporter can hear you. Come right over here.
21 Now, tell me what you were getting ready to tell me,
22 you favor doctors in what respect?

23 POTENTIAL JUROR: I believe they make decisions
24 in the best of their knowledge.

25 THE COURT: And you don't think --

1 POTENTIAL JUROR: I don't think they purposely
2 harm anyone, not purposely.

3 THE COURT: Not purposely?

4 POTENTIAL JUROR: No.

5 THE COURT: But do you think they make mistakes?

6 POTENTIAL JUROR: Everybody makes mistakes, yes,
7 sir.

8 THE COURT: I said, do you think doctors make
9 mistakes?

10 POTENTIAL JUROR: Yes, sir.

11 THE COURT: But you tend to -- you side with the
12 doctors if there's any question about the mistake?

13 POTENTIAL JUROR: Yes, sir.

14 THE COURT: You would always side with the
15 doctors?

16 POTENTIAL JUROR: I guess. It depends on the
17 circumstances, but...

18 THE COURT: Any questions?

19 POTENTIAL JUROR: By the way, Dr. Van Bakel also
20 is the one who decided to hire me two years ago in that
21 department.

22 THE COURT: Okay. Any questions from the
23 plaintiff?

24 MR. APOSTOLOU: No.

25 THE COURT: Defendant?

1 MR. COOKE: No questions.

2 THE COURT: You can go have a seat. Any motions
3 on her, for cause?

4 MR. RANSOM: Yes. Judge, I move to strike her
5 for cause just because she's an employee and she knows
6 these folks.

7 THE COURT: I'm going to strike her.

8 MR. COOKE: I think you probably need to.

9 THE COURT: I'm going to strike for cause since
10 she's an employee and she knows two of the doctors.
11 And I think she's -- as she said, says she's for the
12 doctors.

13 MR. COOKE: I think she would be a great juror,
14 but you're probably right.

15 THE COURT: I think she would be great for you.

16 MR. RANSOM: Thank you, Your Honor.

17 (End of side bar.)

18 THE COURT: The next name is Dr. Michael Zile --
19 is it Zile, Zale -- Zile. Dr. Michael Zile,
20 cardiology, MUSC. Anybody related by blood or
21 marriage, or anybody know Dr. Zile or been treated by
22 Dr. Zile? If so, please stand.

23 (There was no response.)

24 THE COURT: The next name is Sheila Scarbrough,
25 Director of Risk Management and Patient Safety at MUSC.

1 Is anybody related by blood or marriage, or anybody
2 know Sheila Scarborough? If so, please stand.

3 (Juror 135.)

4 THE COURT: Yes, ma'am. You can have a seat.
5 Thank you very much.

6 (There was no response.)

7 THE COURT: Anybody else? The next name is
8 Patricia Aysse. Patricia Aysse, Former Clinical
9 Coordinator for PICIS system at MUSC; anybody related
10 by blood or marriage, or does anybody know Patricia
11 Aysse? If so, please stand.

12 POTENTIAL JUROR: Does she spell her last name
13 A-s-s-e-y?

14 THE COURT: A-y-s-s-e. A different spelling.
15 Do you know somebody by that name?

16 POTENTIAL JUROR: Yeah. I used to work at MUSC.
17 I'm retired from there.

18 THE COURT: Okay.

19 POTENTIAL JUROR: And she was a nurse RN, worked
20 in cardiology.

21 THE COURT: Okay. All right. What is your
22 name?

23 POTENTIAL JUROR: My name is Julia Smithlewis.

24 THE COURT: Do you know your number?

25 POTENTIAL JUROR: Two-eighty.

1 THE COURT: Two-eighty?

2 POTENTIAL JUROR: Uh-huh.

3 THE COURT: Okay, Ms. Smithlewis, thank you very
4 much. Dr. Daniel Scheurer S-c-h-e-u-r-e-r, Chief
5 Quality Officer at MUSC. Is there anybody related by
6 by blood or marriage, or does anybody know Dr.
7 Scheurer? If so, please stand.

8 (There was no response.)

9 THE COURT: The next name is Annette Thompson.
10 Anybody related by blood or marriage, or does anybody
11 know Annette Thompson? If so, please stand.

12 (There was no response.)

13 THE COURT: The next name is Andrew Kofke,
14 doctor of Anesthesiology and Critical Care in
15 Pennsylvania. Is anybody related by blood or marriage
16 to Dr. Andrew Kofke, or does anybody know Dr. Kofke?
17 If so, please stand.

18 (There was no response.)

19 THE COURT: The next name is Dr. James B. Berry,
20 Nashville, Tennessee, anesthesiologist. Does anybody
21 know Dr. James Berry, or is related by blood or
22 marriage to James Berry? If so, please stand.

23 (There was no response.)

24 THE COURT: The next name is Bobbi Jo O'Neal,
25 Deputy Coroner here in Charleston. Is anybody related

1 by blood or marriage, or does anybody know Bobbi Jo
2 O'Neal? If so, please stand.

3 (There was no response.)

4 THE COURT: The next name is Dr. Richard
5 Browder. Anybody related by blood or marriage, or does
6 anybody know Dr. Richard Browder, or been treated by
7 Dr. Browder? If so, please stand.

8 (There was no response.)

9 THE COURT: The next name is Dr. Jeffrey M.
10 Akhtar. Is anybody related by blood or marriage, or
11 does anybody know Dr. Akhtar? It's A-k-h-t-a-r. If
12 so, please stand.

13 (There was no response.)

14 THE COURT: The next name is John Fisher. Is
15 anybody related by blood or marriage, or does anybody
16 know John Fisher? If so, please stand.

17 (There was no response.)

18 THE COURT: The next name is Dr. George M.
19 Inabinet. Is anybody related by blood or marriage, or
20 does anybody know Dr. George M. Inabinet, or been
21 treated by Dr. Inabinet? If so, please stand.

22 (There was no response.)

23 THE COURT: Is any member of the jury panel, or
24 any member of your immediate family, ever been a
25 plaintiff in a lawsuit? A plaintiff is the person that

1 brings the lawsuit. If so, please stand.

2 (There was no response.)

3 THE COURT: Is any member of the jury panel or a
4 member of your immediate family been a defendant in a
5 lawsuit? A defendant is the person that the lawsuit is
6 brought against. If so, please stand. Yes, sir, your
7 name.

8 POTENTIAL JUROR: Lorin Lawrence, 170.

9 THE COURT: One-seventy. Yes, sir, Mr.
10 Lawrence, what type of suit was it?

11 POTENTIAL JUROR: It was a contractual
12 disagreement.

13 THE COURT: How long ago was it?

14 POTENTIAL JUROR: Four or five years ago.

15 THE COURT: Four or five years ago. Did it go
16 to a jury trial or was it settled, or how was it
17 resolved?

18 POTENTIAL JUROR: No. It was basically dropped.

19 THE COURT: It was dropped. Okay. Do you have
20 any bias or prejudice as a result of being a defendant
21 in that lawsuit?

22 POTENTIAL JUROR: I don't think so.

23 THE COURT: Can you be fair and impartial in
24 this case?

25 POTENTIAL JUROR: I will do my best.

1 THE COURT: Can you be fair to both the
2 plaintiff and the defendant?

3 POTENTIAL JUROR: I'll do my best.

4 THE COURT: Can you base your decision on
5 testimony you hear in the courtroom?

6 POTENTIAL JUROR: Correct.

7 THE COURT: Not based on your prior experience
8 as a defendant; is that correct?

9 POTENTIAL JUROR: Correct.

10 THE COURT: All right. Thank you, Mr. Lawrence.
11 Mr. Ransom, you want to stand and introduce yourself.

12 MR. RANSOM: Thank you, Your Honor. Good
13 morning, ladies and gentlemen. My name is Rob Ransom.
14 I'm a lawyer up in Columbia. I practice with the law
15 firm of Leventis & Ransom.

16 THE COURT: Introduce yourself.

17 MR. APOSTOLOU: I'm Alex Apostolou. I'm an
18 attorney here in Charleston. My office is in North
19 Charleston. I practice for the Apostolou Law Firm.

20 THE COURT: Is any member of the jury panel a
21 friend or acquainted with Mr. Ransom or Mr. Apostolou,
22 or been represented by either party or anyone in their
23 law firm? If so, please stand.

24 (There was no response.)

25 THE COURT: Mr. Cooke, if you'll stand and

1 introduce yourself.

2 MR. COOKE: Thank you, Your Honor. I'm Dawes
3 Cooke. I'm with the law firm Barnwell Whaley Patterson
4 & Helms here in Charleston.

5 MS. FLEMING: My name is Alissa Fleming. And
6 I'm with the law firm of Barnwell Whaley Patterson &
7 Helms here in Charleston.

8 THE COURT: All right. Any member of the jury
9 panel social friends or acquaintances with either Mr.
10 Cooke or Ms. Fleming, or anyone else in their law firm,
11 or been represented by anyone in the law firm or them
12 personally? If so, please stand. Yes, ma'am. Your
13 name.

14 POTENTIAL JUROR: Angela Valmus, 314.

15 THE COURT: Three fourteen. Yes, ma'am. Who
16 represented you?

17 POTENTIAL JUROR: I just had a friendship with
18 someone in their law firm.

19 THE COURT: Who?

20 POTENTIAL JUROR: Bruce Miller.

21 THE COURT: All right. You -- a friendship?

22 POTENTIAL JUROR: Not --

23 THE COURT: Tell me about the friendship.

24 POTENTIAL JUROR: Friends with his family.

25 THE COURT: Do see him on a regular basis or

1 occasionally or what?

2 POTENTIAL JUROR: No. I ran into him about
3 three weeks ago, but I rarely see him.

4 THE COURT: I mean, did you go to him for legal
5 advice, or is he in your neighborhood --

6 POTENTIAL JUROR: No. No legal advice. It was
7 a personal friendship.

8 THE COURT: Pardon? Pardon?

9 POTENTIAL JUROR: It was a personal friendship.

10 THE COURT: All right. You ran into him three
11 weeks ago. Have you seen him since then?

12 POTENTIAL JUROR: No, sir.

13 THE COURT: Do you anticipate seeing him again?

14 POTENTIAL JUROR: No, sir.

15 THE COURT: All right. Would that cause you any
16 difficulty in sitting on this jury?

17 POTENTIAL JUROR: No, sir.

18 THE COURT: Can you be fair and impartial to
19 both the plaintiff and the defendant?

20 POTENTIAL JUROR: Yes.

21 THE COURT: Can you base your decision on
22 testimony you hear in the courtroom?

23 POTENTIAL JUROR: Can you say that again?

24 THE COURT: Can you base your decision on the
25 testimony you hear in the courtroom?

1 POTENTIAL JUROR: Yes.

2 THE COURT: And not with your friendship -- I
3 forget the gentleman's name.

4 POTENTIAL JUROR: Correct.

5 THE COURT: All right. Thank you, very much.
6 Yes, sir. Your name?

7 POTENTIAL JUROR: Daniel -- Daniel Jost.

8 THE COURT: Do you know your number?

9 POTENTIAL JUROR: One fifty-six.

10 THE COURT: Yes, sir, Mr. Jost.

11 POTENTIAL JUROR: I used to do consulting for
12 Mr. Dawes' law firm.

13 THE COURT: What type of consulting work?

14 POTENTIAL JUROR: Information Technology
15 consulting?

16 THE COURT: I'm sorry. What?

17 POTENTIAL JUROR: IT consulting, computer
18 consulting.

19 THE COURT: All right. How long ago was this?

20 POTENTIAL JUROR: More than seven years ago.

21 THE COURT: Who was your contact in the law
22 firm?

23 POTENTIAL JUROR: Donald Lagdon (ph) and I had
24 some interaction with ---

25 COURT REPORTER: I'm sorry, Your Honor. I can't

1 hear him.

2 THE COURT: Speak up. We can't hear you.

3 POTENTIAL JUROR: Donald Lagdon was their office
4 manager, and I did most of the work with him.

5 THE COURT: So that's who you worked with as
6 office manager?

7 POTENTIAL JUROR: Yes.

8 THE COURT: Did you know Mr. Cooke?

9 POTENTIAL JUROR: I recognize him, but I don't
10 think I remember him.

11 THE COURT: So that was seven years ago?

12 POTENTIAL JUROR: Yes.

13 THE COURT: Do you have any bias or prejudice
14 against that law firm since you worked for them for a
15 while?

16 POTENTIAL JUROR: No, sir, I do not.

17 THE COURT: Can you set that aside and be fair
18 and impartial in this case?

19 POTENTIAL JUROR: Yes, sir.

20 THE COURT: Can you base your decision on
21 testimony you hear in the courtroom?

22 POTENTIAL JUROR: Yes, sir.

23 THE COURT: Thank you, Mr. Jost. Yes, ma'am.
24 If y'all -- if y'all -- if y'all stand up and keep
25 standing, stretch your legs. Stand up -- instead of

1 standing up one at a time, so I'll know how many people
2 we got out there that I got to question. What's your
3 name?

4 POTENTIAL JUROR: Patricia Lee.

5 THE COURT: What's your number?

6 POTENTIAL JUROR: One seventy-three.

7 THE COURT: One seventy-six?

8 POTENTIAL JUROR: One seventy-three.

9 THE COURT: Okay. Thank you, ma'am. Yes,
10 ma'am, Ms. Lee, who do you know?

11 POTENTIAL JUROR: Mr. Cooke indirectly.

12 THE COURT: How do you know him?

13 POTENTIAL JUROR: He's the attorney for my
14 employer.

15 THE COURT: He's what?

16 POTENTIAL JUROR: The attorney for my employer.

17 THE COURT: Okay. Have you had any direct
18 contact with him?

19 POTENTIAL JUROR: None at all.

20 THE COURT: Do you know him other than he
21 represents your employer?

22 POTENTIAL JUROR: No, sir.

23 THE COURT: Have you been involved in any
24 conversations with -- between him and your employer?

25 POTENTIAL JUROR: No, sir.

1 THE COURT: Do you think that would cause you
2 any difficulty in sitting on this jury?

3 POTENTIAL JUROR: It would not.

4 THE COURT: Pardon?

5 POTENTIAL JUROR: It would not.

6 THE COURT: It would not -- can you be fair and
7 impartial to both the plaintiff and the defendant?

8 POTENTIAL JUROR: Yes, sir.

9 THE COURT: Can you base your decision on the
10 testimony you hear in the courtroom?

11 POTENTIAL JUROR: Yes, sir.

12 THE COURT: Thank you, Ms. Lee. Is any member
13 of the jury panel or member of your immediate family
14 been a patient at Medical University South Carolina?
15 If so, please stand.

16 All right. Starting on my left with the
17 gentleman in the back. When were you a patient and how
18 long ago was it?

19 POTENTIAL JUROR: All my health is there. I've
20 got my cardiologist, Dr. Neilson. And I've been under
21 their care now for about five years.

22 THE COURT: All right. And what is your name?

23 POTENTIAL JUROR: William Buckey Waters, number
24 384 I believe.

25 THE COURT: Three eighty-four?

1 THE CLERK: Three twenty-eight, Your Honor.

2 THE COURT: Three twenty-eight. All right.

3 Mr. Waters, would that cause you any difficulty in
4 sitting on this jury since MUSC is the defendant in
5 this action?

6 POTENTIAL JUROR: No, sir.

7 THE COURT: Can you be fair and impartial?

8 POTENTIAL JUROR: I can.

9 THE COURT: Can you base your decision on the
10 testimony you hear in the courtroom?

11 POTENTIAL JUROR: I can.

12 THE COURT: Thank you. Mr. Waters. Yes, sir,
13 your name?

14 POTENTIAL JUROR: Jerome Glover, 105.

15 THE COURT: Yes, sir, Mr. Glover.

16 POTENTIAL JUROR: My wife saw a MUSC doctor
17 about four years ago in the neurology department.

18 THE COURT: She was there?

19 POTENTIAL JUROR: She was. She saw a doctor in
20 neurology.

21 THE COURT: Okay. Your wife did?

22 POTENTIAL JUROR: Yes, sir.

23 THE COURT: But you haven't?

24 POTENTIAL JUROR: No, sir.

25 THE COURT: Just your wife?

1 POTENTIAL JUROR: Just my wife.

2 THE COURT: All right. Would that cause you any
3 difficulty in sitting on this jury?

4 POTENTIAL JUROR: No, sir.

5 THE COURT: Can you be fair and impartial to the
6 plaintiff and the defendant?

7 POTENTIAL JUROR: Yes, sir.

8 THE COURT: I didn't hear your answer?

9 POTENTIAL JUROR: Yes, sir.

10 THE COURT: Thank you, Mr. Glover. Yes, ma'am.

11 POTENTIAL JUROR: Shelley Cannon, number 42.

12 THE COURT: You got to speak up.

13 POTENTIAL JUROR: Shelley Cannon, number 42. My
14 son is a -- a patient there. He was pediatric, but he
15 sees Dr. Ted Mire, and he's the ENT. We haven't dealt
16 with any of the other doctors.

17 THE COURT: Just your son?

18 POTENTIAL JUROR: Just my son, but I've always
19 had to be with him because he is --

20 THE COURT: How old is your son?

21 POTENTIAL JUROR: He's now 18.

22 THE COURT: Okay. Would that cause you any
23 difficulty in sitting on this jury?

24 POTENTIAL JUROR: No, sir.

25 THE COURT: Can you be fair and impartial to

1 both the plaintiff and the defendant?

2 POTENTIAL JUROR: Yes, sir.

3 THE COURT: Thank you very much. Yes, ma'am.
4 The lady in the white and pink.

5 POTENTIAL JUROR: Lauren Collins, number 51.

6 THE COURT: Fifty-one. Yes, ma'am, Ms. Collins.

7 POTENTIAL JUROR: They delivered my twins about
8 three years ago, and I'm also an employee.

9 THE COURT: All right. Who -- what department
10 did you see two years ago?

11 POTENTIAL JUROR: OBGYN.

12 THE COURT: Okay. Do you have any bias or
13 prejudice as a result of your experience at MUSC?

14 POTENTIAL JUROR: No, sir.

15 THE COURT: Do you have any difficulty sitting
16 on this jury?

17 POTENTIAL JUROR: No, sir.

18 THE COURT: Can you be fair and impartial to
19 both the plaintiff and the defendant?

20 POTENTIAL JUROR: Yes, sir.

21 THE COURT: Thank you, very much. Yes, ma'am.
22 Hold on just a second. Yes, ma'am.

23 POTENTIAL JUROR: Laura Varn, 315. All of my --

24 THE COURT: Hold on just a second. I'm not that
25 quick. What number now?

1 POTENTIAL JUROR: Three one five.

2 THE COURT: Three one five?

3 POTENTIAL JUROR: Yes, sir.

4 THE COURT: Yes, ma'am, Ms. Varn.

5 POTENTIAL JUROR: All of my care is at MUSC.

6 THE COURT: Okay. What departments?

7 POTENTIAL JUROR: OBGYN, dermatology, primary
8 care.

9 THE COURT: How long have you been a patient
10 there?

11 POTENTIAL JUROR: Two years.

12 THE COURT: Would that cause you any difficulty
13 sitting on this jury?

14 POTENTIAL JUROR: No, sir.

15 THE COURT: Can you be fair and impartial to
16 both the plaintiff and the defendant?

17 POTENTIAL JUROR: Yes, sir.

18 THE COURT: Can you base your decision on
19 testimony here in the courtroom?

20 POTENTIAL JUROR: Yes, sir.

21 THE COURT: Thank you, Ms. Varner. Yes, sir.

22 POTENTIAL JUROR: William Hilton, 133.

23 THE COURT: One thirty-three. Yes, sir, Mr.
24 Hilton.

25 POTENTIAL JUROR: My daughter, when she born,

1 spent a little bit of time in the Neonatal Care Unit
2 there.

3 THE COURT: Do you have any bias or prejudice
4 towards MUSC since that?

5 POTENTIAL JUROR: No, sir.

6 THE COURT: Can you be fair and impartial to
7 both the plaintiff and the defendant?

8 POTENTIAL JUROR: Yes, sir.

9 THE COURT: Do you have any difficulty sitting
10 on the jury since your daughter was a patient at MUSC?

11 POTENTIAL JUROR: No, sir.

12 THE COURT: Can you base your decision on
13 testimony you hear in the courtroom?

14 POTENTIAL JUROR: Yes, sir.

15 THE COURT: All right. Thank you very much.
16 Yes, sir.

17 POTENTIAL JUROR: David Tucker, 308.

18 THE COURT: Yes, sir, Mr. Tucker.

19 POTENTIAL JUROR: My son was born there, and he
20 was also involved in a bone density study when he was
21 eight years old.

22 THE COURT: How long ago was that?

23 POTENTIAL JUROR: Seven years.

24 THE COURT: Do have any bias or prejudice
25 towards MUSC as result of your son's involvement with

1 MUSC?

2 POTENTIAL JUROR: No.

3 THE COURT: Can you be fair and impartial to
4 both the plaintiff and the defendant?

5 POTENTIAL JUROR: Yes.

6 THE COURT: Can you base your decision on
7 testimony you hear in the courtroom?

8 POTENTIAL JUROR: Yes.

9 THE COURT: Thank you, sir. Yes, ma'am. You
10 were retired?

11 POTENTIAL JUROR: Yes.

12 THE COURT: How long you been retired?

13 POTENTIAL JUROR: Since 2009, I think it is. I
14 worked there 31 years.

15 THE COURT: What is your number?

16 POTENTIAL JUROR: Two eighty.

17 THE COURT: Two eighty. I thought I had you
18 marked. Okay. Go ahead.

19 POTENTIAL JUROR: My brother was a patient there
20 a year ago in the intensive Care Unit.

21 THE COURT: And you retired when?

22 POTENTIAL JUROR: In 2009 happily.

23 THE COURT: You've been retired for what six,
24 seven years?

25 POTENTIAL JUROR: Yeah.

1 THE COURT: Have you worked anywhere else?

2 POTENTIAL JUROR: Yeah, A Cleaning Solution.

3 THE COURT: What did you do at MUSC?

4 POTENTIAL JUROR: I was a secretary, and I
5 worked in numerous departments.

6 THE COURT: What -- what department?

7 POTENTIAL JUROR: The last department I worked
8 was Oncology with Doctor Carolyn Reed and --

9 THE COURT: Would that cause you any difficulty
10 sitting on this jury?

11 POTENTIAL JUROR: No, sir.

12 THE COURT: I'm sorry?

13 POTENTIAL JUROR: No.

14 THE COURT: Can you be fair and impartial to
15 both the plaintiff and the defendant?

16 POTENTIAL JUROR: Yes.

17 THE COURT: Can you base your decision on the
18 testimony you hear in the courtroom?

19 POTENTIAL JUROR: Uh-huh.

20 THE COURT: Thank you, Ms. Smithlewis.

21 POTENTIAL JUROR: You're welcome.

22 THE COURT: Yes, ma'am. Your name? I'm sorry.
23 You're sneaking standing up over there. What's your
24 name?

25 POTENTIAL JUROR: Charlene Gathers, number 99.

1 THE COURT: One ninety-nine.

2 POTENTIAL JUROR: Ninety-nine.

3 THE COURT: Yes, Ms. Gathers.

4 POTENTIAL JUROR: I was patient there and also
5 my son was as well.

6 THE COURT: I'm sorry. Speak up.

7 POTENTIAL JUROR: I was a patient there and my
8 son was.

9 THE COURT: How long ago?

10 POTENTIAL JUROR: It's been a while, probably
11 more than ten years.

12 THE COURT: Which department?

13 POTENTIAL JUROR: My son was in the Children's
14 Hospital, and I was in the eye surgery.

15 THE COURT: All right. How long ago did you say
16 it was?

17 POTENTIAL JUROR: More than ten years.

18 THE COURT: Okay. More than ten years ago?

19 POTENTIAL JUROR: Yes, sir.

20 THE COURT: Do you have any difficulty in
21 sitting on this jury as a result of that?

22 POTENTIAL JUROR: No, sir.

23 THE COURT: Can you be fair and impartial to
24 both the plaintiff and defendant?

25 POTENTIAL JUROR: Yes, sir.

1 THE COURT: Thank you very much. Yes, ma'am.

2 POTENTIAL JUROR: Jodi Truluck, 306.

3 THE COURT: Three zero six? Yes, ma'am, Ms.

4 Truluck.

5 POTENTIAL JUROR: My father was a patient -- has
6 been a patient multiple times at MUSC, but it's been
7 years -- probably -- the last time was probably five
8 years ago, six years ago.

9 THE COURT: Do you have any bias or prejudice
10 towards MUSC as a result of treatment your father
11 received?

12 POTENTIAL JUROR: No.

13 THE COURT: Can you be fair and impartial to
14 both the plaintiff and the defendant?

15 POTENTIAL JUROR: Yes.

16 THE COURT: Do you have any personal reasons why
17 you couldn't sit on the jury with MUSC being the
18 defendant?

19 POTENTIAL JUROR: No, sir.

20 THE COURT: Can you base your decision on
21 testimony you hear in the courtroom?

22 POTENTIAL JUROR: Yes, sir.

23 THE COURT: Thank you, ma'am. Yes, ma'am.

24 POTENTIAL JUROR: Patricia Lee, 173.

25 THE COURT: Yes, ma'am, Ms. Lee.

1 POTENTIAL JUROR: My father was a patient at
2 Medical University off and on for the past six years.

3 THE COURT: Can you be fair and impartial to
4 both the State -- excuse me -- both the plaintiff and
5 the defendant?

6 POTENTIAL JUROR: Yes.

7 THE COURT: Do you have any difficulty sitting
8 on this jury?

9 POTENTIAL JUROR: No, sir.

10 THE COURT: Do you have any bias or prejudice as
11 a result of the treatment that your father received?

12 POTENTIAL JUROR: No, sir.

13 THE COURT: Thank you, Ms. Lee. Yes, ma'am.

14 POTENTIAL JUROR: Fran Cote, juror number 59.

15 My grandfather --

16 THE COURT: Hold on just a second.

17 POTENTIAL JUROR: I'm sorry.

18 THE COURT: All right. Go ahead.

19 POTENTIAL JUROR: My grandfather, both my
20 parents and my son are patients at MUSC.

21 THE COURT: Presently or in the past?

22 POTENTIAL JUROR: Well, my son had surgery there
23 five years ago. My parents see a score of doctors
24 there, and so does my 94 year old grandfather.

25 THE COURT: All right. Do you have any bias or

1 prejudice toward MUSC as a result of treatment they
2 received?

3 POTENTIAL JUROR: No, sir.

4 THE COURT: Can you be fair and impartial to
5 both the plaintiff and the defendant in this case?

6 POTENTIAL JUROR: Yes, sir.

7 THE COURT: Can you base your decision on the
8 testimony you hear in the courtroom?

9 POTENTIAL JUROR: Yes, sir.

10 THE COURT: Thank you very much. Yes, ma'am,
11 lady in black.

12 POTENTIAL JUROR: Alicia White, 332.

13 THE COURT: Three thirty-two?

14 POTENTIAL JUROR: Yes.

15 THE COURT: Yes, ma'am, Ms. White.

16 POTENTIAL JUROR: Patient OBGYN Department for
17 about a year.

18 THE COURT: When is the last time you were
19 there?

20 POTENTIAL JUROR: January.

21 THE COURT: Of this year?

22 POTENTIAL JUROR: Yes.

23 THE COURT: Do you have any bias or prejudice
24 towards MUSC from the treatment you received?

25 POTENTIAL JUROR: No, sir.

1 THE COURT: Can you set that treatment aside and
2 be fair and impartial in this case?

3 POTENTIAL JUROR: Yes, sir.

4 THE COURT: Can you base your decision on
5 testimony you hear in the courtroom?

6 POTENTIAL JUROR: Yes, sir.

7 THE COURT: Thank you very much. Yes, sir.

8 POTENTIAL JUROR: Dustin Tincher, 300.

9 THE COURT: Yes, sir, Mr. Tincher.

10 POTENTIAL JUROR: I had surgery there on my hip
11 about three years ago. And my sister is a nurse there
12 currently.

13 THE COURT: Do you have any bias or prejudice
14 toward or against?

15 POTENTIAL JUROR: No, sir.

16 THE COURT: Can you be fair and impartial to
17 both the plaintiff and the defendant?

18 POTENTIAL JUROR: Yes.

19 THE COURT: Can you base your decision on
20 testimony you hear in the courtroom?

21 POTENTIAL JUROR: Yes.

22 THE COURT: Thank you, Mr. Tincher. Yes, sir.

23 POTENTIAL JUROR: James Koonce, 164.

24 THE COURT: Yes, sir, Mr. Koonce.

25 POTENTIAL JUROR: My wife was a patient there

1 about a year and a half ago. And I worked there for 19
2 years, and saw physicians while I was employed there.

3 THE COURT: Do you -- did you get patient
4 treatment there?

5 POTENTIAL JUROR: Yes, sir.

6 THE COURT: How often did you get patient
7 treatment?

8 POTENTIAL JUROR: I haven't in the last 20
9 years, but I did before then.

10 THE COURT: Okay. But your wife was a patient?

11 POTENTIAL JUROR: Yes, sir.

12 THE COURT: All right. Do you have any bias or
13 prejudice as a result of treatment your wife received?

14 POTENTIAL JUROR: No.

15 THE COURT: Can you be fair and impartial?

16 POTENTIAL JUROR: Yes.

17 THE COURT: Thank you, Mr. Koonce.

18 POTENTIAL JUROR: Lorin Lawrence, 170.

19 THE COURT: Yes, sir, Mr. Lawrence.

20 POTENTIAL JUROR: About a month ago, I was a
21 patient for a physical exam within MUSC, just once.

22 THE COURT: Do you go there on a regular basis?

23 POTENTIAL JUROR: No.

24 THE COURT: For medical care?

25 POTENTIAL JUROR: (Nodded negatively.)

1 THE COURT: Somebody sent you there for a -- say
2 yes or no, instead of shaking your head.

3 POTENTIAL JUROR: (Nodded negatively.)

4 THE COURT: Pardon?

5 POTENTIAL JUROR: I do not get regular care. It
6 was just one visit.

7 THE COURT: One visit. Do you have any bias or
8 prejudice towards MUSC as a result of that visit?

9 POTENTIAL JUROR: I do not.

10 THE COURT: Can you be fair and impartial to
11 both the plaintiff and the defendant in this case?

12 POTENTIAL JUROR: Yes, sir.

13 THE COURT: Thank you very much. Okay. Is
14 there any member of the jury panel, or member of your
15 immediate family have any complication during or as a
16 result of having a colonoscopy? If so, please stand.

17 (There was no response.)

18 THE COURT: Has any member of the jury panel or
19 member of your immediate family, ever had an
20 unpleasant, unsatisfactory or complication during or as
21 a result of anesthesia? If so, please stand.

22 (There was no response.)

23 THE COURT: Does any member of the jury panel
24 have any interest in the outcome of this case, whether
25 it's financial, personal or otherwise? If so, please

1 stand.

2 (There was no response.)

3 THE COURT: If any member of the jury panel has
4 expressed or formed an opinion based upon what you've
5 heard in the courtroom this morning, with regard to
6 this case or any aspect of it, please stand.

7 (There was no response.)

8 THE COURT: Has any member of the jury panel
9 undergone a colonoscopy procedure at the Medical
10 University of South Carolina? If so, please stand.
11 Yes, ma'am. You can have a seat.

12 Ms. Lewis Smith, number what? I don't remember
13 your number.

14 POTENTIAL JUROR: Two-eighty.

15 THE COURT: How long ago?

16 POTENTIAL JUROR: It was about five years ago.

17 THE COURT: Do you have any bias or prejudice as
18 a result of that?

19 POTENTIAL JUROR: No, sir.

20 THE COURT: Can you be fair and impartial in
21 this case?

22 POTENTIAL JUROR: Yes, sir.

23 THE COURT: All right. Thank you, ma'am. Any
24 member of the jury panel -- excuse me -- is any member
25 of the jury panel a member of a medical association or

1 other professional organization in the healthcare
2 industry? If so, please stand. Yes, ma'am, lady in
3 the black coat.

4 POTENTIAL JUROR: American Pharmaceutical
5 Association.

6 THE COURT: What's your name?

7 POTENTIAL JUROR: Carol Franklin. I don't
8 remember my number. Sorry.

9 THE COURT: Ninety-four. Yes, ma'am, Ms.
10 Franklin, what organization are you a member of?

11 POTENTIAL JUROR: American and South Carolina
12 Pharmaceutical Association. American and South
13 Carolina Pharmaceutical Association.

14 THE COURT: Okay. Are you a pharmacist?

15 POTENTIAL JUROR: I am.

16 THE COURT: Where do you -- where do work -- or
17 are you employed?

18 POTENTIAL JUROR: Well, retail with Wal-Mart.

19 THE COURT: In Mount Pleasant or where?

20 POTENTIAL JUROR: I'm sorry. North Charleston.

21 THE COURT: North Charleston?

22 POTENTIAL JUROR: Yes, sir.

23 THE COURT: Okay. And how long have you been --
24 did you graduate from MUSC?

25 POTENTIAL JUROR: I did.

1 THE COURT: How long have you been a pharmacist?

2 POTENTIAL JUROR: Thirty one years.

3 THE COURT: Okay. You don't look that old.

4 POTENTIAL JUROR: Thank you.

5 THE COURT: Do you have any bias or prejudice
6 towards MUSC as a result of your education there?

7 POTENTIAL JUROR: No.

8 THE COURT: Can you be fair and impartial in
9 this case?

10 POTENTIAL JUROR: Yes, sir.

11 THE COURT: Can you base your decision on the
12 testimony you hear in the courtroom?

13 POTENTIAL JUROR: I can.

14 THE COURT: Thank you, Ms. Franklin. Yes,
15 ma'am.

16 POTENTIAL JUROR: I'm a registered nurse, case
17 manager.

18 THE COURT: You're a registered nurse?

19 POTENTIAL JUROR: Yes, sir.

20 THE COURT: What is your name and number?

21 POTENTIAL JUROR: Three fourteen.

22 THE COURT: Three fourteen. Valmus?

23 POTENTIAL JUROR: Yes, sir.

24 THE COURT: Okay, Ms. Valmus. What association
25 are you a member of?

1 POTENTIAL JUROR: CCMC, Certified Case Managers.

2 THE COURT: Okay. And are you working as a
3 nurse presently?

4 POTENTIAL JUROR: Yes, sir.

5 THE COURT: Whereabouts?

6 POTENTIAL JUROR: I work for an MCO, a manage
7 care organization.

8 THE COURT: And have you worked for MUSC in the
9 past?

10 POTENTIAL JUROR: I worked on a temporary
11 contract with one of clinics there.

12 THE COURT: Okay. That involvement in the
13 nursing industry or the -- or your association, do you
14 have any bias or prejudice for or against medical
15 malpractice cases?

16 POTENTIAL JUROR: No, sir.

17 THE COURT: Can you be fair and impartial in
18 this case?

19 POTENTIAL JUROR: Yes.

20 THE COURT: Thank you very much. Yes, ma'am.

21 POTENTIAL JUROR: Anna Monk, 209.

22 THE COURT: What number?

23 POTENTIAL JUROR: Two zero nine.

24 THE COURT: Yes, ma'am, Ms. Monk.

25 POTENTIAL JUROR: Yes. I'm a registered nurse

1 at Roper, and I am a part of the Oncology Nurses
2 Association.

3 THE COURT: Okay. Do you have any bias or
4 prejudice towards medical malpractice cases while being
5 a nurse?

6 POTENTIAL JUROR: No, sir.

7 THE COURT: Okay. Can you be fair and impartial
8 in this case?

9 POTENTIAL JUROR: Yes, sir.

10 THE COURT: Can you base your decision on
11 testimony you hear in the courtroom?

12 POTENTIAL JUROR: Yes, sir.

13 THE COURT: Thank you. Yes, ma'am, you can have
14 a seat. Thank you for standing. Yes, sir.

15 POTENTIAL JUROR: Dustin Tincher, 300.

16 THE COURT: Yes, sir, Mr. Tincher.

17 POTENTIAL JUROR: I'm a pharmacist. American
18 Pharmacist Association, South Carolina Pharmaceutical.

19 THE COURT: And where do you work?

20 POTENTIAL JUROR: I'm a retail pharmacist at
21 Wal-Mart.

22 THE COURT: Where?

23 POTENTIAL JUROR: Wal-mart, Summerville.

24 THE COURT: Wal-Mart, Summerville. Okay. Did
25 you graduate from MUSC?

1 POTENTIAL JUROR: I did not.

2 THE COURT: All right. Do you have any bias or
3 prejudice toward medical malpractice cases?

4 POTENTIAL JUROR: No.

5 THE COURT: As a result of being a pharmacist?

6 POTENTIAL JUROR: No.

7 THE COURT: Can you be fair and impartial in
8 this case?

9 POTENTIAL JUROR: Yes.

10 THE COURT: Can you base your decision on
11 testimony you hear in the courtroom?

12 POTENTIAL JUROR: Yes.

13 THE COURT: All right. Thank you very much.
14 Any member of the jury panel a -- a member of an
15 organization that promotes reform of the civil justice
16 system? If so, please stand.

17 (There was no response.)

18 THE COURT: Is there a member of the jury panel
19 or a member of your immediate family that's worked at,
20 been employed by or had a business relationship with
21 MUSC -- if -- presently or in the past? If so, please
22 stand. I'll start on my left, gentleman.

23 POTENTIAL JUROR: I think I'm number 17, Dylan
24 Bazzle.

25 THE COURT: What number?

1 POTENTIAL JUROR: Seventeen, I believe.

2 THE COURT: Okay.

3 POTENTIAL JUROR: My aunt is a pharmacist.

4 THE COURT: Your aunt is a pharmacist?

5 POTENTIAL JUROR: Yes, sir.

6 THE COURT: Okay. Whereabouts?

7 POTENTIAL JUROR: MUSC.

8 THE COURT: MUSC?

9 POTENTIAL JUROR: Yeah.

10 THE COURT: All right. Would that cause you any
11 difficulty in sitting on this jury?

12 POTENTIAL JUROR: No, sir.

13 THE COURT: Can you be fair and impartial toward
14 the plaintiff and the defendant?

15 POTENTIAL JUROR: Yes, sir.

16 THE COURT: Can you base your decision on
17 testimony you hear in the courtroom?

18 POTENTIAL JUROR: Yes, sir.

19 THE COURT: Thank you very much. Yes, ma'am.

20 POTENTIAL JUROR: Number 99, Charlene Gathers.
21 I used to be employed at MUSC.

22 THE COURT: I'm sorry, what number?

23 POTENTIAL JUROR: Ninety-nine.

24 THE COURT: Ninety-nine. Yes, ma'am.

25 POTENTIAL JUROR: I used to be employed

1 temporary at the Wellness Center at MUSC.

2 THE COURT: How long ago were you employed?

3 POTENTIAL JUROR: Over 10 years ago.

4 THE COURT: Ten years ago?

5 POTENTIAL JUROR: Yes, sir.

6 THE COURT: Okay. But you haven't been employed
7 since then?

8 POTENTIAL JUROR: No, not there.

9 THE COURT: Do you have any bias or prejudice
10 for or against MUSC as a result of your employment?

11 POTENTIAL JUROR: No, I don't.

12 THE COURT: Can you be fair and impartial in
13 this case?

14 POTENTIAL JUROR: Yes, sir.

15 THE COURT: All right. Thank you very much.
16 Yes, sir.

17 POTENTIAL JUROR: Jerome Glover, 105.

18 THE COURT: Yes, sir, Mr. Glover.

19 POTENTIAL JUROR: My wife worked in the
20 Neurology Department probably 12 years ago. She hasn't
21 worked there since.

22 THE COURT: Do you have any bias or prejudice
23 for or against MUSC as a result of your wife's
24 employment at MUSC?

25 POTENTIAL JUROR: No, sir.

1 THE COURT: Can you be fair and impartial in
2 this case?

3 POTENTIAL JUROR: Yes, sir.

4 THE COURT: Thank you, Mr. Glover. Yes, ma'am.
5 Your name and number?

6 POTENTIAL JUROR: Lauren Collins, number 51.

7 THE COURT: Yes, ma'am, Ms. Collins.

8 POTENTIAL JUROR: I'm -- I'm currently employed
9 at MUSC.

10 THE COURT: And where are you employed?

11 POTENTIAL JUROR: In the Cancer Center.

12 THE COURT: Where?

13 POTENTIAL JUROR: The Cancer Center.

14 THE COURT: The Cancer Center?

15 POTENTIAL JUROR: Yes, sir.

16 THE COURT: What do you do at the Cancer Center?

17 POTENTIAL JUROR: I work in the clinical trials
18 office. I'm a regulatory specialist.

19 THE COURT: All right. Just have a seat for
20 right now. Yes, ma'am, your name.

21 POTENTIAL JUROR: Laura Varn, number three one
22 five.

23 THE COURT: Three one five?

24 POTENTIAL JUROR: Yes, sir.

25 THE COURT: Yes, ma'am, Ms. Varn.

1 POTENTIAL JUROR: I'm a CPA in a finance
2 department under hospital authority.

3 THE COURT: In the finance department?

4 POTENTIAL JUROR: Yes, sir.

5 THE COURT: At MUSC?

6 POTENTIAL JUROR: Yes, sir, the hospital.

7 THE COURT: Okay. Thank you.

8 POTENTIAL JUROR: You're welcome.

9 THE COURT: Yes, ma'am, name and number?

10 POTENTIAL JUROR: Anna Monk, 209.

11 THE COURT: Two zero nine?

12 POTENTIAL JUROR: Yes, sir.

13 THE COURT: Yes, ma'am.

14 POTENTIAL JUROR: I was a registered nurse at
15 the Hollings Cancer Center for about three months,
16 about three months ago.

17 THE COURT: So you worked there temporarily
18 three months ago?

19 POTENTIAL JUROR: Yes.

20 THE COURT: You don't work there now?

21 POTENTIAL JUROR: I do not.

22 THE COURT: All right. Do you have any bias or
23 prejudice for or against MUSC?

24 POTENTIAL JUROR: No, sir.

25 THE COURT: -- as a result of your employment?

1 POTENTIAL JUROR: No, sir.

2 THE COURT: Can you be fair and impartial in
3 this case?

4 POTENTIAL JUROR: Yes, sir.

5 THE COURT: Thank you, Ms. Monk. Yes, ma'am.
6 Ms. Lewissmith (ph), you worked there and retired; is
7 that correct?

8 POTENTIAL JUROR: Yes, sir.

9 THE CLERK: Smithlewis.

10 THE COURT: Smithlewis. I'm sorry. I said
11 Lewissmith. Excuse me.

12 POTENTIAL JUROR: That's all right.

13 THE COURT: You retired, what did you say, 10
14 years ago?

15 POTENTIAL JUROR: Yeah, 2009.

16 THE COURT: And you have been working somewhere
17 else since?

18 POTENTIAL JUROR: Yeah.

19 THE COURT: Do you have any bias or prejudice
20 for or against MUSC as a result of your employment?

21 POTENTIAL JUROR: No.

22 THE COURT: Can you be fair and impartial in
23 this case?

24 POTENTIAL JUROR: Yes, sir.

25 THE COURT: Thank you very much. You can have a

1 seat. Yes, ma'am.

2 POTENTIAL JUROR: Angela Valmus, 314.

3 THE COURT: Okay, 314. Yes, ma'am.

4 POTENTIAL JUROR: I worked a temporary contract
5 there in Pediatric Epilepsy back in 2008.

6 THE COURT: Do you have any bias or prejudice
7 for or against MUSC?

8 POTENTIAL JUROR: No, sir.

9 THE COURT: As a result of your employment?

10 POTENTIAL JUROR: No, sir.

11 THE COURT: Can you be fair and impartial to the
12 plaintiff and the defendant in this case?

13 POTENTIAL JUROR: Yes, sir.

14 THE COURT: All right. Thank you very much.

15 POTENTIAL JUROR: Alicia White, 332.

16 THE COURT: Yes, ma'am, Ms. White.

17 POTENTIAL JUROR: My mother is a CNA at MUSC.

18 THE COURT: How long has she been there?

19 POTENTIAL JUROR: Twenty years.

20 THE COURT: How long?

21 POTENTIAL JUROR: Twenty years.

22 THE COURT: Have you got any bias or prejudice
23 for or against MUSC because of your mother's
24 employment?

25 POTENTIAL JUROR: No, sir.

1 THE COURT: Can you be fair and impartial in
2 this case?

3 POTENTIAL JUROR: Yes, sir.

4 THE COURT: All right. Thank you very much.
5 Yes, sir.

6 POTENTIAL JUROR: Three hundred.

7 THE COURT: Yes, sir, Mr. Tincher.

8 POTENTIAL JUROR: My sister is currently a nurse
9 at MUSC.

10 THE COURT: Who?

11 POTENTIAL JUROR: My sister is currently a nurse
12 at MUSC.

13 THE COURT: Your sister. All right. Would that
14 cause you any difficulty in sitting on this jury?

15 POTENTIAL JUROR: No.

16 THE COURT: Can you be fair and impartial?

17 POTENTIAL JUROR: Yes.

18 THE COURT: In this case. Thank you, Mr.
19 Tincher. Yes, ma'am.

20 POTENTIAL JUROR: One seventy-one.

21 THE COURT: One seventy-one? Diane Lawson.

22 POTENTIAL JUROR: Yes, sir.

23 THE COURT: Yes, ma'am.

24 POTENTIAL JUROR: My cousin works at radiology
25 and she's a secretary.

1 THE COURT: How long has she worked there?

2 POTENTIAL JUROR: She's been there 13 years.

3 THE COURT: Do you have any bias or prejudice
4 for or against MUSC because of her employment?

5 POTENTIAL JUROR: No, sir.

6 THE COURT: Can you be fair and impartial in
7 this case?

8 POTENTIAL JUROR: Yes, sir.

9 THE COURT: Can you base your decision on
10 testimony you hear in the courtroom?

11 POTENTIAL JUROR: Yes, sir.

12 THE COURT: Thank you, Ms. Lawson. Yes, sir.

13 POTENTIAL JUROR: James Koonce, one six four.

14 THE COURT: One six four. You retired after 19
15 years; right?

16 POTENTIAL JUROR: No. I left there after 19
17 years.

18 THE COURT: You left there after 19 years.

19 POTENTIAL JUROR: And I worked there from '77 to
20 '96.

21 THE COURT: Okay. Do you have any bias or
22 prejudice for or against MUSC as a result of your
23 employment there for 19 years?

24 POTENTIAL JUROR: No, sir.

25 THE COURT: Can you be fair and impartial in

1 this case?

2 POTENTIAL JUROR: Yes, sir.

3 THE COURT: All right. Thank you very much.

4 Yes, ma'am.

5 POTENTIAL JUROR: Number 253, Carol Savage. I
6 retired from MUSC Library in 2004.

7 THE COURT: All right. Do you have any bias or
8 prejudice for or against MUSC because of your
9 employment there?

10 POTENTIAL JUROR: No, I do not.

11 THE COURT: Can you be fair and impartial in
12 this case?

13 POTENTIAL JUROR: I believe so, yes.

14 THE COURT: What did you do at MUSC when you
15 were employed?

16 POTENTIAL JUROR: An administrator in the
17 library.

18 THE COURT: How long did you work there?

19 POTENTIAL JUROR: Thirteen years.

20 THE COURT: Thirteen years. Okay. Thank you so
21 very much. All right, Ms. Monk and Ms. Collins, would
22 y'all stand and come around, please, ma'am. Come up
23 front.

24 (The following side bar was reported.)

25 THE COURT: All right. Ms. Varn?

1 POTENTIAL JUROR: Yes, sir.

2 THE COURT: Would you come around?

3 POTENTIAL JUROR: Yes, sir.

4 THE COURT: Y'all go back and sit for -- I'll
5 get you back up here in just a second. Let me see the
6 lawyers up here. Just go have a seat. I'll call you
7 back up in a second.

8 (The following side bar was reported.)

9 THE COURT: My inclination is if they're
10 presently employed at MUSC excuse them for cause,
11 unless you got some violent objection to it -- I'm not
12 going to do the retired people, but the people
13 presently employed. There's two of them. I'm just
14 trying to save time.

15 MR. COOKE: One of them works at St. Francis.

16 THE COURT: She worked there for three months
17 temporarily about three months ago, but now she's at
18 St. Francis. I'm just talking about those two.

19 MR. RANSOM: Yes, sir, Ms. Collins and Ms. Varn.

20 THE COURT: One works in finance and the other
21 works -- I forget.

22 MR. COOKE: I think if they are current
23 employees --

24 THE COURT: If they are current employees, I'm
25 just going to excuse them for cause.

1 MR. COOKE: Yeah.

2 MR. RANSOM: Thank you.

3 (The side bar was concluded.)

4 THE COURT: Okay. Other than the people that
5 already -- have already stood concerning employment
6 with MUSC, is there any member of the jury panel that
7 has not stood that works in the health care industry
8 that hasn't already stood? If so, please stand. Yes,
9 ma'am.

10 POTENTIAL JUROR: Number 99.

11 THE COURT: What number?

12 POTENTIAL JUROR: Ninety-nine.

13 THE COURT: Yes, ma'am, Ms. Gathers.

14 POTENTIAL JUROR: Yes. I work for -- I do home
15 health. I'm a CNA for Sea Island Comprehensive Health
16 Care on Johns Island.

17 THE COURT: Okay.

18 POTENTIAL JUROR: Yes, sir. And I also work for
19 the Disabilities Board for -- of Charleston County.

20 THE COURT: Would that cause you any difficulty
21 sitting on this jury?

22 POTENTIAL JUROR: No, sir.

23 THE COURT: Can you be fair and impartial?

24 POTENTIAL JUROR: Yes, sir.

25 THE COURT: Thank you, Ms. Gathers. Yes,

1 ma'am.

2 POTENTIAL JUROR: I'm a retired registered
3 nurse.

4 THE COURT: What is your name?

5 POTENTIAL JUROR: Sandy Bauer, number 15.

6 THE COURT: Fifteen?

7 POTENTIAL JUROR: Yes.

8 THE COURT: Okay, Ms. Bauer.

9 POTENTIAL JUROR: I was an oncology research
10 nurse and infectious disease nurse for about the last
11 20 years before I retired eight years ago.

12 THE COURT: Whereabouts did you work?

13 POTENTIAL JUROR: Private practice mostly.

14 THE COURT: Okay. Would that cause you any
15 difficulty sitting on this jury?

16 POTENTIAL JUROR: No, sir.

17 THE COURT: Can you be fair and impartial to
18 both the plaintiff and the defendant?

19 POTENTIAL JUROR: Yes, sir.

20 THE COURT: Thank you, Ms. Bauer. Does any
21 member of the jury panel believe it's never appropriate
22 to question the decisions of medical care providers?
23 If you believe that, please stand?

24 (There was no response.)

25 THE COURT: Does any member of the jury panel

1 believe medical care providers often make mistakes? If
2 you believe that, please stand. Yes, ma'am.

3 POTENTIAL JUROR: I -- I'm sorry --

4 THE COURT: Just give me your name. Give me
5 your name.

6 POTENTIAL JUROR: Heidi Mortimer.

7 THE COURT: What number?

8 POTENTIAL JUROR: Two thirteen.

9 THE COURT: Two-thirteen?

10 POTENTIAL JUROR: Heidi Mortimer.

11 THE COURT: All right. Come around if you
12 would, please, ma'am.

13 (The following side bar was reported.)

14 POTENTIAL JUROR: I --

15 THE COURT: Hold on just a second.

16 POTENTIAL JUROR: Yeah. Yeah. Yeah.

17 THE COURT: Hold on just a second, wait until
18 they get up here. And your name is?

19 POTENTIAL JUROR: Heidi Mortimer.

20 THE COURT: Juror number 213; right?

21 POTENTIAL JUROR: Yes.

22 THE COURT: All right. Okay. Tell me you which
23 question did you stand in response to?

24 POTENTIAL JUROR: That --

25 THE COURT: The second one?

1 POTENTIAL JUROR: That physicians don't -- they
2 often make mistakes.

3 THE COURT: Any member of the jury panel believe
4 medical care providers often make mistakes, and you
5 said yes?

6 POTENTIAL JUROR: Yeah.

7 THE COURT: Tell me why you stood.

8 POTENTIAL JUROR: Because I read a lot and I
9 read statistics. Also, my uncle was a physician and
10 was in a malpractice suit. I happen to know the errors
11 he made. My late husband was a patient and he died
12 under a physician's care, so some errors were made.

13 THE COURT: Okay.

14 POTENTIAL JUROR: I just -- I unfortunately have
15 had a lot of dealings with the medical community.

16 THE COURT: How would that affect you sitting on
17 this jury?

18 POTENTIAL JUROR: I think I'm a fair person. I
19 would try to be fair and impartial.

20 THE COURT: We all think that. I'm a New York
21 Yankee fan. I don't like the Boston Red Socks. So we
22 all got our prejudices, so there's nothing wrong with
23 having prejudices. Okay.

24 POTENTIAL JUROR: I -- it's -- it's --

25 THE COURT: Nobody wants to stand up and say

1 they are prejudiced. But my question to you is, is
2 that going to influence you against the doctors in this
3 case, against MUSC? And if it is, that's fine. If
4 it's not, that's fine.

5 POTENTIAL JUROR: I -- it -- it -- it might.
6 It's tough. I happen to know mistakes that were made
7 on my husband who died.

8 THE COURT: Okay. Okay. Any question from the
9 plaintiff?

10 MR. RANSOM: Nothing.

11 THE COURT: Anything from the defendant?

12 MR. COOKE: No.

13 THE COURT: You can go have a seat. Okay.

14 POTENTIAL JUROR: Thanks.

15 THE COURT: Any motions?

16 MR. COOKE: I move that she be excused for
17 cause.

18 THE COURT: Any arguments?

19 MR. RANSOM: Oh, I think -- she didn't express
20 any prejudice.

21 THE COURT: Well, I'm going to grant it... I'm
22 going to excuse her for cause. All right. Do y'all
23 have any more -- that's number 213. Do y'all have any
24 more questions?

25 MR. RANSOM: No other voir dire from the

1 plaintiff.

2 THE COURT: Any questions?

3 MR. COOKE: None from us.

4 THE COURT: All right. I'll ask you to put it
5 on the record real quick.

6 (The side bar was concluded.)

7 THE COURT: Any further questions from the
8 plaintiff?

9 MR. RANSOM: Nothing further, Your Honor.

10 THE COURT: Anything further from the defendant?

11 MR. COOKE: None, Your Honor, thank you.

12 THE COURT: All right. How long do y'all -- how
13 long is it going to take you to get a strike sheet?
14 How long do y'all need to look at the strike sheet?

15 MR. RANSOM: May it please the court, Your
16 Honor. I've got a couple of motions for cause that I'd
17 like to make on just a few of these other jurors.

18 THE COURT: Well, answer my question first and
19 then I'll listen to you.

20 MR. RANSOM: Yes, sir.

21 THE COURT: How long is it going to take once
22 you get a strike sheet?

23 MR. RANSOM: I'd like to have about 20 to 25
24 minutes.

25 MR. COOKE: 15 to 20 minutes.

1 THE COURT: All right, 15 to 20 minutes. You
2 got something on some of the jurors?

3 MR. RANSOM: Yes, Your Honor.

4 THE COURT: All right. Do you want to come up
5 front and make those motions?

6 MR. RANSOM: Yes, sir.

7 THE COURT: Or do you want to make them after
8 you see the strike sheet?

9 MR. RANSOM: We can do it after we see the
10 strike sheet.

11 THE COURT: If any of them are on that strike
12 sheet, I'll be glad to listen to your motions. Okay?

13 MR. RANSOM: Sure.

14 THE COURT: It may not even be on the strike
15 sheet.

16 MR. RANSOM: That's right.

17 THE COURT: Okay.

18 MR. RANSOM: It suits us to wait.

19 THE COURT: All right. Take a look at the
20 strike sheet. And before you have to strike, I'll
21 listen to your motion.

22 MR. RANSOM: Thank you, Your Honor.

23 THE COURT: And if we've got to put some more
24 people on there, we will. Okay?

25 MR. RANSOM: Yes.

1 THE COURT: All right. Ladies and gentlemen,
2 while he's doing the strike sheet, what's going to
3 happen is they're going to do a strike sheet. I'm
4 going to give the lawyers 15 or 20 minutes to look at
5 that strike sheet. Then they will come in and they
6 have certain strikes, and they'll -- we'll draw a jury
7 and probably get two -- I think two alternates will be
8 sufficient -- or do we need three? What's the
9 attorney's thoughts on two or three?

10 MR. RANSOM: I would think with the anticipated
11 length of the trial, judge, more would be better than
12 less.

13 THE COURT: All right. We'll plan on three --
14 three alternates. So we're going to draw 12 jurors and
15 three alternates. I generally ask the question in --
16 while they are doing this process, and I've been amazed
17 at the number of people that stood up. Is there any
18 member of the jury panel that's related to each other?
19 What's the relationship?

20 POTENTIAL JUROR: Husband and wife.

21 THE COURT: Well, that is close. I've been
22 amazed at the number of people that are related that
23 show up on juries. I had a trial up in Lexington --
24 excuse me -- Lancaster a few years ago. And we had
25 been trying it for about three days. And Wednesday

1 afternoon, the bailiffs came and said, judge, this
2 juror has got to talk to you.

3 So I brought the juror out. And the juror said,
4 Judge, I've been in that jury room off and on with my
5 older sister. She's been telling me all my life what
6 to do, and I can't stay there anymore. So I've been
7 asking jurors if they are related. And the second
8 question is, can you get along in a jury room together?

9 POTENTIAL JUROR: Sure.

10 POTENTIAL JUROR: Yes.

11 THE COURT: I appreciate it. Thank you so very
12 much. All right. All right, members of the jury
13 panel, the lawyers are looking at the strike sheet.
14 It's 10 minutes after 1:00. If y'all will be back in
15 the jury room at 1:30 -- or you're welcome to stay in
16 this courtroom, whatever you want to do, but be back in
17 the courtroom at 1:30. You're welcome to stay. I'm
18 going to give them about 20 minutes, and then we'll
19 strike at 1:30.

20 (WHEREUPON, a recess was taken.)

21 MR. RANSOM: Yes. If now is the right time, I'd
22 like to make one motion on one of these jurors.

23 THE COURT: Well, if he's finished looking --
24 give him a chance to finish looking, I -- because he's
25 going to want to listen to what you're saying.

1 MR. RANSOM: That's fine.

2 THE COURT: When he's ready to hear you, I'll be
3 glad to listen to both of you.

4 MR. COOKE: I think I'm ready, Your Honor.
5 Thank you.

6 THE COURT: All right. Which -- which jurors --
7 I'm looking at the strike sheet you are referring to.

8 MR. RANSOM: Yeah, using the numbers on the
9 left, it's juror number 20.

10 THE COURT: Number 20?

11 MR. RANSOM: Yes, sir.

12 THE COURT: Number 20. All right. Let me find
13 her on my other list.

14 MR. RANSOM: Yeah, she was number 332.

15 THE COURT: Okay. I'll be glad to hear you on
16 juror 332, Alissa D. White.

17 MR. RANSOM: The information that I have on Ms.
18 White is --

19 THE COURT: Hold on just a second. Don't let
20 any jurors come in, please, sir. Okay. All right. Go
21 ahead.

22 MR. RANSOM: She's a current patient of the OB
23 practice at MUSC. She was last seen there in January
24 of 2016. And, perhaps, even more importantly she said
25 her mother had worked at MUSC for 20 years.

1 THE COURT: She was the black lady in the black
2 dress on my right, in the back?

3 MR. RANSOM: That's correct.

4 THE COURT: Okay. Her mother worked there how
5 many years?

6 MR. RANSOM: I thought she said 20 years.

7 THE COURT: And she's been an OBGYN patient now,
8 I believe she said, for eight or nine years. The last
9 time she was there was in January.

10 MR. RANSOM: That's right.

11 THE COURT: I think I asked her would that cause
12 her any problems, any prejudice for or against MUSC;
13 and I think she said no. And I think she answered
14 those questions. Why do you think I should excuse her?

15 MR. RANSOM: I think she'd have to go home and
16 explain to her mother why she gave a verdict against
17 the Medical University, and she would be uncomfortable
18 going over there being an existing patient if she gave
19 a verdict against them.

20 THE COURT: Anything else?

21 MR. RANSOM: No. That's -- that's the essence
22 of it, Judge.

23 THE COURT: All right. Mr. Cooke?

24 MR. COOKE: We think the court qualified her. A
25 number of these jurors have had some association either

1 being a patient or not. You asked them if they had
2 bias for or against. Her mother, I think, was a
3 nursing assistant for some period of time, but she's
4 not any longer. And all -- all the jurors --

5 THE COURT: I don't -- her mother had retired;
6 right?

7 MR. COOKE: Correct..

8 THE COURT: That's what I thought. She wasn't
9 present. Because I excused the employees presently
10 employed.

11 MR. COOKE: That's correct.

12 THE COURT: Motion denied.

13 MR. RANSOM: Thank you, Your Honor.

14 THE COURT: Any more?

15 MR. RANSOM: Juror number 11, Patricia Lee. The
16 strike sheet number 11, her juror number is 173.

17 THE COURT: One what?

18 MR. RANSOM: One seventy-three..

19 THE COURT: Patricia Lee. Okay.

20 MR. RANSOM: She indicated that she's an -- that
21 her employer --

22 THE COURT: Wait a minute. I'm looking at the
23 wrong person. Hold on just a second. You're talking
24 about juror 20 on the strike sheet, juror 332?

25 MR. RANSOM: No, sir. I'm talking about 11 on

1 the strike sheet, number 173. Sorry.

2 THE COURT: Okay. All right. Go ahead.

3 MR. RANSOM: Yes. I understand that she is
4 currently employed by the Citadel, has been embroiled
5 in litigation, where Mr. Cooke's office has represented
6 the Citadel for many years. And I think that that
7 would probably create a bias in his favor, so we'd ask
8 that --

9 THE COURT: She just said her employer, and she
10 had no contact with him personally through the
11 litigation process. I didn't -- I didn't think she had
12 anything to do with the litigation, other than she knew
13 who he was. The Citadel has how many employees?

14 MR. RANSOM: Well, they have many employees, but
15 it's a fairly high profile case as I understand it,
16 that he's handled for them over the years.

17 THE COURT: Well, why -- why do you think that
18 would automatically prejudice her and I should excuse
19 her? She -- because I think I remember asking her, did
20 she have any personal contact with Mr. Cooke, and she
21 said no, just her employer had hired him. And I didn't
22 go into what the employment was, because I didn't think
23 it was any of my business. I mean, tell me why you
24 think I should excuse her.

25 MR. RANSOM: Again, I think that she would have

1 a natural tendency to favor Mr. Cooke's position in the
2 case because of the representation that he's provided
3 for the Citadel in high profile cases over the years.

4 THE COURT: Well, there's a lot of sentiment in
5 the other direction, ie, the Citadel -- I assume you're
6 talking about the sexual predator; is that correct?

7 MR. RANSOM: If that's what it involves.

8 THE COURT: Right. A lot of sentiment in the
9 other direction, the Citadel should have reported it,
10 and done some different things. Now, whether that
11 filters down to employers -- employees or not, I don't
12 know. I just don't think you can -- well, I don't
13 know. I'll be glad to hear you, Mr. Cooke.

14 MR. COOKE: Well, I think you asked the right
15 questions. And she -- she doesn't know me. I don't
16 really know her. And she probably knows who I am. I
17 think she's an administrator -- an administrative
18 assistant at the Citadel. And you're right, not
19 everybody at the Citadel agrees with anything I do, let
20 alone everything, and I'm not a party to the case.
21 And if I were a party to the case, maybe it would be
22 more questionable, but I'm just a lawyer.

23 THE COURT: I'm going to deny that motion. Now,
24 if she had known him personally, and been involved in
25 it, I would grant your motion. Okay.

1 MR. RANSOM: Yes, sir.

2 THE COURT: But having said that, I'm going to
3 deny your motion. Any others?

4 MR. RANSOM: On the strike sheet number 9, juror
5 number 94, Carol Franklin, is a pharmacist who said
6 that she attended the Medical University.

7 THE COURT: She said that was 19 years -- how
8 many years ago?

9 MR. RANSOM: I wouldn't give a verdict against
10 my alma mater, Judge.

11 THE COURT: Do you think that's really her alma
12 mater? Do you think -- where did you go to law school?

13 MR. RANSOM: I went to the University of South
14 Carolina.

15 THE COURT: Do you consider that your alma
16 mater? Where did you go to undergraduate?

17 MR. RANSOM: University of Michigan.

18 THE COURT: You consider the Wolverines your
19 alma mater, don't you?

20 MR. RANSOM: Yes, sir.

21 THE COURT: Do you consider USC your alma mater?

22 MR. RANSOM: I do.

23 THE COURT: Oh, okay. All right. Just because
24 she graduated from MUSC, how many years ago was it --
25 19 or 9 -- or what did she say?

1 MR. RANSOM: I didn't write down how long ago
2 she had graduated, Judge.

3 THE COURT: Mr. Cooke?

4 MR. COOKE: I was going to say, going back to
5 the Citadel analogy, we've got a lot of alumni at the
6 Citadel that are mad at the Citadel for various things.
7 And I think that would -- in some ways, people would
8 hold their alma mater to a higher standard than another
9 university, so I don't think she's disqualified.

10 THE COURT: All right. Motion denied. Any
11 others?

12 MR. RANSOM: Nothing else, Your Honor. Thank
13 you.

14 THE COURT: All right. Are y'all ready to
15 strike?

16 MR. COOKE: Well, I was going to ask if we could
17 have five minutes to step out, so we can talk among
18 ourselves?

19 THE COURT: Yeah. I'll give you whatever time
20 you need.

21 MR. COOKE: All right. We'll be right back.

22 THE COURT: Okay.

23 (WHEREUPON, a recess was taken.)

24 THE COURT: All right. Do we have all the
25 jurors back?

1 THE BAILIFF: Yes, sir.

2 THE COURT: All right. I just have a couple of
3 questions I want to ask before we strike, does any
4 member of the panel know of any reason or any kind of
5 description why they cannot be a fair and impartial
6 juror in this particular case? If so, please stand.
7 Yes, ma'am. I've already -- you're not on this panel.
8 Okay.

9 POTENTIAL JUROR: I just wanted to make sure.

10 THE COURT: You can have a seat, too.

11 POTENTIAL JUROR: What was that question?

12 THE COURT: The question is, does any member of
13 this jury panel know of any reason of any kind or
14 description whatsoever why he or she cannot serve and
15 be a fair and impartial juror in this case?

16 POTENTIAL JUROR: I can serve. I have another
17 question, though, if that's okay.

18 THE COURT: No. I'm not asking -- what kind of
19 question do you have? If you want to come forward,
20 I'll listen to it.

21 POTENTIAL JUROR: It's about the length of the
22 trial.

23 THE COURT: What -- I don't know how long it's
24 going to take. Okay. What is your problem about
25 length of trial?

1 POTENTIAL JUROR: I have a flight on Friday.

2 THE COURT: Pardon?

3 POTENTIAL JUROR: I have a flight on Friday
4 morning.

5 THE COURT: Well, did you take that up
6 downstairs?

7 POTENTIAL JUROR: That was not -- it was not
8 discussed.

9 THE COURT: Yes, it was. Judge Young very
10 specifically asked about problems this week and next
11 week, is that correct -- is that incorrect?

12 POTENTIAL JUROR: He said it was going to be
13 brought up later. I have one Saturday.

14 THE COURT: All right.

15 MR. COOKE: He's not on the list either.

16 THE COURT: All right. What is your name and
17 number?

18 POTENTIAL JUROR: Three hundred, Dustin Tincher.

19 THE COURT: Okay.

20 POTENTIAL JUROR: Sorry.

21 THE COURT: All right. Who else has a problem
22 with travel?

23 POTENTIAL JUROR: One ninety-three, McGurk,
24 Saturday -- next Wednesday -- not Monday, Tuesday.

25 THE COURT: All right. Where -- when do you

1 have travel problems?

2 POTENTIAL JUROR: I leave Saturday. I'm good
3 all this week.

4 THE COURT: Okay.

5 POTENTIAL JUROR: Mary Wade, 319. I have a
6 flight on the 27th, which is a week from Wednesday.

7 THE COURT: Okay. All right. Let me see the
8 attorneys up here.

9 (WHEREUPON, a bench conference was had.)

10 THE COURT: All right. Is the plaintiff ready
11 to strike?

12 MR. RANSOM: Yes, sir.

13 THE COURT: Is the defense ready?

14 MR. COOKE: Yes, Your Honor.

15 THE COURT: Clerk, give us a jury, please.

16 THE CLERK: Starting with the plaintiff, four
17 and four. Ladies and gentlemen, when I call your juror
18 number and name, please gather all your belongings have
19 a seat in the jury box.

20 (WHEREUPON, the jurors selected were seated in
21 the jury box.)

22 THE COURT: All right. Ladies and gentlemen of
23 the jury, I'm going to ask you to go to the jury room
24 and follow the bailiff. Please don't discuss the case
25 amongst yourselves. And I'll get you back very

1 shortly. If you'll just follow the bailiff to the jury
2 room.

3 (WHEREUPON, the jury leaves the courtroom at 1:50
4 p.m.)

5 THE COURT: All right. Any other motions from
6 the plaintiff on the drawing of the jury other than
7 what -- the motions you've already made and the court
8 has ruled on? Any other motions?

9 MR. RANSOM: Just a moment if you please, Your
10 Honor.

11 THE COURT: And the same request from the
12 defendant.

13 MR. RANSOM: Nothing from the plaintiff, Your
14 Honor.

15 THE COURT: Any from the defendant?

16 MR. COOKE: Nothing for the defense, Your Honor.

17 THE COURT: All right. For the record, I want
18 to say that we -- the parties voluntarily strike -- on
19 the strike sheet number five, number 17 -- I believe
20 number 5 and number 17; is that correct?

21 MR. COOKE: That's correct.

22 MR. RANSOM: That's correct, Your Honor.

23 THE COURT: Okay. All right. All right. The
24 rest of the panel is -- it's now 10 minutes to 2:00.
25 Be back in the jury assembly room at 3:30 -- be back in

1 the jury room assembly room downstairs at 3:30. Have a
2 good day.

3 (WHEREUPON, the remaining jurors were excused.)

4 THE COURT: If I bring this jury back at 3:30,
5 will that give us time to hear your motions, and give
6 y'all time for opening statements, and get the
7 witnesses you need in today?

8 MR. RANSOM: It should allow us to get some of
9 the witnesses, yes, Your Honor.

10 THE COURT: I mean, I'll run until 5:30 or 6:00
11 to accommodate you, if necessary. I'm not going past
12 6:00. 6:00 is quitting time. Okay?

13 MR. RANSOM: Yes, sir, Judge.

14 THE COURT: Even if you're in the middle of a
15 sentence, it quits. Okay? Do you think that will be
16 sufficient if I bring them back at 3:30?

17 MR. RANSOM: I think so.

18 MR. COOKE: We -- I don't think the motions will
19 take very long but, you know, everybody needs lunch,
20 too, so.

21 THE COURT: Well, I'm going to come back at
22 three, and I assume that will give us 30 minutes for
23 the motions. Is that -- I'll bring them back at 3:15
24 if you think you can do it in 15 minutes?

25 MR. COOKE: 3:30 is safe.

1 THE COURT: I think 3:30 is probably safe. All
2 right.

3 (WHEREUPON, the jury enters the courtroom
4 at approximately 1:53 p.m.)

5 THE COURT: All right. Members of the jury
6 panel, we're going to take a break for lunch at this
7 time. What I want you to do is be back in the jury
8 room at 3:30 and we'll get started at that time.

9 When you come to the courthouse, come straight
10 to the jury room. The bailiff will show you where to
11 come at 3:30. And I do not want you to do any type of
12 electronic investigation of medical malpractice case,
13 or anything about colonoscopy, or anything else. I
14 want you to base your decision on what you hear in the
15 courtroom, not what you do independent research on the
16 computer, on the internet, iPhone, but no electronic
17 investigation, no Facebooking, no tweeting, no anything
18 about this case. Period.

19 You might as well leave your computers at home.
20 You will not have your phones in the jury room with
21 you. No electronic investigation or communication.
22 Period. See you at 3:30. Have a good lunch.

23 (WHEREUPON, the jury leaves the courtroom at 1:55
24 p.m.)

25 THE COURT: All right. We'll adjourn to 3:00.

1 See you at 3:00.

2 (WHEREUPON, a lunch break was taken.)

3 THE COURT: All right. What have we got? A
4 motion to exclude testimony; is that correct?

5 MR. COOKE: That's correct, Your Honor.

6 THE COURT: All right. I'll be glad to hear
7 you.

8 MR. COOKE: There are -- there are essentially
9 two parts to the motion, but they kind of go together.
10 We have moved to exclude certain testimony of Dr.
11 Kofke. One, in that -- to the extent that he's going
12 to be trying to offer new opinions, which were only
13 disclosed last week. We object to those.

14 And we also object to his being allowed to give
15 testimony concerning the causal connection between the
16 events of October 1, 2010, and Mr. Mikell's death in
17 January of 2011. So I'll address those separately.

18 We received answers -- answers to
19 interrogatories way back in 2014 that identified Dr.
20 Kofke, wherein the part where he describes the
21 substance of his testimony, he refers back to the
22 affidavit that he had given at the start of the case.
23 And on pages one and two of our motion, we quote what
24 those were. So it was -- it was fairly clear then what
25 his opinions were going to be.

1 He was deposed in March of 2015, and asked his
2 opinions. And he gave his opinions and said he
3 still -- they're still the same as they were in that
4 affidavit. But now, as of April 11th, there are five
5 new points that he may testify to, and those are set
6 out in page three of our motion.

7 The first one I don't think is necessarily
8 prejudicial. He says, "The anesthesia record has too
9 many discrepancies and internal inconsistencies to be
10 of much use in determining what really happened. The
11 whole purpose of electronic medical records is to avoid
12 reliance on people's memories", which is what we are
13 left with in this case? I'm -- I'm not that concerned
14 about that statement because I think we've been on
15 notice that that's what the plaintiffs contended for a
16 long time.

17 But then the next three are troublesome. And
18 then the fifth one is the one that bothers me the most.
19 Talking about the text messages, do you remember the 12
20 minute gap that we have --

21 THE COURT: Right.

22 MR. COOKE: -- running up until -- up until 7:48
23 when the data starts recording in the PICIS system,
24 well the testimony was when Donna Embrey got in there
25 and got everything set up, she sees the -- the numbers

1 coming on the machine, but she also knows that they --
2 notices that they are not flowing onto her electronic
3 chart, which means that they're not going into the
4 PICIS system and populating her chart.

5 So she texts the IT Department -- the PICIS IT
6 people, which is what she is instructed to do, and says
7 essentially that it's not recording. And then she does
8 it again and the PICIS people fix it. And it turns out
9 that what happens is, when you go from the -- from the
10 preoperative area, you have to push a button on the
11 computer that transfers the patient electronically to
12 the operating room or to -- to the procedure room.

13 And the records show that she pushed the button.
14 But for whatever reason, it didn't transfer. And
15 that's what happened. So the PICIS IT person had to do
16 that for her. So now -- and that's not -- that's not
17 new -- that's not new testimony. This has been known
18 for quite a while.

19 But you see the doctor -- the expert is now
20 saying if the text messages and phone calls took place
21 before Mr. Mikell desaturated, then that activity
22 probably caused the cardiac arrest because the
23 anesthesia providers were distracted from what they
24 were developing. If the text messages and the phone
25 calls took place during the desaturation, that is even

1 worse because that activity would have interfered with
2 managing the airway leading to the cardiac arrest.

3 And Donna Embrey, by the way, testified that
4 there was nothing bad going on when she was doing that.
5 This was when she first set him up and everything was
6 going fine. And she just -- she just noticed that it
7 wasn't recording.

8 Then the last one is just kind of -- you know,
9 darn if you do, darn if you don't -- the text message
10 and phone calls had nothing to do with it, and there is
11 no excuse for failing to manage the airway so as to
12 avoid the cardiac arrest entirely. We know that's his
13 opinion. We don't really have a problem with that one.

14 And then the fifth one, this one is the one that
15 I think is particularly dangerous. If you'll remember,
16 we moved for summary judgment on the wrongful death
17 cause of action, because we didn't think that Dr. Kofke
18 had said what he needed to say as an expert witness to
19 establish the causation and the -- the cause of death.

20 And, in fact, there was no autopsy done. If you
21 recall the excerpts from Dr. Kofke's deposition, where
22 he said he did not know the cause of death. He did not
23 examine any of the records of the -- of Mr. Mikell to
24 determine whether he had returned to the baseline --
25 his baseline condition or not.

1 He felt that because of the -- I guess the --
2 the disruption of the fact that he did not go home the
3 night of the 1st as he had planned to do, that --
4 that -- that that must have had something to do with it
5 or contributed to the death even though he doesn't know
6 what the cause of death was. But he said several times
7 in his deposition that he could not say that it caused
8 it and he could not say what caused the death.

9 But now he says following his debilitating
10 hospitalization, Mr. Mikell never returned to his
11 pre-event baseline. Well, that's the first time he
12 ever said that. And, in fact, it's contrary to the
13 medical evidence in the case. But he now -- evidently
14 now he's going to say that he's read those records that
15 he hadn't read a year ago, and he said "several
16 medications which have been used to keep him stable
17 were changed while he was in the hospital. This made
18 him more susceptible to the type of heart dysfunction
19 described as" --

20 THE COURT: Where are you reading from?

21 MR. COOKE: I'm sorry. I'm reading from -- from
22 the letter -- I'm actually reading from page three of
23 our motion, but it's from the letter that Mr. Ransom
24 sent me on the 11th, describing the new opinions.

25 THE COURT: Because I don't -- I don't think

1 I -- all right. Go ahead. I don't have that letter in
2 front of me, but go ahead.

3 MR. COOKE: Okay. He says --

4 THE COURT: It says Exhibit C, and I don't have
5 Exhibit C. Maybe it's in here.

6 MR. COOKE: I can hand up my copy if you'd like.

7 THE COURT: All right. Let me see -- here -- I
8 guess it's in this notebook. All right. Here's the
9 letter. I got the letter. Where -- it's just the same
10 thing as number five as in the letter; is that correct?

11 MR. COOKE: Item five, exactly.

12 THE COURT: Okay.

13 MR. COOKE: It says "following this debilitating
14 hospitalization, Mr. Mikell never returned to his
15 pre-event baseline". So that's new -- that's new
16 testimony from a year ago when he said that he had not
17 reviewed the records of Mr. Mikell after his -- after
18 the event of the 1st.

19 He said "several medications which had been used
20 to keep him stable were changed while he was in the
21 hospital. This made him more susceptible to the type
22 of heart dysfunction described as being the likely
23 cause of his death".

24 Well, described as being a likely cause of his
25 death, we don't know the cause of his death. There was

1 no autopsy done, and so we don't -- we don't know that
2 -- we literally have no idea what the cause of his
3 death was. So he's at -- he's adding this testimony
4 based on the presumptive cause of death and the same --
5 certain medications that Mr. Mikell was on made him
6 more susceptible to the type of heart dysfunction.

7 Now, again, under the Shearer vs. James line of
8 cases, that is not -- that's not relevant testimony, to
9 say that he was more susceptible is not -- does not
10 establish proximate cause, so we would object to that
11 testimony as being improper and speculative and -- and
12 not relevant.

13 Your Honor, Rule 26 (e) on supplementation of
14 responses specifically says, "In addition, a party is
15 under a duty seasonably to supplement his response with
16 respect to any question directly addressed to (1) the
17 identity of and location of persons having knowledge
18 and discoverable matters. And (2) the identity of each
19 person expected to be called as an expert witness at
20 trial, the subject matter of which he is expected to
21 testify, and the substance of his testimony."

22 So there was no supplementation of Dr. Kofke's
23 testimony. So my -- my objections to it are two fold:
24 One, that was not seasonably supplemented so that we
25 could respond to it. And, two, it's not relevant any

1 way because it -- all it says at best is that whatever
2 medications Mr. Mikell was on, made him more
3 susceptible to the type of heart dysfunction described
4 as being the likely cause of his death.

5 And that -- that -- that goes to the second
6 motion which is to exclude his testimony as to
7 causation of death.

8 THE COURT: Okay. Anything else?

9 MR. COOKE: That's all. Thank you.

10 THE COURT: I'll be glad to hear you.

11 MR. RANSOM: May it please the court, Your
12 Honor. Judge, I want to start my response by just
13 pointing out that many of the aspects of Dr. Kofke's
14 testimony, that Mr. Cooke has just spoken about, are
15 the subject of the hearing that you held on the Medical
16 University's motion for partial summary judgment, when
17 they contend that there was no evidence that the
18 negligence in this case had caused Mr. Mikell's death.
19 And you found at this time that there was at least a
20 scintilla of evidence on this causation issue that
21 they're now trying to exclude the evidence that you
22 considered when you heard that motion.

23 There are a couple of things about Dr. Kofke's
24 March 2015 testimony that I think Mr. Cooke is
25 misstating. It's not true that he didn't review the

1 records. He did review the records. He had all of the
2 records. He had almost five thousand pages of records.
3 He made a remark at one point in time, late in his
4 deposition, that he said he hadn't focused on them --
5 the part of the record related to Mr. Mikell's death --
6 -- instead he had focused on the part of the record
7 relating to the provision of the anesthesia. He never
8 said that he didn't read the records.

9 He also said that Mr. Cooke says he didn't know
10 what the cause of death was. What he meant was, that
11 he hadn't looked at the death certificate to determine
12 what the cause of death was. Interestingly enough, he
13 did review the testimony of two of Mr. Mikell's
14 treating cardiologists, Dr. Van Bakel and Dr. Zile.

15 And you'll have to forgive me because I can't
16 remember off the top of my head which one of them it
17 was that said, when I handed -- I think it was Dr. Van
18 Bakel. I gave him the death certificate at his
19 deposition, and asked him if he agreed with what it
20 said. He says, no, I don't agree. I think Mr. Mikell
21 died from what he called sudden cardiac death.

22 So my point is, Dr. Kofke had that testimony.
23 He was aware of Dr. Van Bakel's belief that it was
24 sudden cardiac death, and which to try to put that in
25 lay terms is, your heart just stops beating. Okay.

1 So it's not really accurate to say that Dr.
2 Kofke didn't review the records and didn't know what
3 the cause of death was. But more importantly, as
4 you'll recall in the March 2015 deposition -- again,
5 this was all heard in a motion for summary judgment.
6 His testimony was, when asked, in essence what do you
7 think the cause of his death was. His response was,
8 unless the man got hit by a truck, it had to have
9 something to do with all of this, meaning the cardiac
10 arrest, the hospitalization, the debilitation and all
11 of those things. All right.

12 And I think on the basis of that
13 characterization of the record that was made by Dr.
14 Kofke, that you denied the motion for summary judgment
15 finding that he had, in fact, rendered a sufficient
16 opinion on the issue to at least make it beyond the
17 Rule 56 state.

18 Now, as Your Honor is fully aware, there have
19 been all sorts of fits and starts and problems with
20 finding out in this case what really happened. All
21 right. And I find it interesting that the Medical
22 University is raising a complaint about Dr. Kofke's
23 final opinions, because one of the exhibits that we
24 have marked, along with our witness list -- I think
25 this is Exhibit 41 -- is the series of records that

1 reflect the information that was provided to the
2 defense medical expert, Dr. Berry -- all right -- for
3 his consideration in the case. And included in the
4 materials that they're sending to their expert, his
5 letter dated February 4, 2016, and a second letter
6 dated March 8, 2016 -- of particular note, Dr. Berry
7 was deposed in June of 2015.

8 Now, they're sending additional material to him
9 because obviously new discovery has taken place, and
10 some of the things that that discovery related to was,
11 number one, these text messages and phone calls, and
12 the February 22, 2016 deposition testimony of Nurse
13 Embrey, where I was finally able to inquire about how
14 all that affected the procedure involving Mr. Mikell.

15 So at the same time that I'm sending that
16 deposition transcript, and additional materials that
17 have been discovered from my expert, they're sending
18 them to their expert. But yet now they're coming along
19 and saying, well, you're too late.

20 And, look, I took the initiative and Mr. Cooke
21 asked me, do you have anything that you need to
22 supplement in your discovery responses. And in
23 response to that specific request, I said you know
24 what, I expect that once Dr. Kofke has had a chance to
25 review Nurse Embry's deposition, as well as being

1 informed of the testimony that was taken a week ago --
2 well, 10 days ago today -- from other depositions that
3 we took that Your Honor allowed, that once Dr. Kofke
4 was able to digest all of that, that he was going to
5 have some new opinions in the case.

6 And the letter that they're relying upon is the
7 letter that I sent to them, doing my best to --
8 pursuant to Rule 26 (e), supplement my discovery to
9 say, yeah, now that he's reviewed all this new
10 information, just like Dr. Berry has reviewed new
11 information, these are the opinions that he has.

12 THE COURT: Well, let me -- let me just ask --
13 reading from his deposition, apparently -- it looks
14 like page 116, line 3 through 19: QUESTION "Do you
15 have any opinion about the cause of Mr. Mikell's
16 death?" ANSWER: "No, I didn't review the chart
17 carefully for damages or, you know, things like that."
18 It goes on to say he didn't address the records in
19 reference to that. Now, how does that tie into number
20 five?

21 In other words -- I -- you got a wrongful death,
22 you got a survival action. And I've got depositions
23 from your expert that says -- that doesn't tie into the
24 causation issue, ie, the cardiac arrest ultimately
25 caused his death -- what, two months later? Three

1 months later?

2 MR. RANSOM: Contributed to it, yes, sir.

3 THE COURT: But that's not sufficient, you know
4 that. So my question is, where are we going as to the
5 death?

6 MR. RANSOM: Well --

7 THE COURT: I'm not saying that doesn't prohibit
8 you from establishing pain and suffering on the medical
9 malpractice prior to death. I'm talking the death, the
10 wrongful action and your survival action.

11 MR. RANSOM: And my response, Judge, is again,
12 it's -- I'm in a little disadvantage, I guess, because
13 Dr. Kofke speaks in somewhat colloquial fashion at
14 times. His phrase was, the only way that I don't see
15 that it's -- it caused his death, is if the man got hit
16 by a truck crossing the street.

17 THE COURT: Well, that may be, but that's not
18 sufficient to come into this courtroom and give an
19 opinion as to cause of death.

20 MR. RANSOM: Well, and so when he comes in and
21 takes the witness stand and testifies, I'm confident
22 that his testimony will be other than through that type
23 of an expression. But as you can see from the letter
24 that we sent, all right, he is of the view that --
25 first off, he suffers this cardiac arrest as a result

1 of the malpractice that he describes through the
2 mismanagement of this airway. And now he also believes
3 that part of the malpractice was being engaged in the
4 process of sending text messages and making phone
5 calls.

6 THE COURT: Right.

7 MR. RANSOM: All right. While the patient is in
8 trouble. He says that that clearly led to the cardiac
9 arrest --

10 THE COURT: Has he -- has he already put -- I
11 think you said he used a bag mask to put him to
12 sleep -- a mask to breathe or breathe -- or did he have
13 the tube in his nose or what?

14 MR. RANSOM: I'm not understanding you.

15 THE COURT: My question -- what stage was she
16 talking about the computer versus him being put to
17 sleep?

18 MR. RANSOM: Ah, so the timeline would
19 demonstrate that she discovers that there's this
20 problem with the equipment, it's something -- I think
21 it's 7:36 --

22 THE COURT: He's already been administered --

23 MR. RANSOM: No.

24 THE COURT: -- anesthesia at that time?

25 MR. RANSOM: He did not.

1 THE COURT: Okay.

2 MR. RANSOM: Then at 7:36, she notices there's a
3 problem with the software. And then at 7:42, they
4 administer the propofol, which is the anesthetic agent
5 that puts the patient to sleep. At -- I think it's 7
6 --

7 THE COURT: Well, what type of breathing
8 apparatus did she have on him at that time?

9 MR. RANSOM: None.

10 THE COURT: Nothing?

11 MR. RANSOM: None. No, the anesthetic is being
12 administered intravenously.

13 THE COURT: Right. Okay.

14 MR. RANSOM: They had oxygen --

15 THE COURT: Just oxygen in the nose -- okay.

16 MR. RANSOM: But they haven't done anything to
17 either protect or secure his airway --

18 THE COURT: All right. So she administered the
19 anesthesiology -- excuse me -- the medicine to put him
20 to sleep. Then was she -- when did she go to the
21 computer to try and straighten out the glitch?

22 MR. RANSOM: Well, during that process.

23 THE COURT: After she administered the medicine?

24 MR. RANSOM: After she administers the medicine,
25 she is still attending, trying to get somebody to call

1 her on the telephone to correct the problem with the
2 machine.

3 THE COURT: Okay. All right. Go ahead. You
4 have answered my question.

5 MR. RANSOM: So -- so Dr. Kofke very clearly
6 relates the cardiac arrest to this mismanagement issue
7 --

8 THE COURT: Well, I understand that. And I -- I
9 don't think that's a problem if -- it depends on what
10 he says at trial, but --

11 MR. RANSOM: Right.

12 THE COURT: I don't know yet. Okay.

13 MR. RANSOM: And the way he connects the death
14 together, Judge, is he says, okay, so now Mr. Mikell,
15 instead of going home that afternoon to watch
16 television or whatever, now he's admitted to the
17 hospital as a critical care patient, where he's
18 breathing on a ventilator and he's in a medically
19 induced coma.

20 He's being placed in a hypothermic state. He
21 has to have a tracheostomy. He's got, most
22 importantly, damage to kidneys that occurs -- because
23 when his heart stops, he's not getting adequate blood
24 supply to his kidneys.

25 Now, this is particularly important in this case

1 according to Dr. Kofke, some of the --

2 THE COURT: Well, was he -- did he have kidney
3 problems prior or was --

4 MR. RANSOM: He did.

5 THE COURT: What kind of treatment was he
6 getting for kidney problems prior?

7 MR. RANSOM: Really nothing that I'm aware of.

8 THE COURT: No medication or nothing?

9 MR. RANSOM: I don't think he was taking
10 medication for his kidneys.

11 THE COURT: Okay.

12 MR. RANSOM: But, importantly, some of the
13 medications -- and I stand to be corrected on that.
14 But, importantly, some of the medications that he's
15 taking for his heart failure are medications, as I
16 understand it, that are cleared -- you know,
17 metabolically, they're cleared through your body,
18 excreting through your kidneys. So that when his
19 kidneys get injured during this cardiac arrest, he
20 can't tolerate those drugs anymore. So they've got to
21 switch him to different drugs.

22 And one of the things they also have to do is
23 stop giving certain drugs. And this is what Dr. Kofke
24 is saying is they end up having to change the
25 medications that the people at the Medical University

1 have spent two, three, four, five years dialing in to
2 treat his heart failure. All right. And then when he
3 gets found -- basically, he gets found dead as a result
4 of heart failure. So -- and -- and I'm kind of
5 glossing over this because I'm not a critical care
6 physician. But what Dr. Kofke is saying is when they
7 have -- when he goes through this debilitating
8 illness -- all right -- and they change all of his
9 medications, those medication changes lead a man to
10 have the very kind of heart problem that Dr. Van Bakel
11 said are the cause of his death. In other words,
12 sudden cardiac death is the thing that happens when you
13 stop taking a blood thinner, when you stop taking an
14 ACE inhibitor, when you stop taking these other drugs
15 --

16 THE COURT: I mean, it's almost like you're
17 trying to -- you're trying to put the cause of death
18 like a doctor would do a differential diagnosis and --
19 and to come in here and give an opinion as to cause of
20 death, it has to be stronger than that.

21 MR. RANSOM: And I'm sure his testimony will be
22 stronger than mine, Your Honor.

23 THE COURT: Pardon?

24 MR. RANSOM: Again, I'm not doing justice to
25 it -- and forgive me about that because -- listen, I

1 mean I'm not -- I'm not a critical care physician, and
2 I'm not doing as good of a job of explaining it as he
3 can. But suffice it to say, when they take the
4 position that he can't make this causal link, I think
5 he's going to be able to make it.

6 THE COURT: Well, it may be, and I don't know it
7 until I hear it, other than what I have read that he
8 said in his deposition. In his deposition, he sure
9 doesn't make a causation issue, legal or --

10 MR. RANSOM: And, again, Judge, I think that
11 from the point in time where he gave his deposition
12 testimony in March of 2015 -- all right -- he's
13 developed his thinking, and he's prepared to present a
14 cogent explanation for how he links these events link
15 together. And the real issue that I'm hearing from Mr.
16 Cooke is, you know, he's got opinions that he didn't
17 disclose to us until you wrote this letter --

18 THE COURT: Right. I understand that. That's a
19 technical argument for --

20 MR. RANSOM: Right.

21 THE COURT: -- suppression. Anything else?

22 MR. RANSOM: I think that's all.

23 THE COURT: Okay.

24 MR. RANSOM: Thank you.

25 THE COURT: Mr. Cooke.

1 MR. COOKE: I think maybe where Your Honor was
2 leading is that you have to hear him --

3 THE COURT: I mean, I really do. I mean, I
4 don't know what he's going to say. And let me say
5 this, and I'm not trying to bad mouth you or anybody,
6 but the way the discovery has proceeded in this case, I
7 can understand. Okay.

8 And I understand that your position is what was
9 missing, what was not produced, doesn't necessarily go
10 to causation -- and I understand that argument. But I
11 think it does cloud the issue as to what the doctor is
12 going to testify to back in -- when was it -- March
13 15th. Because a lot of stuff at that point in time,
14 the doctor didn't even know, nor did the plaintiff's
15 counsel.

16 MR. COOKE: Well --

17 THE COURT: And I'm not sure how -- how it would
18 have played out with his deposition, I don't know. But
19 my problem is, I don't know what he's going to testify
20 to. Okay. And I -- I guess I don't buy into your
21 argument that Rule 26 (e) hasn't been complied with. I
22 think Rule 26 (e) has been complied with.

23 MR. COOKE: Last week.

24 THE COURT: I understand. I understand.

25 MR. COOKE: I'm sorry.

1 THE COURT: But part of that is because it took
2 you a year, a year and a half, two years to produce
3 what they've been trying to get you to produce for a
4 year. Okay.

5 Now, I understand your position is that that
6 doesn't affect the causation issue, and I understand
7 that argument. Okay. But I don't know what he's going
8 to say concerning that issue sitting here today.

9 Now, what I'm going to do is take your motion --
10 I'm not going to suppress -- your motion is going to be
11 denied, and I'm going to address it further at the --
12 at the -- excuse me -- the directed verdict stage.

13 However, I am going to listen to his testimony
14 on causation in camera before it goes to the jury.

15 MR. COOKE: Thank you. That's what I --

16 THE COURT: And I think what I should do, rather
17 than denying your motion, I'm going to take it under
18 advisement until I have an opportunity to listen to the
19 doctor's explanation as to why he didn't give that
20 opinion in March of '15, and giving it two weeks now.
21 And I'm going to listen to that in camera. And then at
22 that point in time, I'll rule on your motion on whether
23 the jury is going to hear it or not. I don't know any
24 other way of doing it.

25 MR. COOKE: I think that's fair enough. Thank

1 you, Your Honor.

2 THE COURT: Okay. Do you understand?

3 MR. RANSOM: Yes, sir, I do. Thank you.

4 THE COURT: Whenever you call the doctor --
5 you're getting ready to go on to the causation issue, I
6 want to listen to it in camera. And at that time, I'll
7 rule on his -- his motion.

8 MR. RANSOM: All right.

9 THE COURT: Okay?

10 MR. RANSOM: Yes, sir.

11 THE COURT: I just don't think him -- being fair
12 to either party -- any way that I can do that in a
13 vacuum. I know what he said in a deposition in March
14 2015, and we got your letter. But what you got in your
15 letter might not be the way it comes out of what he
16 says. I don't know. And what's crucial is what's he
17 going to tell the jury.

18 MR. RANSOM: That's right.

19 THE COURT: Not what he tells you in
20 preparation. Any other motions?

21 MR. COOKE: That's all. Thank you.

22 THE COURT: Anything from the plaintiff?

23 MR. RANSOM: Nothing, Your Honor.

24 THE COURT: All right. Now, let me lay some
25 ground rules about spoliation. That's not going to be

1 mentioned by either party at this -- especially the
2 plaintiff at this time, do you understand?

3 MR. RANSOM: I --

4 THE COURT: In opening statements I'm referring
5 to.

6 MR. RANSOM: Judge, I'm not meaning to
7 quibble -- but just so that I'm clear -- what is it
8 that you don't want me to mention?

9 THE COURT: I don't want you to tell the jury
10 that MUSC has been hiding anything from them. You're
11 welcome to say it's not a -- what's the name of the
12 card -- Mayday card. They don't have a Mayday. It's
13 been destroyed. Okay.

14 You can state the facts, but I don't -- I'm not
15 going to allow you to say they've been hiding something
16 from you, or some spoliation issue in this case until I
17 make a decision on whether I'm going to make that
18 charge; do you understand?

19 MR. RANSOM: Yes, sir.

20 THE COURT: Does that clarify it?

21 MR. RANSOM: I hope so, yes, sir.

22 THE COURT: Okay. No problem with you stating
23 the facts as they lie, okay, but not the conclusion of
24 hiding something.

25 MR. RANSOM: Right. And I'm not to use the

1 words "hiding" or "withholding" --

2 THE COURT: Right.

3 MR. RANSOM: -- or anything like that?

4 THE COURT: Right. Okay?

5 MR. RANSOM: Yes, sir.

6 THE COURT: All right. Anything else? Are
7 y'all ready for opening statements?

8 MR. COOKE: Yes, Your Honor.

9 THE COURT: All right.

10 (Pause.)

11 (Whereupon, a recess was taken.)

12 THE COURT: We got all the jurors?

13 THE BAILIFF: Yes, sir.

14 THE COURT: Bring the jury, please.

15 (WHEREUPON, the jury enters the courtroom at
16 approximately 3:41 p.m.)

17 THE COURT: Okay. Thank you very much. Ms.
18 Laura Long, would you swap seats with -- the chair down
19 here. I'm going to appoint you as forelady, please,
20 ma'am. Ms. Long, if you'll just always sit in that
21 seat. The alternates sit where they are. And the rest
22 of you can sit where you please. It just depends on
23 how you file into the courtroom.

24 Mr. Clerk, if you'll swear the jury, please.

25 (Whereupon, the jury was given their oath.)

1 THE CLERK: Please be seated. Any juror who
2 cannot accept this oath, please stand.

3 (No response.)

4 THE CLERK: Please let the record reflect all
5 jurors are seated.

6 THE COURT: All right. Ladies and gentlemen of
7 the jury, we're getting ready to start the trial, as I
8 told you earlier, the caption of the case -- I'm going
9 to give you a brief -- a very brief summary of what's
10 going to transpire during the trial.

11 We're going to have opening statements. And in
12 the opening statements, each party -- each attorney
13 will tell you what they plan on proving during the
14 process of this case.

15 After opening statements, then the plaintiff
16 will start calling witnesses, and the plaintiff will
17 have the witnesses on direct examination, and the
18 defense will have the witnesses on cross-examination.

19 The distinction between direct examination and
20 cross-examination is you can't ask leading questions on
21 direct. On cross-examination, you can ask a leading
22 question. A leading question is a question that
23 suggests the answer.

24 After the plaintiff has presented all their
25 testimony, then the defense will have an opportunity to

1 present testimony, and they will have their witnesses
2 on direct and the plaintiff -- excuse me -- the defense
3 will have the witnesses on direct, and the plaintiff
4 will be on cross-examination.

5 After all the testimony has been produced to the
6 jury, then we'll have closing arguments by the
7 attorneys, and I will charge you on the law that's
8 applicable in the case.

9 Now, during the course of the trial, I would ask
10 you not to discuss the case amongst yourselves or with
11 anyone else, because I want you to hear all the
12 testimony before you start trying to make a decision on
13 who is right or who is wrong involved in the case. I
14 want you to make a decision on what you hear in the
15 courtroom, not what you talk to your husband about or
16 boyfriend or girlfriend, because they don't know what's
17 going on in the courtroom.

18 And I've already told you, no electronic
19 investigation or anything concerning the case. Because
20 I don't want you to be influenced by any outside
21 influence as much as possible, just merely what you
22 hear in the courtroom, and the opinions that you form
23 in the courtroom about the information and about the
24 people that offer testimony. And I will charge you
25 about credibility of the witnesses and other matters at

1 the end of the case during the closing arguments.

2 For your information, we'll probably start every
3 morning at 9:30 -- as soon as possible at 9:30. We'll
4 run to approximately 1:00. And at 1:00, we'll probably
5 take a break to either 2:00 or 2:30. It depends upon
6 the process and how far along we are.

7 And then in the afternoon, we'll run to 5:30 or
8 6:00. We'll try to -- I'll try to stick to that
9 schedule as much as possible.

10 During the morning session, we'll take about a
11 20 or 30 minute break each morning, the same thing in
12 the afternoon, to give you an opportunity to stretch
13 your legs. And any smokers, they will take you to the
14 appropriate place to smoke. So that will be the
15 schedule.

16 How long the trial is going to take, my
17 prediction is it's going to take at least the greater
18 part of this week, if not all week. I'm not going to
19 tell you it's going into next week, but there's always
20 that possibility. I don't know at this point in time.
21 But at some point in time during the week, I can
22 probably give you a better indication how long the
23 trial is going to last for your benefit. Opening
24 statements, please.

25 MR. RANSOM: Thank you, Your Honor. May it

1 please the court. Good afternoon, ladies and
2 gentlemen. My name is Rob Ransom. I met you earlier
3 this morning. I just wanted to make a couple of brief
4 remarks.

5 You know, the jury selection process that
6 resulted in each of you being seated on this jury, is
7 something that's called for by our constitution. These
8 types of proceedings are taking place all across the
9 country today. Here in Charleston, up in Columbia, out
10 in Seattle, Washington; up in Manhattan in New York
11 City. All across the United States, on Monday morning
12 people show up for jury service and go through a
13 process just as you have today.

14 I mention that just so that you'll understand
15 that it is an honorable and noble undertaking provided
16 for by our constitution that brings us here together
17 today. Thank you for participating.

18 You know, it's a basic legal principle in this
19 country that if you're in a hurry, and you become
20 distracted, and you make a mistake and somebody gets
21 seriously hurt, then you are responsible for all the
22 resulting harm.

23 Now, let me tell you the story of what happened
24 in this case. Sometime in 2009, the Medical University
25 implemented an electronic medical record system that it

1 used during operating room type procedures called
2 PICIS, P-I-C-I-S. You're going to hear that phrase
3 throughout this trial. Sometimes we may mispronounce
4 it PICIS, it's really PICIS. And it's an electronic
5 medical record system.

6 It makes a detailed record of patient care,
7 including all the patient's vital signs during any
8 procedure involving anesthesia. And on September 30,
9 2010, a 52 year old man came into the Medical
10 University for a pre-procedure evaluation. He was
11 having trouble with constipation. And he was at the
12 age for a screening colonoscopy.

13 He had two important underlying medical
14 conditions that are pertinent to the procedure he was
15 undergoing. The first was obstructive sleep apnea.
16 All right. And this is a little diagram that shows you
17 the biology behind sleep apnea.

18 Now, when you fall asleep and you have
19 obstructive sleep apnea, what happens is the muscles in
20 the back of your throat, in and around your tonsils and
21 the soft pallet, they relax and some of the tissue can
22 collapse back into your throat -- all right -- and
23 obstruct your airway.

24 And this is what happens to people with
25 obstructive sleep apnea when they're at home, laying in

1 the bed asleep. And it's also what happens to them
2 when you put them to sleep in the hospital using
3 anesthetic drugs.

4 The second condition that the patient has is
5 heart failure. And the heart failure he had made him
6 especially sensitive to low levels of oxygen in his
7 blood and high levels of carbon dioxide in his blood.
8 And low levels of oxygen and high levels of carbon
9 dioxide are what happens when your airway closes off
10 for too long.

11 So you see up here, we've got a diagram of the
12 oxygen coming in -- and that's the blue arrows. And
13 the carbon dioxide coming out -- that's the yellow
14 arrows. And when you see that the tongue falls back
15 and obstructs the airway, well, the oxygen can't get in
16 and the carbon dioxide can't get out.

17 Now, the anesthesia providers for this man's
18 procedure were well aware of both of these conditions,
19 the sleep apnea and the heart failure. And there are
20 steps that they could take, which if properly followed,
21 almost always keep a patient from getting into trouble.

22 All right. One of the simplest things is to
23 manipulate the patient's chin and the neck, you tilt
24 them and you pull it back -- all right -- using both
25 hands, so that the airway opens up and effective

1 breathing is re-established.

2 Now, back on October 1st of 2010, the patient
3 was brought into a pre-procedure holding room. He was
4 hooked up to some vital signs monitors, which display
5 his heart rate and the blood oxygen saturation levels,
6 among other things.

7 He's given an IV in his arm. All right. And
8 that's followed by a drug that they give him to relax
9 him, not to put him to sleep, but just relax him. And
10 then he's moved from the pre-procedure room into the
11 procedure room.

12 And in that process of moving him from room to
13 room, a nurse anesthetist -- all right -- has to
14 transfer the vital signs monitor from one computer
15 station in the pre-procedure room to another computer
16 station in the procedure room. And she does that just
17 by taking a mouse and clicking on an icon. And if
18 that's done correctly, then the patient's record is
19 automatically transferred by the computer system from
20 the pre-procedure room to the procedure room.

21 The patient is taken into the pre -- into the
22 procedure room -- all right -- and then he's given the
23 anesthetic drug, and it's called Propofol in this case,
24 is the drug that they actually used to put you to
25 sleep. And that renders him unconscious and the

1 colonoscopy procedure begins.

2 But because of his sleep apnea -- all right --
3 when the drug puts him to sleep, what happens? His
4 airway obstructs. Okay. The tongue falls back, the
5 airway obstructs, and his blood oxygen saturation
6 drops. All right. This resulted in a condition that
7 they call hypoxia.

8 And when he starts getting hypoxic, then his
9 heart rate slows down. And this is a condition that
10 they call bradycardia. All right. So hypoxia is a
11 lack of oxygen; bradycardia is a slowing heart rate.
12 All right. And then, his heart rate stops altogether.
13 His heart just stops.

14 So a Mayday or code is called. And the medical
15 care providers come in, and they place a breathing tube
16 down his throat in order to open his airway back up,
17 and his heart is shocked with paddles -- like what you
18 see on television -- so that it starts beating again.
19 And the patient is rescued from the cardiac arrest and
20 he actually survives.

21 But rather than going home that afternoon, after
22 what was supposed to be a routine screening
23 colonoscopy, now the patient is being admitted to the
24 hospital in the Intensive Care Unit. And he remains in
25 the hospital for the next seven weeks.

1 When he's finally released from the hospital
2 after this critical illness, he's weak and debilitated.
3 And importantly, many of the medications that he's been
4 taking to control his heart failure, have either been
5 changed or stopped all together.

6 Now, once he gets home, he receives healthcare
7 visits from nurses who come to see him at his house.
8 And he undergoes a series of evaluations, medical
9 appointments with doctors who follow up with him after
10 he's released from the hospital.

11 And as the new year approaches, he's got a bad
12 cough and he's not feeling well. His elderly mother
13 has been staying at his home -- house, looking after
14 him. And she comes over one morning to check on him,
15 on January 2nd of 2011, and she finds her son on the
16 couch dead. His heart has stopped beating. Now, that
17 patient's name is Charles Mikell.

18 Now, this colonoscopy was a routine screening
19 colonoscopy. It's not supposed to result in
20 respiratory and cardiac arrest. So Mr. Mikell's family
21 wanted to know what had happened, so they asked MUSC
22 for Mr. Mikell's medical records. And they brought
23 those to my office.

24 And I sent them to an anesthesiologist up in
25 Philadelphia -- his name is Dr. Kofke -- for Dr. Kofke

1 to review. And what the evidence that you're going to
2 hear during this trial, it's going to show that
3 virtually every part of the anesthesia chart from Mr.
4 Mikell's colonoscopy has got some kind of a problem.

5 All right. It's either been corrupted, altered,
6 lost or destroyed. I want to tell you a little bit
7 about that.

8 You're going to have in evidence -- we're going
9 to have parts of the anesthesia record in this blow-up,
10 is one of the things that's going to go into evidence,
11 and you'll see here -- I hope you can see this -- up
12 here along this top line is a line where the
13 recordkeeping system, this PICIS system, is supposed to
14 be recording the blood oxygen saturation values for the
15 patient all throughout the procedure. And what you see
16 here is a lot of these boxes are empty.

17 The other thing that you'll see in these medical
18 records is that they have what they call a "real time
19 graph" down here. And this real time graph is really
20 just a computer system that's taking data that's
21 supposed to be up here in this part of the chart, and
22 it's plotting it on a graph. All right. And what
23 you'll see is that the graph doesn't start at the start
24 of the procedure.

25 There's also another part of the record that

1 you're going to hear a lot about, that's called the
2 anesthesia narrative. And this is a part of the
3 anesthesia record that the anesthesia providers are
4 able to put comments about what's taking place.

5 And what you're going to find out is that the
6 anesthesia narrative throughout in this case has been
7 changed several times. And you're going to hear that
8 it's been changed in ways that some of the witnesses in
9 this case were really quite surprised.

10 In fact, you're going to hear from a defense
11 expert, his name is Dr. Berry up in Nashville. He's
12 coming to testify. And he's going to tell you that he
13 didn't even believe it was possible to change an
14 anesthesia record in the way that the evidence is going
15 to show this record has been changed.

16 Now, the folks at the Medical University are
17 going to tell you, don't worry about any of that. The
18 fact that the records have been corrupted, altered,
19 lost or destroyed, just count on us and we'll give you
20 the truth about what really happened.

21 Several fairly important things are going to
22 come through the evidence that you're going to hear in
23 this case, and it's going to establish that what took
24 place with Mr. Mikell's colonoscopy was, when they
25 moved him from the pre-procedure room to the procedure

1 room, there was some sort of a glitch with the computer
2 system, so that his record didn't transfer from one
3 room to the other. And that prevented the vital signs
4 data from going into the chart.

5 That's the explanation for why these boxes up
6 here are empty, is that there was some sort of software
7 glitch.

8 And what you're also going to hear is that there
9 was a series of text messages and phone calls that took
10 place in an effort to try to contact a technician that
11 was in another part of the hospital -- not in the
12 procedure room -- but somewhere else, contact this
13 technician to try to solve this software problem to get
14 this chart to working correctly.

15 And during the time that those text messages and
16 phone calls were going on, the anesthesia providers
17 were distracted from Mr. Mikell's condition. And what
18 the evidence is going to show is, that it's during the
19 time that his blood oxygen saturation levels are
20 dipping to dangerously low levels, part of that time
21 they're sending text messages and making phone calls,
22 and trying to overcome this computer software problem.

23 You are also going to find -- the evidence is
24 going to show that there was -- since a Mayday was
25 called, a code was called, there's supposed to be what

1 the hospital calls a Mayday record. And this is a
2 record of what takes place during the effort to
3 resuscitate the patient.

4 And you're going to find out that that record
5 has either been lost or destroyed in this case. And
6 instead of admitting that, the Medical University has
7 presented one of its anesthesia faculty members who has
8 testified that there was never any Mayday called, and
9 that's why there is no Mayday record.

10 Now, during the course of the trial, we're going
11 to present evidence that records were changed and
12 records were destroyed, and that you shouldn't really
13 rely upon the testimony of the people who were involved
14 in doing those things.

15 Now, Shon Turner is Mr. Mikell's stepson. All
16 right. He's my client and he's been appointed personal
17 representative of Mr. Mikell's estate. He's the
18 plaintiff in this case.

19 And he's bringing the case on behalf of his
20 stepbrother, Dadrian Michael, who's seated just back
21 there in the dark blue shirt next to his mother, who is
22 Louann Arthur. And Shon's also bringing the case on
23 behalf of his stepsister, Madison Mikell. All right.
24 They are the beneficiaries of Mr. Mikell's estate.

25 Shon is suing MUSC for medical malpractice,

1 which ruined his stepfather's health and ultimately
2 caused his death. He's bringing this lawsuit for a
3 couple of reasons.

4 First, we allege that the anesthesia providers
5 chose to put Mr. Mikell to sleep knowing that he had
6 obstructive sleep apnea, knowing that he had a heart
7 condition, and also knowing that there was a problem
8 with the vital signs monitoring equipment. That choice
9 was wrong. Because MUSC has a hospital policy which
10 requires that all the equipment be checked out and be
11 found in proper working order before any procedure
12 starts.

13 That choice was also unsafe because it meant
14 that the anesthesia providers were distracted from
15 their patient, trying to fix the equipment when the
16 patient obstructed and his blood oxygen saturation
17 levels went down.

18 Instead of making that unsafe choice, what the
19 anesthesia providers should have done was fix the
20 equipment problem before they put the patient to sleep.
21 They didn't do that, because they were in a hurry and
22 they were busy. Mr. Mikell was the first patient that
23 day and they had lots of other patients coming along
24 behind him, and they had to keep the schedule. But if
25 the anesthesia providers has chosen to wait until the

1 equipment was working properly, they would have been
2 paying attention to Mr. Mikell when his airway
3 obstructed, and they would have been able to keep him
4 from de-saturating and going into cardiac arrest.

5 If they had just fixed the problem before
6 putting Mr. Mikell to sleep, he would have gone home
7 safe to his family later that day, instead of spending
8 the next seven weeks in the hospital as a critical care
9 patient.

10 Now, one of the questions that Judge Nicholson
11 is going to give you to deliberate on at the end of
12 this case is how much money will it take to make up for
13 the harm that Mr. Mikell and his children have
14 suffered. When figuring that out, the only thing that
15 you're allowed to take into account is the amount of
16 the harm and the amount of the loss that's occurred in
17 this case. Nothing else. No outside reasons.

18 Now, you don't have any experience in how to do
19 this, because you're going to be asked to place a value
20 on things that don't come with an invoice or a price
21 tag attached to them, so you probably don't really have
22 any good idea how to do it. But let me just tell you,
23 that sort of thing goes on down here at the courthouse
24 every week.

25 And at the end of the case, I'm going to give

1 you some ideas about how you can do that. But for
2 right now, it's just important for you to understand a
3 little bit about what all the harms and losses are.

4 I am not showing you the harm and the loss in
5 this case to get your sympathy. Mr. Mikell died almost
6 five years ago. The time for sympathy is long since
7 passed. Instead, we are here to get the money that it
8 takes to compensate for the harm that his children have
9 suffered, which are the only things that you're allowed
10 to take into consideration in deciding the amount of
11 your verdict.

12 So let me tell you about the harm and the loss.
13 Although Mr. Mikell was a heart failure patient at the
14 Medical University for several years before this
15 colonoscopy, in the months before this colonoscopy, his
16 doctors felt that he was doing fairly well and that his
17 condition -- while it was being managed by medications,
18 diet, and exercise, were stable.

19 Mr. Mikell was leading an active lifestyle. He
20 was working as a bus driver to a retirement home here
21 in Charleston. He was swimming and walking for
22 exercise. He was involved in his church. He spent
23 time with his children, Madison, Dadrrian and Shon. He
24 had many friends. And he was a well loved, respected,
25 and an admired member of the local community.

1 After the cardiac arrest, he was in a coma. His
2 body temperature was artificially lowered and he was
3 given drugs to keep him unconscious. For several
4 weeks, he had to be hooked up to a machine called a
5 ventilator that did the breathing for him. And the
6 ventilator machine was connected to him with a tube
7 that was surgically placed through his throat called a
8 tracheostomy.

9 For a time, he had to be fed by a tube that was
10 run through his nose, down into his stomach. And
11 because of damage to his kidneys from the lack of blood
12 flow during the cardiac arrest, his heart medications
13 had to be changed. He needed blood transfusions. He
14 needed kidney dialysis treatments. He had to get
15 physical and occupational therapy to regain the
16 strength to be able to walk again. He had to learn how
17 to talk again when the tracheostomy was removed, and he
18 was finally sent home after a total of 49 days in the
19 hospital.

20 He was debilitated. He was weak. He had
21 developed pneumonia in the hospital while being on the
22 ventilator. And when he got home, he had a bad hacking
23 cough. He was unable to exercise. He needed nurses to
24 come to his house and do therapy with him two days a
25 week. He had to attend multiple doctor's appointments

1 and he was not fully recovered from the crisis that
2 took place at the time of his death.

3 He died just 93 days after going into MUSC for
4 that routine screening colonoscopy, and 49 of those
5 last 93 days he spent as a critical care patient in the
6 hospital.

7 His children, Madison and Dadrian, they were
8 just teenagers at the time. And in addition to the
9 grief of losing their father, they now face the rest of
10 their lives without him. They are not with their
11 father, and he is not with them to share in their
12 successes, to comfort them in their struggles. And
13 everything that we show you during this trial, is for
14 you to see that his children and his estate should be
15 compensated in how much money will equal the amount of
16 the harm and the loss caused by being in a hurry and
17 becoming distracted.

18 And by the end of the trial, you will see why
19 the evidence will compel me to ask you for a verdict of
20 several million dollars to compensate the harm and the
21 loss that's occurred in this case. You'll see that
22 that amount of money equals the harm to Mr. Mikell
23 himself, and the harm to his children. And those are
24 the only things that you can consider in determining
25 the amount of your verdict. Thank you very much.

1 THE COURT: Mr. Ransom, do you want to take your
2 charts down, please, sir.

3 MR. RANSOM: Yes, sir.

4 THE COURT: Thank you very much.

5 MR. RANSOM: Thank you.

6 MR. COOKE: May it please the court?

7 THE COURT: Yes, sir.

8 MR. COOKE: Good afternoon, ladies and
9 gentlemen. My name is Dawes Cooke. I think I
10 introduced myself earlier probably at a time when you
11 didn't know you were going to have to remember that
12 name. But I'm with the law firm Barnwell Whaley
13 Patterson and Helms; seated with me is Alissa Fleming.
14 Next to her is Donna Cool. Donna is the University --
15 Medical University Clinical Risk Manager. Then Debbie
16 Tolls (ph) with my office, she's a legal assistant. So
17 those are the folks you're going to be seeing. You're
18 going to be meeting a lot of other folks from the
19 Medical University, nurses, doctors and -- and other
20 folks as well.

21 I'm going to agree with two things that my
22 colleague, Mr. Ransom, told you; and then you probably
23 won't hear us agree about anything else the rest of the
24 week.

25 The first is, I want to thank you for being

1 here. I know you were summonsed to be here. But as
2 you heard, there are plenty of ways of getting out of
3 jury duty if you want to do it, and you folks didn't do
4 it. So you're here and I appreciate that. And I
5 appreciate your attentiveness.

6 The second thing that I want to agree with him
7 about is that you wouldn't be a human being if you --
8 if you -- if your heart didn't go out to the family of
9 Mr. Mikell, and wish like anything that he was still
10 here. But what I'm going to ask you, when this case is
11 over, I'm going to ask you to return a verdict that
12 reassures this family that their father died of heart
13 disease, of natural conditions, not because of
14 inattention or being in a hurry or negligence. These
15 people did everything they could to save his life and
16 to give him a decent life.

17 So this is a story about a man, Mr. Mikell, who
18 was very sick, but needed a colonoscopy. Now, think
19 about that. You know, we all -- all grow up and our
20 doctors and people tell us you should take care of your
21 health. You should eat healthy. You should exercise.
22 You should do all those kinds of things. You should
23 see a doctor. Why? To maintain your health.

24 And the time comes in some people's lives when
25 they haven't been able to do that. They are not

1 healthy, but then they need more medical help. And
2 that's exactly where Mr. Mikell was in this case.

3 He had been under the care of cardiologists
4 since 2003. He suffered from congestive heart failure
5 with cardiomyopathy; insulin dependent diabetes;
6 obstructive sleep apnea, which required him to use a --
7 what they call a CPAP machine. You're going to hear
8 all these terms explained later as we go throughout the
9 week.

10 Chronic Renal Insufficiency, which is damage to
11 his kidneys; morbid obesity; hypertension; high
12 cholesterol. These are all things that his doctors had
13 been trying to help him with at least since 2003.

14 But in 2010, he had another problem. He was --
15 he was suffering from -- from -- digestive problems.
16 He was constipated. He was bloated. And his regular
17 doctor said I think you're going to need a colonoscopy.

18 Now, you don't just subject anybody to
19 anesthesia without thinking twice about it. In this
20 particular case, because of the problems he had, he had
21 to go through a special evaluation to determine can he
22 even undergo this procedure.

23 And what you're going to find -- you're going to
24 hear a more technical explanation -- but what you're
25 going to find is that, yes, he was sick, but he didn't

1 have any evidence of present cardiac instability of
2 this condition. So under the guidelines that are
3 accepted in the world of medicine in anesthesiology, he
4 -- it was okay for him to undergo this procedure.

5 But the folks at the Medical University didn't
6 want to take any chances, even though a colonoscopy is
7 a relatively low risk procedure, you're still under
8 anesthesia. Any time a human being goes under
9 anesthesia, there is some risk involved. And
10 somebody -- for the reasons that Mr. Ransom described,
11 somebody with the problems that Mr. Mikell had, is at a
12 greater risk when he undergoes anesthesia.

13 So in order to minimize the risk that he would
14 suffer from any complications, and in order to maximize
15 the likelihood that they could rescue him if he ran
16 into complications, he was given a very special team.

17 His gastroenterologist was Dr. Mark Payne, who
18 happens to be sitting right back there. He's a board
19 certified gastroenterologist. The Medical University
20 recruited him in 1997 from the University of Kansas,
21 where he had been on faculty there for quite a period
22 of time, and they brought him to Charleston to become
23 the Clinical Director of the Gastroenterology Division
24 and the Director of GI Endoscopy at the Medical
25 University. And he had been that since 1997. So he

1 was as good as you could possibly have as the
2 gastroenterologist.

3 With all due respect to Dr. Payne, he had the
4 easy part of this case. The more difficult part -- the
5 part that was affected by Mr. Mikell's sickness was the
6 anesthesiology.

7 So they brought in a special anesthesiologist.
8 His name is Dr. Eric Nelson. You're going to meet him
9 as well. He is a cardiac anesthesiologist. So in
10 addition to four years of medical school, he did a one
11 year internship, followed by three years of
12 anesthesiology residency, at which time he became board
13 certified as an anesthesiologist. And then he did an
14 additional year, a fellowship, in cardiac
15 anesthesiology. So all he did all day, every day, was
16 provide anesthesia to people who are undergoing heart
17 surgery or caring for patients who had heart disease,
18 who were undergoing other procedures.

19 And then he was assisted by a woman you're going
20 to meet named Donna Embrey. She is an experienced
21 Certified Registered Nurse Anesthetist. CRNA she is
22 sometimes called. So she had been a nurse. She got
23 her nursing degree from the University of South
24 Carolina back in 1987. In 1996, she obtained a Masters
25 in Science Anesthesiology from Mary College down in

1 Florida. And she had worked as a CRNA since that time.
2 She was certified in advanced cardiac life support,
3 which means she's trained to provide CPR and
4 resuscitation for somebody who is suffering a cardiac
5 event.

6 So that was the all star team that was provided
7 to Mr. Mikell. And the idea for that was that they
8 would know the techniques to minimize the risk that one
9 of these problems would occur. And if the risk did
10 occur, they would be the best people who could
11 resuscitate Mr. Mikell.

12 And as it turns out, that's exactly -- that's
13 exactly what happened. He was not -- because of his
14 conditions, he was not able to tolerate the anesthesia.
15 And so even though everything was done exactly right,
16 the right drugs were used -- he was given a -- a dose
17 of Versed, then a wonderful drug called Propofol which
18 normally -- if somebody like us went in for -- for a
19 colonoscopy, we would probably be put to sleep quickly
20 with what they call a bolus of that. Instead he was
21 given a reduced dose, and it was given over a slow
22 period of time. So that contrary to being in a hurry,
23 Dr. Payne was going to have to wait a little longer for
24 him than he would for other people, while he was slowly
25 put under the anesthesia.

1 And everybody that you are going hear testify,
2 including the plaintiff's own expert who's being paid
3 to come and give expert testimony, is going -- is going
4 to tell you that that's exactly the way you should
5 handle a patient like Mr. Mikell, who is undergoing a
6 colonoscopy.

7 A very few minutes into the procedure, it became
8 apparent to Ms. Embrey that he was not tolerating the
9 anesthesia. He did begin to what they call desaturate,
10 which they're constantly monitoring the oxygen
11 saturation in his blood. And it started to go down.
12 And at that point, she calls Dr. Nelson, who
13 immediately comes to her aid.

14 They turn him on to his back. They intubate
15 him. They begin -- they -- they bag him. They do all
16 the -- they give him Epinephrine. They do all the
17 things that they're supposed to do, and gradually the
18 oxygen rates improve.

19 They start doing chest compressions so that --
20 even though his heart -- his heart never stopped by the
21 way. His heart stopped pumping blood, but it was
22 always -- it was always beating, but it stops
23 effectively pumping the blood, so they give chest
24 compressions while they're doing this resuscitation.
25 And you'll start to see, as you look at the records,

1 that the oxygenation improves. The carbon dioxide
2 improves.

3 Finally, they shock him to put his heart back
4 into what we call normal science rhythm, which is the
5 heart rate that hopefully all of us have. And then to
6 make sure that he has no organ damage, they lower his
7 body temperature, and they put him into an induced
8 coma, and it worked.

9 I mean, what -- what you're going to hear is
10 that this was a magnificent piece of medical work that
11 was done. Everybody did what they needed to do and
12 everything that they did worked.

13 Contrary to what you may have guessed from Mr.
14 Ransom's opening statement, all of -- all of
15 Mr. Mikell's critical organ functions returned to
16 normal before he was released to come home. He
17 suffered no damage to his heart muscle. And you'll
18 hear cardiologists who will explain that.

19 His function of his heart was as good after --
20 after he recovered as it was before October 1st of
21 2010. His renal function, we know it had been impaired
22 previously, was returned to the kidney function, renal
23 function -- the same thing -- was returned to the level
24 that it was before. Metabolically, physically, he had
25 completely recovered at the time that he passed away --

1 the time he passed away.

2 What you're going to learn also is that
3 Mr. Mikell was at risk of dying any time -- at any
4 time. You're going to hear this from his own
5 physicians, the ones who were taking care of him
6 because of -- because of his condition. We don't know
7 to this day what caused him to -- to die on January
8 2nd. No autopsy was done. And so you're going to be
9 asked, I suppose, to speculate that what happened to
10 him back in October contributed, as what we call under
11 the law, proximate cause of his death. But I'm going
12 to submit to you that there is no evidence to support
13 that. That because of the heroic efforts of this
14 medical team, he was saved from this complication, from
15 this cardiac arrest that he suffered on the table.

16 I'm want to talk about a couple of other aspects
17 of this. Mr. Ransom spent a lot of time talking to you
18 about medical records. And what he said was that --
19 and I wrote the terms down -- he said that they were
20 altered, changed, damaged, lost, scrambled -- every
21 negative term that you could think of. That is simply
22 not true..

23 He's also going to suggest to you that somehow
24 the monitoring equipment was not working. That is
25 simply not true. You're going to hear from the people

1 who were working that day, that the records that were
2 kept in this case are -- are -- are excellent records
3 from almost every perspective. They are light years
4 ahead of what records would have been anywhere from 10
5 or 15 years ago, when most of us were growing up.

6 In the old days -- and by "old days", I mean
7 about 10 years ago, everything had to be hand charted
8 on records. The Medical University has been -- to
9 improve patient care and to improve the quality of its
10 records, it's been moving to computerized systems one
11 bit at a time.

12 And so at the time that Mr. Mikell was being
13 taken care of, the records were essentially kept on
14 computer. Some -- some records were kept automatically
15 by the computer. And you're going to find that the
16 vital signs would go directly from the monitoring
17 equipment into the computer, and then into the hospital
18 chart. You're going to see all that.

19 The -- the glitch that Mr. Ransom is referring
20 to, where he says that -- and he has this image of
21 Donna Embrey running around, trying to get the machine
22 to work -- trying to get the machine to work -- that's
23 not true at all. You're going to hear from her.
24 You're going to hear from the people that she worked
25 with. That at every moment that Mr. Mikell was under

1 her care, she was monitoring him. She had all of the
2 things plugged into him. She had a -- a thing on
3 his -- on his finger to measure his oxygen saturation
4 rate.

5 She was monitoring his heart rate. She was
6 monitoring all of his vital signs continuously. It's
7 in a very small room. The screen is right there in
8 front of them.

9 The one thing that did happen was when they
10 first moved him into the procedure room, she noticed --
11 she noticed that the data that was being displayed was
12 not flowing into the computer, and then into the chart..
13 All that means is that it's not being recorded. It's
14 like -- it's like -- if I had tape recorder sitting
15 here, and I'm talking to you folks, and I look down to
16 see the machine is not recording -- that doesn't mean
17 that we didn't have the conversation. It didn't mean
18 that I wasn't talking. It just means that that -- that
19 that conversation was not recorded.

20 And that's what she noticed. And for a period
21 of about 12 minutes -- and she did exactly what she was
22 instructed to do, she said get in touch with the IT
23 folks, the PICIS people here. And when something like
24 this happens, you call them and they will fix it. And
25 they did. They remotely entered the computer, reset it

1 or whatever they had to do, and transferred the
2 patient. And then all the data was there.

3 The other thing that Mr. Ransom would accuse the
4 Medical University folks is -- I think he used the word
5 "altering" or changing records. In the old days --
6 again, going back 10 long years -- everything was
7 written by hand or -- or -- or punched into a computer.
8 When a procedure is over, nobody in this world has time
9 to write every single thing down. And you're going --
10 you're going to be amazed at the amount of data that is
11 recorded during this procedure. Nobody has time to do
12 that as it's happening all the time, particularly when
13 there is an emergency like there was in this situation,
14 your job is to take care of the patient, and then take
15 care of the chart and the records.

16 So what they did is what they always do. When
17 the dust had settled and the procedure was over,
18 Mr. Mikell was safe. They're taking care of other
19 patients later in the day, Donna Embrey came and did
20 exactly what she was supposed to do. She opens up the
21 chart, and she plugs in numbers that didn't get
22 recorded in time. And when she sees that there's a
23 discrepancy in time, she correct the time.

24 And the reason you're going to learn about this,
25 this is all part of the philosophy of the Medical

1 University, we want to know what happened. That's how
2 we get better in medicine. We want to know second by
3 second, minute by minute, what happened. And it's her
4 responsibility to go put that information in. And for
5 that, she's being accused of altering or changing the
6 medical record. She's going to explain to you exactly
7 what she did in that regard.

8 The -- Mr. Ransom is right. Nobody can find the
9 Mayday sheet. The Mayday sheet is one thing that is
10 not computerized -- or one of the few things that is
11 not computerized. It's a -- it's a separate sheet that
12 when a Mayday is called, or a code is called -- not in
13 all parts of the hospital, but -- but -- but when there
14 is a Mayday called, it's a separate sheet they can --
15 there -- the nurses watching it can use to record data.

16 We believe one was done. We believe it existed.
17 You're going to hear that the Medical University has
18 gone to a great bit of trouble to see if they can
19 recover that data, and they've been able to recover
20 almost all the data that was on that Mayday sheet.
21 You're going to hear later about how that was done.

22 But more importantly, what you're going to find
23 is that there's virtually no criticism of the
24 resuscitative efforts that were made once this Mayday
25 sheet was started. So there's absolutely nothing that

1 could have been on this Mayday sheet that would reflect
2 what had happened before that. You're going to see
3 that too. We're going to explain that to you.

4 The last thought that I want to leave you with
5 is the concept of risk. Any time we're here in the
6 courtroom, something bad has happened. And we -- and
7 we look back and it's easy for me to look at
8 Mr. Mikell's family and say, hey, you know, he was at
9 great risk. He was at great risk. But for the people
10 who are in that family, the risk was 100 percent
11 because it happened. For people that it doesn't happen
12 to, it's zero percent.

13 But I'm going to tell you, and you're going to
14 hear, that with all the care in the world, with all the
15 care in the world, all you can do is reduce the risk.
16 You can't eliminate the risk. So for this family, it
17 seems like they didn't reduce the risk, because it
18 happened. He had 100 percent -- he had 100 percent
19 complication rate in this procedure.

20 But medicine is all about trading one risk for
21 another risk. It's trading -- it's a decision that the
22 patient and the physicians have to make together, where
23 they say if we don't do this procedure, or we don't do
24 it this way, what are your risks? Can we put you at a
25 lower risk by doing that procedure and -- and -- and

1 trade a smaller risk for a greater risk.

2 But never, ever, if anybody can ever get that
3 risk to zero, there is a noble prize in it for them.
4 Because it just can't happen. And I hope that by the
5 time you listen to everybody, listen to the testimony
6 in this case, what you're going to conclude is that we
7 have the best, and the brightest, and the most
8 dedicated people that you could possibly want working
9 at the Medical University, trying to help people no
10 matter how sick they are.

11 It's dedicated, smart people doing the best that
12 they can do to take the best possible care of even the
13 sickest patients. And we're going to ask you to
14 conclude at the end of this trial that, yes, he did
15 have complications. Yes, he did suffer. But it was
16 not as a result of the negligence of those dedicated
17 people who were taking care of him. Thank you.

18 THE COURT: Mr. Ransom, if you'll call your
19 first witness, please.

20 MR. RANSOM: Thank you, Your Honor. The
21 plaintiff calls Dr. Danielle Scheurer.

22 DR. DANIELLE SCHEURER, after
23 having been duly sworn, testified as follows:

24 THE CLERK: Please state your first and last
25 name, and spell your last name loudly and clearly into

DR. SCHEURER -- DIRECT

1 the microphone.

2 THE WITNESS: Okay. The first name Danielle,
3 last name Scheurer, S-c-h-e-u-r-e-r.

4 **DIRECT EXAMINATION BY MS. RANSOM:**

5 Q. Good afternoon, Dr. Scheurer. You are the
6 Chief Quality Officer at the Medical University?

7 A. Yes, sir.

8 Q. All right. And you, over the course of your
9 career, have given lectures to the medical staff?

10 A. Yes, sir.

11 Q. Okay. That includes the doctors and the
12 nurses and the medical residents?

13 A. Yes. Part of my mission is to educate people
14 about quality, yes.

15 Q. And some of these presentations are recorded
16 when you give them?

17 A. Probably.

18 Q. And then the recorded presentations are posted
19 on a MUSC website?

20 A. I do give presentations in a number of venues,
21 some of them are recorded, yes.

22 Q. And then because MUSC is a teaching
23 institution, those recorded presentations are put some
24 place where doctors, nurses, students and other members
25 of the medical community can get access to them online

DR. SCHEURER -- DIRECT

1 so they don't have to attend the presentation as you're
2 giving it live; they can pick it up later?

3 A. I think for the most part, that's for the
4 medical students. There's a site called Tegrity for
5 medical students.

6 Q. Okay. And some of the lectures that you have
7 given have been recorded or actually posted and
8 available on the Tegrity website; right?

9 A. As far as I know, yes.

10 Q. One of the presentations that you've given at
11 the university -- the Medical University is called Life
12 Cycle of an Event?

13 A. I -- forgive me. I do give hundreds of
14 educational seminars a year. But I do believe I gave
15 one called that, yes.

16 Q. Okay. And that's one of the ones that's
17 posted on the Tegrity website?

18 A. As far as I know.

19 Q. Okay. And, again, the Tegrity website is
20 available to anybody who's got access to the internet;
21 right?

22 A. I do not think that's true. I believe it's
23 within the firewall of MUSC.

24 Q. Okay. One of the things that you told your
25 audience, when you gave this presentation called Life

DR. SCHEURER -- DIRECT

1 Cycle of an Event, was that if there is an adverse
2 event at the Medical University -- meaning something
3 like a patient that suffers an unexpected cardiac
4 arrest, right -- that would be an adverse event?

5 A. It's generally considered an adverse event,
6 yes.

7 Q. So, for example, when Mr. Mikell in this case
8 suffered an unexpected cardiac arrest, we would call
9 that an adverse event?

10 A. I think that's fair.

11 Q. So one of the things that you said during your
12 presentation was that in the event of an adverse event,
13 the medical care providers who are involved in that --
14 with that patient, they should never use the terms
15 "negligence" or "accident" when describing what
16 happened?

17 A. Those are not generally terms that we use in
18 the clinical setting.

19 Q. Okay. Yeah. And you tell the people there,
20 the medical care providers, that they shouldn't use
21 those terms when describing an adverse event?

22 A. We describe the event as the facts, but don't
23 insert other words. We just describe the event as it
24 happened.

25 Q. And you specifically, said don't use the terms

DR. SCHEURER -- DIRECT

1 "negligence" or "accident"?

2 A. Well, we generally don't know at the time of
3 the event, when we're describing the event. We just
4 describe the facts.

5 Q. One of the other things that you told the
6 folks at MUSC not to do in your presentation called
7 Life Cycle of an Event, is don't ever point fingers at
8 one another?

9 A. So we encourage team work and
10 multidisciplinary care teams to work together, and so
11 finger pointing doesn't help us be better teams.

12 Q. Right. And so they're specifically told don't
13 point fingers at one another?

14 A. That's correct. We have to depend on each
15 other as a team.

16 Q. One of the other things that you said during
17 this presentation, was that they should never, ever
18 alter documentation?

19 A. Yeah. Well, of course. The purpose of
20 documentation is an accurate reflection of what
21 happened.

22 Q. But we can agree that you -- that the rule at
23 the Medical University is don't alter documentation?

24 A. Well, when you say "alter", sometimes if the
25 facts -- or more information becomes available later,

DR. SCHEURER -- DIRECT

1 we do document that information. So I don't -- I don't
2 want to get too granular on the word "alter". But the
3 medical record is there to represent what happened when
4 you know it's happening.

5 Q. Okay. And if changes need to be made to a
6 medical record, is it supposed to be done in a way so
7 that people who later look at the record can see that
8 that's been done?

9 A. Yes.

10 Q. Okay. So anytime when I -- if I -- if I --
11 instead of calling it altering the medical record, if I
12 called it changing the medical record, you would agree
13 that when you change a medical record, it should be
14 done in a way that makes it clear that you have been --
15 in fact, made a change?

16 A. Uh-huh.

17 Q. Yes?

18 A. Yes.

19 Q. Okay. You've also said during your
20 presentation to the medical care providers, the Life
21 Cycle of an Event, that they need to be aware of the
22 fact that patient's medical record is a legally
23 discoverable document?

24 A. It is, yes.

25 Q. And by legally discoverable, you mean that

1 ultimately a patient's family or their legal counsel
2 would be able to get the medical record?

3 A. Yeah. It's their medical record. Yeah, it's
4 the patient's record.

5 Q. Okay. And so as a consequence to that, one of
6 the other things that you recommended, when you were
7 giving your presentation, was that medical care
8 providers should never write something that they don't
9 later want a lawyer to be reading?

10 A. Well, that's not the intent of the medical
11 record.

12 Q. But what you told the people who were hearing
13 this presentation was -- that they shouldn't ever write
14 something that they wouldn't later want a lawyer to be
15 reading?

16 A. Because that's not the intent of the medical
17 record.

18 MR. RANSOM: Okay. Thank you. I don't have any
19 other questions.

20 THE COURT: Cross-examination.

21 MR. COOKE: Thank you.

22 **CROSS EXAMINATION BY MR. COOKE:**

23 Q. Doctor, tell us a little bit about your
24 background.

25 A. I am internal medicine physician, and I work

1 in the inpatient setting. And then on top of that, I
2 have an extensive history in quality improvement of
3 patient safety.

4 Q. How long have you been in that area,
5 quality -- quality improvement area?

6 A. I was in Boston at Brigham Women's Hospital
7 for five years, and did extensive work in quality
8 information patient safety there. And then I returned
9 to MUSC in 2010, and have worked in quality improvement
10 patient safety here since then. So six years here.

11 Q. I want to -- I want to press you a little bit
12 on some of the things that Mr. Ransom asked you about.
13 First of all, the question of altering or changing or
14 adding to medical records, I'm going to ask you to
15 assume for the sake of argument, that later in the day,
16 when this procedure took place on October 1, 2010, that
17 the members of the nursing staff went back and added
18 things to the record, or corrected times that may have
19 been wrong, that may have not been manually entered in
20 the first place; is that or is that not acceptable?

21 A. Yeah. That's acceptable as long as it
22 reflects what happened. I mean often times, as you can
23 imagine in the clinical setting, you can't work and
24 document at the same time. So we -- we often do our
25 work, and then later document a recollection of what

1 happened. So it's very difficult, if not impossible,
2 to do both at the same time.

3 Q. Now, when you -- when you document the record
4 back then in 2010, did that include typing into a
5 computer terminal? Is that -- is that how the record
6 would be documented?

7 A. Yeah. The anesthesia record was an electronic
8 medical record at that time.

9 Q. And that's what we were referring to as the
10 PICIS?

11 A. PICIS.

12 Q. And did PICIS keep track of who was entering
13 what, when, into that record?

14 A. Yeah, I get -- there are some advantages and
15 some disadvantages to the electronic medical record.
16 One of the advantages is you can tell what was
17 documented and when and by whom, based on log ins and
18 time stamps.

19 Q. So I kept talking about in the old days -- in
20 the old days, if you -- if you went back and changed an
21 entry, you were supposed to initial it; is that right,
22 so you can see if that somebody had changed that?

23 A. Right. On the paper medical record, it was
24 much more difficult to accurately reflect what happened
25 and when it happened, because you would mark through

1 it, or put your initials or retime stamp it, but it was
2 just based on mark outs.

3 Q. But by 2010, did PICIS do that for you by
4 keeping an audit trail of who was in the computer and
5 changing what?

6 A. Correct.

7 Q. So if you were inclined to do it, you could
8 find out who wrote what, when and what numbers were
9 changed, and what numbers were not changed?

10 A. Yeah. That is one of the large advantages of
11 the electronic medical record.

12 Q. And does that give you a level of confidence
13 in the integrity of the records?

14 A. It -- it does.

15 Q. Now, you were asked about some statements that
16 you had made about don't point the finger at each
17 other, and don't write things in the chart that lawyers
18 might pick up on later. Without me putting words in
19 your mouth, tell the jury if you would, what is the
20 Medical University's philosophy about -- like can I use
21 the word "self critical analysis" -- does that mean
22 anything to you?

23 A. Uh-huh.

24 Q. What -- what do you call the process by which
25 you analyze what goes on in a hospital, what happens,

DR. SCHEURER -- CROSS

1 and what goes wrong? What do you call that process?

2 A. Well, we call that quality improvement. And
3 we do use a methodology called Continuous Quality
4 Improvement where we routinely -- and I would say
5 continuously -- are self critical pretty much on
6 everything we do in an attempt to always make it better
7 so that what we call CQI, or Continuous Quality
8 Improvement, so we always have to reflect on everything
9 we do within teams of which there's -- in -- in your
10 critical interdependencies within teams to self-reflect
11 on events or near events, make sure that we did
12 everything we could have done, and always make it
13 better for the next patient. That's -- that's the
14 entire job of the quality department, to instill that
15 into all of our practitioners.

16 Q. Have you ever told people that they should
17 cover up mistakes that they have made?

18 A. Absolutely not..

19 Q. Do you ever tell them that they should sugar
20 coat things to try to make it look like it was a
21 natural event, rather than an act of negligence?

22 A. No, definitely not. In fact, I would say just
23 the opposite, we have fully embraced transparency, and
24 we always ask providers to tell us everything they
25 know, when they know it, and most importantly to tell

1 the patient and the family. And that is -- that is our
2 goal, is to continuously get better.

3 Q. And why do -- why do you go to this level of
4 analysis with -- with what goes wrong in a clinical
5 setting?

6 A. Really, like I said, just to make it better
7 for the next patient the next day. I mean, that's --
8 that's the entire purpose of our existence is to
9 provide good care.

10 MR. COOKE: Thank you.

11 THE COURT: Any redirect?

12 **REDIRECT EXAMINATION BY MR. RANSOM:**

13 MR. RANSOM: Yes, Your Honor, very briefly.

14 BY MR. RANSOM:

15 Q. Dr. Scheurer, do you have any personal
16 knowledge of the actual changes that were made to the
17 anesthesia record in Mr. Mikell's case?

18 A. No, sir.

19 MR. RANSOM: Thank you. I don't have any other
20 questions.

21 THE COURT: Any recross?

22 MR. COOKE: None. Thank you.

23 THE COURT: You may step down. Thank you very
24 much. Any reason she can't be excused?

25 MR. RANSOM: Yes, Your Honor.

DR. PAYNE -- DIRECT

1 THE COURT: There is a reason?

2 MR. RANSOM: Oh, no. I'm sorry. Yes, she can
3 be excused.

4 THE COURT: Okay. Doctor, you may be excused.
5 Thank you very much. Call your next witness.

6 MR. RANSOM: The next witness is Dr. Mark Payne.

7 THE COURT: Hold on. Call your next witness:

8 MR. RANSOM: Dr. Mark Payne.

9 DR. MARK PAYNE, after
10 having been duly sworn, testified as follows:

11 THE CLERK: Please state your first and last
12 name, and spell your last name clearly into the
13 microphone.

14 THE WITNESS: My name is Kenneth Payne. Last
15 name P-a-y-n-e. My middle name is Mark.

16 **DIRECT EXAMINATION BY MR. RANSOM:**

17 Q. Dr. Payne, you are the physician employed by
18 the Medical University?

19 A. I am.

20 Q. And you were the gastroenterologist who
21 performed the colonoscopy on Charles Mikell on October
22 1, 2010?

23 A. I am.

24 Q. It's true that you had never met Mr. Mikell at
25 any time before that morning?

DR. PAYNE -- DIRECT

1 A. That's true.

2 Q. Okay. You didn't speak to any of Mr. Mikell's
3 other medical providers prior to performing this
4 procedure?

5 A. I did not.

6 Q. Now, because of his heart condition,
7 Mr. Mikell wasn't a candidate for what is called
8 moderate sedation; right?

9 A. That's correct.

10 Q. Okay. And moderate sedation is what you would
11 normally use on a colonoscopy patient, that would be a
12 level of medication that you could use to put a patient
13 to sleep that you, as the gastroenterologist and with
14 your nurse assistant, would feel comfortable
15 administering yourself?

16 A. It's used for a couple of reasons. One is --
17 is the illness of the patient. Second, for patients
18 who are on medications that make them very difficult to
19 sedate, so both of those would be reasons to do it.

20 Q. Okay. Well, my point was, with some patients
21 who are going to receive moderate sedation, as opposed
22 to deep sedation, you actually provided the sedation
23 yourself?

24 A. That's right.

25 Q. Without an anesthesiologist?

DR. PAYNE -- DIRECT

1 A. That's correct.

2 Q. Without a nurse anesthetist?

3 A. Correct.

4 Q. You just do that yourself and your nurse?

5 A. Correct.

6 Q. Okay. Patients with sleep apnea, though, they
7 are at risk for what medical term is -- I think --
8 hypoventilation?

9 A. Yes.

10 Q. Okay. Can you explain to us what
11 hypoventilation is?

12 A. Hypoventilation is -- is decreased oxygen so
13 that the person's oxygen saturation can fall. In sleep
14 apnea, it typically occurs during sleep. That's why
15 they call it sleep apnea.

16 Q. Right.

17 A. It means not breathing.

18 Q. Okay. And the sleep apnea, the mechanism then
19 is -- we had perhaps discussed that -- I didn't notice
20 if you were in the courtroom -- but during opening, I
21 described where you go to sleep, the muscles in the
22 back of your throat relax, and your airway obstructs?

23 A. That's basically correct.

24 Q. Okay. And that can happen when you're asleep
25 at home in your bed?

DR. PAYNE -- DIRECT

1 A. Yes.

2 Q. And it can happen when you're put to sleep
3 with drugs in the hospital?

4 A. Correct.

5 Q. Okay. And hypoventilation is just reduced
6 breathing, if you will, that comes about as a result of
7 that?

8 A. Hypoventilation is a respiratory rate times
9 how much air you're taking in. So if you're not taking
10 enough in, you hypoventilate.

11 Q. Okay. So if you've got a patient that's got
12 obstructive sleep apnea, and they're at risk for
13 hypoventilation, the way that that is handled is you
14 get an anesthesia provider who has some greater
15 experience managing airways?

16 A. Not every time, but it depends on the patient.
17 We often do for patients with sleep apnea.

18 Q. Okay. Because you, as a gastroenterologist,
19 when you're in the procedure room, you actually have to
20 have your attention directed towards manipulating --
21 they call it the endoscope, which is the camera that's
22 placed up into the intestines to look around; right?

23 A. Yes. But, again, when I do moderate sedation,
24 I do both.

25 Q. Correct. But you don't have the hands free,

DR. PAYNE -- DIRECT

1 if you will, to manipulate a patient's airway if they
2 get into trouble?

3 A. Well, if I'm doing moderate sedation, and they
4 get into trouble, I stop the endoscopy and do that,
5 yeah.

6 Q. Okay. And this is why where you've got a
7 patient that's going to receive deep sedation, you want
8 an anesthesia provider to help you?

9 A. For deep sedation, I do.

10 Q. Now, I think -- you don't have any
11 recollection of whether or not Dr. Nelson, the
12 anesthesiologist during Mr. Mikell's colonoscopy, you
13 don't recall whether he was present in the procedure
14 room when the colonoscopy actually started?

15 A. I don't remember.

16 Q. Okay. So you don't know if he was there or
17 not?

18 A. I don't know if he was there or not, correct.

19 Q. And what you do remember is that after the
20 colonoscopy started, Mr. Mikell developed a slow heart
21 rate and hypoxia?

22 A. At some point in time, yes, uh-huh.

23 Q. And you were busy doing the procedure using
24 the endoscope, and you looked up and saw that
25 Mr. Mikell was hypoxic and had bradycardia?

DR. PAYNE -- DIRECT

1 A. I did.

2 Q. You removed the endoscope?

3 A. I did.

4 Q. Okay. And Mr. Mikell didn't have a pulse?

5 A. I don't know at that point in time if we had a
6 pulse or not. I removed the endoscope that -- when
7 they were managing his airway --

8 Q. Okay.

9 A. Or to let them manage the airway, I guess is a
10 better way --

11 Q. Well, once you got the scope removed, they
12 started doing CPR?

13 A. Once the scope was removed, they started mask
14 ventilating the patient. I can't tell you which time
15 they checked the pulse, that sort of thing.

16 Q. Okay. And then they actually called the
17 Mayday?

18 A. Yes, eventually did, yes.

19 Q. Now, after the procedure was over, you went
20 out into the waiting room and you spoke to Mr. Mikell's
21 mother?

22 A. Yes.

23 Q. All right. You told her a little bit about
24 what had happened?

25 A. Yes.

DR. PAYNE -- DIRECT

1 Q. You explained to her that he had had a cardiac
2 arrest?

3 A. I explained to her that he had had a
4 complication and that he had arrested, and that -- he
5 regained the blood pressure, and all that sort of
6 thing, yes.

7 Q. And you explained to her that he was going to
8 have to be admitted to the hospital?

9 A. I explained to her that he was going right now
10 to the ICU, when things were stable enough.

11 Q. Okay. And then after the room had cleared, if
12 you will, Mr. Mikell had been taken off to another area
13 of the hospital, you went back into the procedure room?

14 A. I don't remember going back into the procedure
15 room.

16 Q. Okay. Do you remember going back in and
17 looking at the PICIS anesthesia record?

18 A. Not then, no.

19 Q. Okay. To try to find out what had happened?

20 A. Not -- not at that time, no.

21 Q. Okay. Did you do that at some other time?

22 A. Yeah. I asked for the paper sort of --
23 print-out sort of thing the next day.

24 Q. Okay. And did you get that?

25 A. I did.

DR. PAYNE -- DIRECT

1 Q. Okay. And it showed a drop in oxygen and
2 blood pressure; right?

3 A. It did. But to be honest with you, I had a
4 very difficult time interpreting it, because I'm really
5 used to looking at anesthesia records, so I really
6 didn't get a whole lot out of it. I didn't really
7 learn more than I knew the day before.

8 Q. I think you had testified earlier --
9 previously, that you weren't able to make a whole lot
10 of sense out of it?

11 A. Yeah. I'm just not used to looking at
12 anesthesia records.

13 Q. Now, would it be fair to say that as the
14 gastroenterologist, you weren't present during very
15 many Maydays?

16 A. That's true.

17 Q. Okay. But you do know that when a Mayday or a
18 code is called, there's usually a record made?

19 A. There's usually a code recorder that writes
20 things down. Uh-huh.

21 Q. And that's on a form -- a documented piece of
22 paper, if you will, that they call a Mayday record?

23 A. I assume so. I really don't know much about
24 the Mayday process. I know that it's a recorder. I
25 don't know what the form looks like.

DR. PAYNE -- DIRECT

1 Q. But you know that there's supposed to be a
2 Mayday record?

3 A. Right. It think it depends on whether it's in
4 an OR, or whether it's in a -- in a moderate sedation
5 room, there would definitely be a recorder.

6 Q. Is the Mayday record sometimes referred to as
7 code documentation?

8 A. Well, a Mayday is frequently referred to as a
9 code, so I think that's probably accurate.

10 Q. Okay. And when you were finished with the
11 colonoscopy procedure, part of your responsibility as a
12 physician there at MUSC was to make a record of the
13 procedure; correct?

14 A. Any procedure I perform, I need to perform a
15 -- to write a procedure note or dictate one.

16 Q. And you did that for Mr. Mikell's colonoscopy?

17 A. I did.

18 Q. All right. What I'd like to do is show you
19 what's been marked as Exhibit 14. Dr. Payne, this is
20 Exhibit 14, does that have your signature down there in
21 the lower left?

22 A. It does.

23 Q. Okay. Is that the procedure note that you
24 prepared for Mr. Mikell's case?

25 A. It is.

DR. PAYNE -- DIRECT

1 Q. Okay. Let me put this on the document
2 projector so that we can all look at it together.
3 Okay. The part that I'm interested in is this phrase
4 right here, it says "please see code documentation" --
5 am I reading that correctly?

6 A. Yes, yes, you are.

7 Q. So this is your procedure note that you signed
8 after the procedure itself, and you're referring to
9 what you call code documentation?

10 A. Correct.

11 Q. All right. That would be the Mayday record?

12 A. Right. Whatever -- whatever is written down
13 for the -- for the Mayday, uh-huh.

14 Q. Now, you've never seen the Mayday record for
15 Mr. Mikell's cardiac arrest; have you?

16 A. I have not.

17 MR. RANSOM: Thank you, Dr. Payne.

18 THE COURT: Cross-examination. Let me do this,
19 let's take a short break, five or ten minute break at
20 this time -- about ten or fifteen minute break at this
21 time before we start cross-examination.

22 Madam Forelady, and ladies and gentlemen of the
23 jury, please don't discuss the case amongst yourselves.
24 If you need a smoke break, let the bailiffs know.
25 They'll take you to the proper place for that. And

DR. PAYNE -- DIRECT

1 we'll take about a 15, 20 minute break at this time, so
2 I'll see you shortly.

3 (WHEREUPON, the jury leaves the courtroom at 4:50
4 p.m.)

5 THE COURT: All right. Dr. Payne, during the
6 break, don't discuss the case with anybody; do you
7 understand?

8 THE WITNESS: Yes, sir.

9 THE COURT: Okay. All right. Because I notice
10 you -- I don't know what you were going to say to the
11 attorney, but they are not --

12 THE WITNESS: I didn't say anything. Just
13 ignorance, I'm sorry.

14 THE COURT: Don't discuss the case with anybody
15 during the break; okay?

16 THE WITNESS: Yes, sir.

17 THE COURT: All right. We're going to take a
18 short break. Thank you very much. You may step down.

19 (WHEREUPON, a brief recess was taken.)

20 THE COURT: Anything from the plaintiff before
21 we bring the jury?

22 MR. RANSOM: Nothing, Your Honor. I'm ready to
23 continue.

24 THE COURT: Anything from the defendant?

25 MR. COOKE: Nothing, thanks.

1 THE COURT: Bring us the jury, please.

2 MR. RANSOM: Your Honor, there is one matter
3 perhaps we could take up without the jury, and that
4 would be for me to offer that Exhibit 14.

5 THE COURT: Don't you want to do that in front
6 of the jury?

7 MR. RANSOM: Well, we can do that.

8 THE COURT: Does the defendant have any
9 objection?

10 MR. COOKE: There's no objection.

11 THE COURT: All right. I'll just tell the jury
12 it's been admitted without objection.

13 (WHEREUPON, Plaintiff's Exhibit No. 14 admitted
14 into evidence.)

15 THE COURT: Bring us the jury please.

16 (WHEREUPON, the jury enters the courtroom at
17 approximately 5:09 p.m.)

18 THE COURT: Madam forelady, ladies and gentlemen
19 of the jury, Plaintiff's Exhibit No. 14, which he had
20 on the screen briefly, has been admitted by the court
21 without objection. Cross-examination, please.

22 **CROSS EXAMINATION BY MS. FLEMING:**

23 Q. Dr. Payne, could you tell the jury a little
24 bit about your educational background, and how long
25 you've been employed by MUSC?

DR. PAYNE -- CROSS

1 A. I have a bachelors degree from the University
2 of Kansas, 1982; medical school '82 to -- excuse me --
3 '78 to '82, medical school. I -- I graduated in 1978
4 from the University of Kansas. I entered medical
5 school in 1978. It ended at '82. Residency and
6 fellowship University of Kansas, and I finished my
7 fellowship in 1987. I've been at the Medical
8 University now for -- I think July will be 17 years..

9 Q. Okay. And were you recruited to come to -- to
10 MUSC from the University of Kansas?

11 A. I was.

12 Q. Okay. And what position do you currently
13 hold -- or what clinical positions do you currently
14 hold at MUSC?

15 A. I'm the Director of GI Endoscopy. I'm the
16 director of Gastroenterology and Hepatology.

17 Q. Now, Mr. Ransom asked you some questions about
18 Mr. Mikell's colonoscopy on October 1, 2010. He asked
19 you whether you met Charles Mikell for the first time
20 on the day of the procedure. Is it usual or typical
21 for you to meet the patient for the first time on the
22 day of the procedure?

23 A. Yes. There's two types of patients. One, we
24 see in clinic. The other is open access endoscopy, so
25 someone can schedule the procedure and we meet them the

1 day of the procedure.

2 Q. And so if a patient is referred to you from
3 his or her primary care physician for a colonoscopy, it
4 wouldn't be unusual for you to meet that patient for
5 the first time that day?

6 A. It would not be unusual.

7 Q. And I think you also testified earlier that
8 there are some cases that you actually provide -- or
9 you do the anesthesia yourself; is that correct?

10 A. That's correct.

11 Q. Now, in Mr. Mikell's colonoscopy, was there a
12 board certified anesthesiologist and CRNA assigned to
13 his case?

14 A. Yes.

15 Q. And -- and how does that -- how does that
16 happen? Was he triaged or screened in order to -- to
17 be assigned that level of care?

18 A. When somebody is referred for a procedure,
19 it's reviewed by a nurse coordinator. And if somebody
20 has as many medical illnesses as Mr. Mikell, it
21 would -- it would -- it would be referred to the preop
22 clinic and assigned an anesthesia case.

23 Q. And was it your understanding that he also had
24 a preoperative anesthesia evaluation in this case?

25 A. Yes.

DR. PAYNE -- CROSS

1 Q. Now, on the day of the procedure, once -- once
2 the patient is brought into the procedure room, how do
3 you make the determination of whether to start -- when
4 to start the case?

5 A. Generally the CRNA administers the medication
6 for anesthesia. And then when the patient gets sleepy,
7 either I'll know because the patient is sleepy, or they
8 will let me know it's time -- it's time for me to
9 start.

10 Q. And are -- are there monitors that are
11 connected to the patient before you start the
12 colonoscopy procedure?

13 A. Yes.

14 Q. And to the best of your recollection, was
15 Mr. Mikell connected to monitors before you started --
16 before you started the colonoscopy in this case?

17 A. Yes. And I wouldn't start a case without
18 somebody being monitored.

19 Q. And would you ever insert the colonoscope if
20 the monitors were not on the patient?

21 A. No. The patient has to be monitored before we
22 start the procedure.

23 Q. Would you recall whether Charles Mikell was
24 connected to monitors when you started the procedure?

25 A. I don't remember the start of the procedure.

DR. PAYNE -- CROSS

1 But, again, I never start a procedure without a patient
2 being monitored, so...

3 Q. Now, do you recall what time you started the
4 procedure?

5 A. I don't.

6 MS. FLEMING: I would like to mark for
7 identification Defendant's Exhibit 1, please.

8 (WHEREUPON, Defendant's Exhibit Number 1 was
9 marked for identification.)

10 BY MS. FLEMING:

11 Q. Dr. Payne, I'd like to hand you what's been
12 marked for identification as Defendant's Exhibit 1.
13 Have you seen this document before?

14 A. Yes.

15 Q. Okay. And can you identify it for the jury
16 please?

17 A. This is a nursing document for the procedure.

18 Q. Okay. And does it -- is it documented by the
19 nurse who's actually in the procedure room with you?

20 A. Yes.

21 Q. So an endoscopy nurse who's assigned to the
22 case?

23 A. Right. It's documented by two nurses. One,
24 the person who set up the room it looks like, and the
25 other person that was in the procedure room.

DR. PAYNE -- CROSS

1 Q. And does this provide any information about
2 when -- when the -- when you started the procedure?

3 A. Well, it notes the scoping was 7:42.

4 Q. Okay. And so that indicates that you inserted
5 the scope and began the procedure at approximately 7:42
6 a.m.?

7 A. Approximately 7:42, uh-huh.

8 MS. FLEMING: Okay. I'd like to go ahead and
9 move Defendant's Exhibit 1 into evidence.

10 MR. RANSOM: No objection.

11 THE COURT: No objection?

12 MR. RANSOM: No objection, Your Honor.

13 THE COURT: Okay. Defendant's No. 1 admitted
14 without objection.

15 (WHEREUPON, Defendant's Exhibit No. 1 was
16 admitted into evidence.)

17 BY MS. FLEMING:

18 Q. Now, Dr. Payne, would you ever insert the
19 scope if the patient was unstable?

20 A. No.

21 Q. Would you -- would you insert it if the
22 patient was desaturating, meaning that his oxygen
23 saturation levels were going down?

24 A. No.

25 Q. Was Mr. Mikell unstable at any time prior the

1 time you inserted the scope?

2 A. I'm not aware of any time that Mr. Mikell was
3 unstable before that time.

4 Q. Was he desaturating at any time before you
5 inserted the scope?

6 A. No. When I start the procedure, he would have
7 normal saturations.

8 Q. Now, at some point after the procedure began,
9 I think you said that he became hypoxic, and his heart
10 rhythm slowed so he became bradycardic?

11 A. Yes.

12 Q. And do you recall at some point in time that
13 Mr. Mikell was turned from his side in the lateral
14 position on to his back?

15 A. Yes.

16 Q. And just to clarify, during a colonoscopy is
17 it -- what position do you ordinarily place a patient
18 in to perform that procedure?

19 A. Almost all procedures are started with someone
20 on their left side.

21 Q. And that's what we call the lateral position?

22 A. Right.

23 Q. And so you recall him being turned on to his
24 back?

25 A. Right.

DR. PAYNE -- CROSS

1 Q. And who did that? Do you recall?

2 A. When -- I think at that point in time, it was
3 the start of ventilation, so I know that the CRNA
4 helped. I think Dr. Nelson was in the room as well,
5 but I can't remember who all was there. The nurse
6 probably would have helped as well. I probably would
7 have helped as well -- I removed the scope.

8 Q. And you said "the start of ventilation", what
9 are you referring to?

10 A. At some point in time, he had bag mask
11 ventilation.

12 Q. So an actual bag placed over his mouth and --

13 A. It's -- it's a face mask, and hooked to a bag
14 that you -- that you -- that you squeeze to get oxygen
15 in.

16 Q. And I think you were asked earlier about your
17 note that you drafted after the procedure. Your note
18 indicates that at some point, the scope was immediately
19 withdrawn without viewing, so the anesthesia attendant
20 could resuscitate the patient; is that correct?

21 A. That's correct.

22 Q. And so if -- if we assume that -- that Donna
23 Embrey, the CRNA, and Dr. Nelson, the anesthesiologist,
24 began bag mask ventilating Mr. Mikell at 7:55 a.m, is
25 that when you most likely removed the scope from Mr.

1 Mikell?

2 A. Right. As soon as he rolled over, I would
3 have removed the scope.

4 Q. And why would you need to why -- why would you
5 remove the scope at that point in time?

6 A. Because we're not going to continue with the
7 procedure, and it really doesn't help with
8 resuscitative efforts at all.

9 Q. And we talked -- you talked a little bit to
10 Mr. Ransom about the Mayday record and the code sheet;
11 did you, as a physician, document in that record?

12 A. I did not.

13 Q. Do you have any understanding of who typically
14 documents in that record?

15 A. Usually there is a -- again, I don't attend
16 too many Maydays, but I think there's usually a nurse
17 recorder that records the sequence of the events.

18 Q. Okay. And so would that be a nurse who's in
19 the -- in the procedure room, who then documents in a
20 record most likely?

21 A. Probably, yeah, or a member of the immediate
22 team, so.

23 MS. FLEMING: Nothing further. Thank you very
24 much.

25 THE COURT: Any redirect?

DR. PAYNE -- REDIRECT

1 MR. RANSOM: Yes, Your Honor.

2 REDIRECT EXAMINATION BY MR. RANSOM:

3 Q. Dr. Payne, did you know that Mr. Mikell had
4 heart failure and obstructive sleep apnea before you
5 started this procedure?

6 A. I did.

7 Q. How did you know that?

8 A. It was in his medical record.

9 Q. So you looked at his medical chart and you
10 were aware of that?

11 A. I was.

12 Q. Okay. Dr. Nelson was coming in and going out
13 during the procedure?

14 A. Yes.

15 Q. All right. Did you make any record of the
16 times in which he entered the room and left the room?

17 A. I did not.

18 Q. Did you make any record of what was taking
19 place during the colonoscopy procedure at those moments
20 when he was coming and going?

21 A. I wouldn't be making a record when I'm doing a
22 colonoscopy.

23 Q. And it's true that you didn't make any record
24 that would identify the specific times of any of the
25 things that were taking place?

1 A. Again, if I had my hands on a colonoscope, I
2 wouldn't be writing anything down, and I didn't write
3 anything down later --

4 Q. No, I understand. But you would agree with me
5 that you didn't create your own record that would allow
6 us to determine what time it was when certain things
7 were taking place?

8 A. Yes, I agree.

9 Q. You said that when you went back and looked at
10 the PICIS anesthesia record, there was part of it that
11 didn't make much sense to you?

12 A. I think I said it all didn't make much sense
13 to me.

14 Q. And with respect to Exhibit 14, what you said
15 in your procedure note, was to see the code
16 documentation for the details of what had actually
17 taken place?

18 A. Correct. If you look -- if you look at the
19 top there is a -- there is a little line for
20 anesthesia, so we usually say see anesthesia records.
21 This would be the same thing.

22 Q. Okay. Now, you didn't make any record of when
23 the Mayday was called?

24 A. I did not.

25 Q. You don't have any independent recollection at

DR. PAYNE -- REDIRECT

1 what specific point in time during the procedure that
2 occurred?

3 A. Well, I knew it occurred after I removed the
4 colonoscope, and they were resuscitating the patient.
5 I do know it was that time, yes.

6 Q. I understand. Do you know what time it was
7 that morning that --

8 A. I don't know what time it was exactly, no.

9 Q. And that's what I mean -- you don't know what
10 time it was when you took the scope out?

11 A. I don't know exactly what time it was when I
12 took the scope out.

13 Q. You don't know what time it was when somebody
14 came in with a Mayday record?

15 A. No. And I wouldn't be looking at a clock
16 during this situation actually.

17 Q. You don't know what information someone may
18 have been writing on a Mayday record?

19 A. I would know that the sequence of the Mayday
20 would be written down, because that's what they do.
21 But I don't -- you know, I really didn't participate
22 much in the resuscitation, so I wouldn't have watched
23 that.

24 Q. The sequence of the Mayday would include the
25 point at which the patient needed to be rescued?

1 A. No. The sequence of the Mayday would be when
2 the Mayday team arrives on the scene, has the
3 medications and cardioversionary shocks that would
4 occur, so it would be a medication record and a record
5 of what takes place during the Mayday itself.

6 Q. And a record of why a Mayday was called?

7 A. I -- I can't tell you if that's what's on a
8 Mayday sheet to be honest with you.

9 Q. Now, do you have independent recollection that
10 it was at 7:55 that morning that Mr. Mikell was turned
11 and you removed the scope?

12 A. Again, I really wouldn't be looking at a clock
13 to say that I know it was 7:55.

14 Q. Okay.

15 A. I mean, I -- I mean it was the sequence of
16 events. I -- at that point in time, I pulled the
17 colonoscope out.

18 Q. No. I understand. But so you remember that
19 he was turned and you took the scope out --

20 A. I remember I took the scope out and then he
21 was turned.

22 Q. You can't tell us what time it was when that
23 happened?

24 A. No, of course not.

25 MR. RANSOM: Thank you. I don't have any other

DR. GULDAN -- DIRECT

1 questions.

2 THE COURT: Any recross?

3 MS. FLEMING: No. Thank you.

4 THE COURT: All right. Any reason Dr. Payne
5 can't be excused?

6 MR. RANSOM: I'm sorry, Your Honor?

7 THE COURT: Any reason he cannot be excused?

8 MR. RANSOM: He can be excused, Your Honor.

9 THE COURT: Doctor, you may step down and you
10 may be excused. Let me see the attorneys up here just
11 a second please.

12 (WHEREUPON, a bench conference was had.)

13 THE COURT: All right. If you would call your
14 next witness, please.

15 MR. RANSOM: The next witness is Dr. George
16 Guldan.

17 DR. GEORGE GULDAN, after
18 having been duly sworn, testified as follows:

19 THE CLERK: Please state your first and last
20 name, and spell your last name loudly and clearly into
21 the microphone.

22 THE WITNESS: It's George Guldán, G-u-l-d-a-n.

23 **DIRECT EXAMINATION BY MR. RANSOM:**

24 Q. I'm sorry, Dr. Guldán?

25 A. Guldán.

DR. GULDAN -- DIRECT

1 Q. Yes, I'm sorry. I've been mispronouncing your
2 name. Forgive me.

3 A. That's okay.

4 Q. All right. Dr. Guldan, you're a member of the
5 faculty there at the Medical University?

6 A. I am, that's correct.

7 Q. And I believe you actually hold an endowed
8 chair in the Department of Anesthesia?

9 A. That's correct. I'm the --

10 COURT REPORTER: I'm sorry?

11 A. It's the Joanne Conroy Endowed Chair for
12 Education and Leadership.

13 BY MR. RANSOM:

14 Q. All right. You graduated from medical school
15 in 2003?

16 A. That is correct.

17 Q. And you were actually one of the medical
18 personnel who responded to Mr. Mikell's Mayday on
19 October 1, 2010?

20 A. That is correct. I was assigned as part of
21 the code team for that afternoon.

22 Q. And you have testified previously that it was
23 Dr. Nelson, the anesthesiologist, who was in charge of
24 the Mayday that day?

25 A. Dr. -- Dr. Nelson was in charge of the

DR. GULDAN -- DIRECT

1 resuscitation. There is a very important distinction
2 about what happens in the OR and what happens elsewhere
3 in the hospital in the situation where patients need
4 resuscitation.

5 Q. Okay. Well, I had asked you at your
6 deposition some time ago was somebody in charge during
7 Mr. Mikell's code; and your answer had been that Dr.
8 Nelson was in charge; is that correct?

9 A. He is in charge, correct, of the code.

10 Q. Now, the code situation or a Mayday situation
11 in the Digestive Disease Center -- and that's where
12 this colonoscopy was taking place; right?

13 A. The colonoscopy was taking place in one of our
14 periphery anesthesia sites. That is very different
15 than the rest of the Digestive Disease Center because
16 of our preparation and our equipment, the medications
17 available. We hold -- in the anesthesia site, we hold
18 a different level of preparation, a different level of
19 staffing than any other sites in the hospital.

20 So you always have two ACLS trained providers
21 taking care of a patient. You always have emergency
22 drugs for -- for in -- in the event of a code. You
23 always have a mechanical ventilation device, the
24 ventilator. Our monitoring is ASA standard monitoring,
25 so EKG, pulse ox, entitle capnography, temperature, all

1 of these things have to be present that aren't
2 necessarily present in other sedation sites, that allow
3 us to provide care for sicker patients than would be in
4 a typical moderate sedation site.

5 And because of that, the response when patients
6 do have adverse events is very different in an OR and
7 the anesthesia -- non -- a NORA site is what we call
8 those sites. It is still set up exactly like our other
9 OR sites, our response is very different.

10 When we call a code on a patient, we are asking
11 for another anesthesiologist, a skilled provider, to
12 come help. When a Mayday is called on the floor in a
13 sedation room, a team of -- it consists of residents,
14 usually one of the cardiology residents responds, along
15 with a pharmacist, a respiratory therapist and an
16 anesthesia provider. It can be either a resident, a
17 CMA and/or an attendant depending on the time of day.
18 So it's not necessarily an attending anesthesiologist
19 that is responding.

20 So -- and that -- that's the situation where
21 it's a all-hands-on-deck situation where you have --
22 usually an unmonitored and un -- or -- unknown reason
23 for someone to get into trouble, and you don't know why
24 that -- why it happened. You are kind of walking to a
25 situation blind. You don't know why the person

DR. GULDAN -- DIRECT

1 arrested, you just know they have arrested. You assess
2 the situation the best you can, and you apply your
3 skills to help that patient.

4 In the OR, it's a very different situation. In
5 the OR -- the NORA site, we know the patient's medical
6 history as the provider -- like Dr. Nelson did -- very
7 well. We know their physiology very well. In Dr.
8 Nelson's case, and my case for -- as cardiac
9 anesthesiologist, so we know that physiology and we
10 take care of patients with heart failure, pulmonary
11 hypertension, sleep apnea --

12 COURT REPORTER: Your Honor, I'm sorry. If he
13 could slow down just a little bit.

14 THE WITNESS: My apologies. I'm sorry, this is
15 what I do.

16 MR. RANSOM: That's all right.

17 THE WITNESS: I apologize for speaking fast.

18 BY MR. RANSOM:

19 Q. We know you're out of your element here at the
20 courthouse.

21 A. I don't -- I take care of patients. I don't
22 speak in the courthouse often, so I'll slow down. But
23 we -- we are providing, you know, care for those
24 patients in those situations with a lot more
25 understanding of what's actually happening so we can

1 get focus treatment.

2 That goes above and beyond what ACLS, Advance
3 Cardiac Life Support, which is what is provided to
4 people in Maydays. It goes above and beyond that.

5 In Mr. Mikell's case, the patient received an
6 arterial line. He was intubated very quickly, which is
7 not part of ACLS because we understood a big part of --
8 you know, once he's in trouble, a big part of helping
9 somebody with pulmonary hypertension and sleep apnea is
10 making sure their oxygen levels get totally returned to
11 normal. And you can do that very effectively with the
12 airway.

13 The reason it's not part of ACLS is most people
14 are not -- I'm slowing down again -- most people are
15 not proficient at placing those devices, especially in
16 someone with a difficult airway like he had, with sleep
17 apnea and a large neck, it's more challenging to place
18 an airway device.

19 We happen to have skilled anesthesia providers
20 there, so they were able to do that without interfering
21 with the CPR, the cardiac pulmonary resuscitation, the
22 regular stuff with doing chest compressions, giving
23 meds, et cetera, so they did that early in the
24 situation. That would not have happened if it -- it
25 was a Mayday on the floor, for instance.

DR. GULDAN -- DIRECT

1 So -- and the other big differentiation factor
2 between the Mayday on the floor or a Mayday in another
3 endoscopy suite where there are not anesthesia
4 providers, is the onerous and the expectation is for us
5 to document everything that happens in a code situation
6 on our electronic medical record, on the anesthesia
7 record. There is not a -- there is not a Mayday sheet
8 in the OR and NORA sites in any situation that I can
9 remember.

10 Everything that we do, all the drugs given, the
11 times given, all those things need to be documented in
12 our record. It is not -- there's -- it is our
13 responsibility to do that as an anesthesiologist and a
14 nurse anesthetist in the case to do that. And we do
15 not rely on a nurse to do that for us.

16 So it needs to be -- we can use nursing
17 documents to help make sure we have the times right.
18 Because in those situations, our total focus is on the
19 patient having the best outcome possible. But a lot of
20 times, we have to supplement our -- our recollection.
21 Because we're so focused on taking care of the patient,
22 we can't chart everything we did at -- in real time.
23 Obviously, we have to go back after the fact and do
24 that. That's very common in these situations.

25 Q. Now, you were called -- or rather you got a

1 page and went to the procedure room where Mr. Mikell
2 was; correct?

3 A. That is correct.

4 Q. And when you got there, he had already been
5 returned to -- I think your phrase was -- returned to
6 spontaneous circulation?

7 A. Yes, sir.

8 Q. Meaning he was breathing again?

9 A. He -- at that point, he was being ventilated
10 by us. His -- his heart was creating a profusing
11 rhythm. During -- during the point where he was in --
12 as you refer to arrest -- it was what we call pulseless
13 electrical activity, PA arrest, so that's different
14 than the heart stopping totally. It's beating, it's
15 just not producing blood pressure. So the heart is
16 beating ineffectively.

17 Q. Right. By the time you got into the room, the
18 crisis had largely passed?

19 A. That is correct. At that point, I proceeded
20 to coordinate his continued care with the PACU, and the
21 upstairs, and I helped arrange to induce the
22 hypothermia treatment to -- to help stabilize him and
23 to prevent organ damage.

24 Q. And so obviously you didn't witness any of the
25 things that took place prior to the time that you

DR. GULDAN -- DIRECT

1 arrived in the room?

2 A. Correct. I just witnessed -- I arrived when
3 they were just finishing up doing the initial chest
4 compressions. They had been secured, and the patient
5 had -- shortly after I arrived, had returned to
6 spontaneous circulations --

7 Q. And so you don't know at what point in time
8 the procedure, before your arrival, Dr. Nelson had been
9 coming in and going out?

10 A. I'm not -- I'm not aware of those times other
11 than looking at the record.

12 Q. And you don't know of your own personal
13 knowledge what may have been going on with Mr. Mikell
14 during the times that the nurse anesthetist, Ms.
15 Embrey, may have been texting and making phone calls?

16 A. I cannot -- I cannot know what happened before
17 I was there.

18 Q. Okay. You didn't, yourself, actually make any
19 entries in the anesthesia record?

20 A. I believe I made an entry in the PACU record
21 later.

22 Q. But the anesthesia record itself --

23 A. No --

24 Q. -- to the point --

25 A. Correct --

DR. GULDAN -- DIRECT

1 Q. -- to the point where he's first given the
2 Propofol to the point where the --

3 A. He was transferred.

4 Q. Yeah. Until he's transferred, you didn't make
5 any of those entries?

6 A. That is -- that is correct because my
7 assistance was not needed.

8 Q. Okay. Now, a code situation in a procedure
9 room where a patient is undergoing a colonoscopy is a
10 fairly rare event; isn't it?

11 A. It is -- it is rare, but it does happen on a
12 regular basis due to the number.

13 Q. This is the only time that you've ever been
14 called to respond to a cardiac arrest during a
15 colonoscopy?

16 A. As I do not cover the code pager during the
17 day, it -- it was.

18 Q. Okay. Now, you were designated at one point
19 in time to speak on behalf of the Medical University
20 about its emergency medical response policy; correct?

21 A. That is correct.

22 Q. Okay. And you would agree with me, there's no
23 question but that in Mr. Mikell's case, a Mayday was
24 actually called?

25 A. I believe someone from the room called a

DR. GULDAN -- DIRECT

1 Mayday, which is fine.

2 Q. Okay. I mean, the record reflects that a
3 Mayday was called; you don't dispute that?

4 A. If -- if somebody thinks they need help in the
5 room, that's -- that's their prerogative as the
6 attending anesthesiologist in the room or the nursing
7 staff in the room. We're a team.

8 Q. That's right. But -- well, we can do this.
9 If you'll look -- I've got this board here -- and if
10 you'll look down at the bottom, it's got a document
11 control number 611 -- right there? Do you see that?

12 A. I do.

13 Q. Let me just carry this over here where you can
14 see it, and I hope these folks can see it. But right
15 here, it says -- there's an entry under Dr. Nelson's
16 initials, time at 8:00 a.m; do you see that?

17 A. Uh-huh.

18 Q. And one of the things that it says is "Mayday
19 team called"; correct?

20 A. Uh-huh.

21 THE COURT: Doctor, instead of saying "uh-huh, "
22 say yes or no, please.

23 A. Yes. Yes.

24 THE COURT: It's hard to understand what uh-huh
25 means.

DR. GULDAN -- DIRECT

1 A. I apologize.

2 THE COURT: Please proceed.

3 BY MR. RANSOM:

4 Q. And that's why I say, there is no question but
5 that a Mayday was actually called?

6 A. Dr. Nelson was calling for help.

7 Q. And that's the -- the term "Mayday" is
8 actually in this record; right?

9 A. The term "Mayday" is used to -- whenever we
10 call for help, and that was used to get me there.

11 Q. Right.

12 A. And the additional CRNA -- not the rest of the
13 team, which actually gets in the way in an OR
14 situation.

15 Q. Okay.

16 A. So the rest of the team was immediately sent
17 away. Does that make sense?

18 Q. Dr. Guldán, let me hand you what we had marked
19 as Plaintiff's Exhibit 2. And this is a printout of
20 the Post Anesthesia Care Unit record. You'll see it's
21 multiple pages. The first one is document control
22 number 604, and it runs through page 612.

23 A. Yes.

24 Q. Okay. And that Exhibit 2 is the record that
25 contains this page 611 that we were just pointing to on

DR. GULDAN -- DIRECT

1 the board?

2 A. Yes.

3 MR. RANSOM: All right. Your Honor, I'd offer
4 Exhibit 2 into evidence at this time.

5 THE COURT: Any objection?

6 MS. FLEMING: No objection.

7 THE COURT: All right. Plaintiff's No. 2
8 admitted without objection.

9 (WHEREUPON, Plaintiff's Exhibit No. 2 admitted
10 into evidence.)

11 BY MR. RANSOM:

12 Q. Now, again, Dr. Guldán, you were designated in
13 November of 2014 to testify on behalf of Medical
14 University concerning its emergency medical response
15 policy; correct?

16 A. Correct.

17 Q. And I've got marked as Plaintiff's Exhibit 9,
18 a document that's entitled MUSC Medical Center Policy
19 Manual, titled Emergency Medical Response; am I reading
20 that correctly?

21 A. That is -- is correct.

22 Q. Okay. And that is, in fact, the emergency
23 medical response policy that you were designated to
24 testify on behalf of the Medical University in November
25 of 2014?

1 A. I believe it is.

2 Q. Okay. And that policy actually requires that
3 a cardiopulmonary resuscitation event form, or
4 quote/unquote Mayday record be created whenever a
5 patient at the Medical University suffers a cardiac
6 arrest?

7 A. That -- that is correct, which does include
8 our electronic medical record.

9 Q. If I could see the exhibit. Thank you. Let's
10 go over part of this, Dr. Guldán. You'll see the part
11 that I've highlighted.

12 THE COURT: Is it on this screen in front of
13 him?

14 THE CLERK: Yes, it is.

15 THE COURT: Doctor, you've got it right in front
16 of you there.

17 THE WITNESS: Yes, sir.

18 (Pause.)

19 BY MR. RANSOM:

20 Q. So the highlighted portion there -- and this
21 is on page 3 of 8, paragraph 4, it reads "Each Mayday
22 is documented under cardiopulmonary resuscitation event
23 form or Mayday record"; correct? The Mayday record is
24 the legal documentation of the Mayday; correct?

25 A. Correct.

DR. GULDAN -- DIRECT

1 Q. It accounts for the physician's orders and
2 medication administration during the Mayday; correct?

3 A. That's what it says.

4 Q. And it says it must be signed by the
5 designated participants; correct?

6 A. Correct.

7 Q. So that this policy envisions a sheet of paper
8 or sheets of paper; correct?

9 A. What happens is on the -- when a Mayday is
10 called on the floor, a nurse is holding a clipboard,
11 and she is helping run the timing of the drugs and the
12 events with the -- usually medicine resident performing
13 the -- running the code in those situations because
14 there is not an attending anesthesiologist there.

15 Q. Right.

16 A. And she's documenting as they go. I did not
17 witness that happening during this event. I did not
18 find that unusual because it is an OR situation, which
19 on page 4 number 11, it does say that a Mayday is not
20 required in the OR.

21 Q.. Page 4?

22 A. Number 11 -- item 11, I believe it was, sir.

23 Q. Okay. Item 11. It says what?

24 A. I believe -- I don't want to quote it
25 verbatim, but I believe the -- the -- the wording is a

DR. GULDAN -- DIRECT

1 Mayday in any area, other than the OR's ICU and ED, a
2 full Mayday team will be called for. And that's from
3 the -- that's the documentation part of that, is with
4 the full Mayday team, which we were in an OR site.

5 Q. Well --

6 A. So that is why it was not unusual to me for
7 there not to be a nurse documenting on a Mayday form.
8 The OR record in those situations should be the record
9 of the code or a Mayday, whatever you would like to
10 term it.

11 Q. So this is page 4, paragraph 11, it doesn't
12 say that you don't need a cardiopulmonary resuscitation
13 event form for events that occur in the area of the
14 hospital where Mr. Mikell was, does it?

15 A. I mean, there's lots of things we do, we don't
16 have verbatim telling us --

17 THE COURT: Doctor, let me interrupt you for a
18 second. Please be responsive to the question; okay?

19 THE WITNESS: Yes, sir.

20 THE COURT: He asked you a question --
21 otherwise, I'm going to get him to repeat it. But
22 please be responsive. Listen to the question, and
23 answer it. And then you can give whatever explanation
24 you want to give. Okay?

25 THE WITNESS: Yes, sir.

DR. GULDAN -- DIRECT

1 THE COURT: Ask the question, please.

2 BY MR. RANSOM:

3 Q. Paragraph 4, page 11 doesn't say that no
4 Mayday record was necessary for Mr. Mikell's event?

5 A. It does not.

6 Q. When you testified back in 2014, you said that
7 this Mayday policy does not apply to Mr. Mikell's
8 situation; right?

9 A. That is correct.

10 Q. And you said that his situation was not a
11 Mayday, and that was why there was no Mayday record?

12 A. It was -- it was an inter-operative (ph) code
13 as far as an anesthesiologist is concerned.

14 Q. Right. But I mean as a representative and a
15 designee of the Medical University, you testified that
16 there was no Mayday?

17 A. That is correct.

18 Q. And that was why there was no Mayday record?

19 A. That is correct.

20 Q. You said that instead of there being a Mayday
21 record, Mr. Mikell's code was documented in the
22 anesthesia record?

23 A. That is correct. All the drugs given, all the
24 times of defibrillation, the times of CPR, all of that
25 was documented -- would be documented on a code sheet,

DR. GULDAN -- DIRECT

1 was documented in the medical record, which is
2 appropriate for an OR situation.

3 Q. Okay. Did you ever see all of that documented
4 in Mr. Mikell's medical record?

5 A. I did see the drugs, the times, the
6 defibrillation note, yes.

7 Q. And when did you see that?

8 A. When I -- when I was asked to look at the case
9 for the deposition.

10 Q. And that's why you testified that there was no
11 Mayday record?

12 A. Correct. Because at that time, there was no
13 Mayday record in any of our electronic files of the
14 case. And I -- because of -- again, because of our
15 policy, the OR is not to have a Mayday record, but to
16 document in the electronic medical record. Unless
17 they're an active practice in anesthesiology, I did not
18 find that unusual at all.

19 Q. Okay. One of the other things that it says
20 here in Exhibit 9, and this is on page 7 of 8, it says
21 "Following the Mayday, the cardiopulmonary
22 resuscitation event form" -- and that's the Mayday
23 record -- "is faxed to Risk Management and then entered
24 into the patient's medical record" -- am I reading that
25 correctly?

DR. GULDAN -- DIRECT

1 A. That is what it says, yes, sir.

2 Q. Okay. But, again, you testified that there
3 was no Mayday record from Mr. Mikell?

4 A. I did not witness a record being written on
5 during my time in the room, and I was not asked to sign
6 it which I would in any other Mayday event in a
7 non-anesthesia site.

8 Q. Well, now, you weren't testifying just as Dr.
9 Guldan, you were testifying as the Medical University
10 with respect to all knowledge known to it; correct?

11 A. I was -- I was testifying in regards to what
12 we do in the OR as anesthesiologists in a code
13 situation.

14 Q. Okay. And you testified that there was no
15 Mayday record?

16 A. I did not witness one, and it is not our
17 practice to do them. It's a nursing function that
18 happens in the non-OR sites.

19 Q. Well, can I get you to agree with me that when
20 I asked you at your deposition in November of 2014 if
21 that policy applied, you told me that it didn't?

22 A. I said that then, and I would agree now, yes,
23 sir.

24 Q. And you would agree with me that when I asked
25 you at your deposition back in November of 2014 whether

DR. GULDAN -- DIRECT

1 or not there was a Mayday record made from Mr. Mikell's
2 case, you said that there was not?

3 A. To the best of my understanding at the time,
4 there was not.

5 Q. Okay. And you were wrong; right?

6 A. Apparently there was a Mayday sheet filled out
7 at some point.

8 Q. Okay. You had the opportunity to obtain a
9 preliminary copy of the transcript of your testimony
10 back in November of 2014?

11 A. I believe so, yes.

12 Q. That's what we call it when the witness reads
13 and signs their testimony?

14 A. Yes.

15 Q. Okay. You actually exercised the right to
16 read and sign your testimony?

17 A. I did.

18 Q. And even though your testimony was false, you
19 didn't make any changes?

20 A. It was not false, sir.

21 Q. Well, you testified that there was no Mayday
22 record; that's false?

23 A. There was not a Mayday record when I was in
24 the room. The Mayday record not being charted on, I
25 was not asked to sign a Mayday record. And there was

DR. GULDAN -- CROSS

1 no Mayday record known when I gave that deposition, so
2 there was no reason for me to believe there ever was.

3 Q. So I asked you back in November of 2014, when
4 you were designated to speak on behalf of the Medical
5 University, is there such a form for Mr. Mikell's case;
6 and you said, "There is not"; do you remember that?

7 A. I do remember that.

8 Q. Okay.

9 A. There was none in any of the electronic
10 records for the case.

11 Q. Okay. And you've reviewed and read and signed
12 that testimony, and didn't change it; did you?

13 A. That is correct because it was correct at the
14 time.

15 MR. RANSOM: Thank you, Dr. Guldan.

16 THE COURT: Cross-examination.

17 **CROSS EXAMINATION BY MS. FLEMING:**

18 Q. Dr. Guldan, I just want to clarify, you made
19 some references to what you call a NORA site, what does
20 that stand for?

21 A. It's what we refer to as a non OR anesthesia
22 site.

23 Q. Okay. And we know that Mr. Mikell's
24 colonoscopy took place in the Digestive Disease Center.
25 Are there rooms within that center that are designated

1 as NORA or non-operating room anesthesia sites?

2 A. That is correct. At the time of his
3 procedure, we had three separate NORA anesthesia sites
4 in DDC.

5 Q. And the rooms that are designated as NORA
6 sites, are those the rooms that the anesthesia
7 providers are assigned to?

8 A. That is correct. We only provide anesthesia
9 in those rooms because of the specialized equipment and
10 drugs available in those rooms that allow us to take
11 care of patients.

12 Q. And so --

13 A. In those situations.

14 Q. I'm sorry. The rooms that are non NORA sites,
15 are those staffed by regular nurses who work in
16 endoscopy?

17 A. They're staffed by endoscopy nurses and the
18 G.I. doctors and fellows, yes.

19 Q. I think you were asked some about the -- the
20 emergency medical response policy?

21 A. Yes.

22 Q. And it's your understanding that for -- you're
23 analogizing the OR and the NORA site as similar, the
24 same?

25 A. As far as our staffing and our procedures,

DR. GULDAN -- CROSS

1 they are treated exactly the same. A NORA site is
2 treated just like an OR site from the anesthesia
3 perspective, patient safety wise.

4 Q. And that's from an anesthesia position
5 perspective?

6 A. That's correct.

7 Q. And I believe you were trying to reference a
8 portion of the policy that says something to the effect
9 that a full Mayday does not need to be called in an OR
10 site?

11 A. That is correct. In fact, a full Mayday team
12 showing up to an OR site can actually impede our care
13 of the patient. Because you have people who are less
14 skilled providers showing up, who do not have full
15 knowledge of the patient.

16 Q. Okay. And I think that's actually -- I think
17 you referenced page 4, paragraph 11, but could you take
18 a look at the -- at the sentence above that, where it
19 says "The emergency departments and ORs do not have to
20 call a full Mayday. Staff may call for a full Mayday
21 any time they determine a need for a full team"; is
22 that what you --

23 A. Yes, that is correct.

24 Q. Is that what you were referring to?

25 A. That is correct, yes.

DR. GULDAN -- CROSS

1 Q. And I think, just to clarify, you testified
2 that you reasonably believed that there was no code
3 sheet or Mayday sheet prepared for Mr. Mikell in this
4 case?

5 A. That is correct. As the anesthesia provider
6 responding to a code in the OR, I would not expect
7 there to be a code sheet filled out on that patient.
8 And if there were, I would be, you know, on the floor
9 -- in the floor situation where we're called to a code,
10 and there's a full Mayday team. There's -- one of the
11 members of that team is a nurse from ICU, and her job
12 is to actually fill out that form. And she actually
13 writes down everyone's names that's in attendance and
14 all the drugs, and she requires us to sign them. And
15 that was not occurring in this case as she was not
16 needed.

17 Q. And just to clarify, have you -- have you seen
18 a code sheet before?

19 A. I have, many times.

20 MS. FLEMING: I'd like to go ahead and mark the
21 cardiopulmonary resuscitation event form as Defendant's
22 Exhibit's 2 for identification please.

23 (WHEREUPON, Defendant's Exhibit No. 2 was marked
24 for identification.)
25

1 BY MS. FLEMING:

2 Q. Dr. Guldan, I would like to show you what's
3 been marked for identification at Defendant's Exhibit
4 2.

5 THE COURT: Defendant's what?

6 MS. FLEMING: Exhibit 2.

7 MR. RANSOM: Your Honor, we object to the use of
8 this document with this witness, or with any other
9 witness.

10 THE COURT: All right. Ladies and gentlemen of
11 the jury panel, I'm going to have to take up this
12 objection out of your presence. The reason I do that
13 is I'm not permitted to comment on the facts of this
14 case during the trial. And in order to rule on certain
15 questions as to whether it's admissible under the Rules
16 of Evidence or not, I want to be free to comment on the
17 facts with the lawyers before I make a decision whether
18 it's admissible under the Rules of Evidence or not
19 admissible under the Rules of Evidence. So I generally
20 ask you to leave the courtroom.

21 And let me correct something I said to you
22 earlier -- well, not correct, but let me add to it.
23 Madam Forelady, ladies and gentlemen of the jury, on
24 direct examination the plaintiff's attorney has been
25 asking -- been asking -- excuse me -- been asking

1 leading questions. One exception to that on direct
2 examination on leading questions is when you are
3 calling a witness what the lawyer refers to as an
4 adverse witness, the law allows you to ask leading
5 questions under that situation.

6 So far the plaintiff has been calling all
7 adverse witnesses, ie, they are representatives of the
8 defendants, so they would be an adverse witnesses, and
9 they can ask leading questions. And I want to add that
10 to what I said earlier on direct, you can't ask leading
11 questions.

12 However, since it's five minutes to 6:00, I'm
13 going to excuse you while I listen to the decision on
14 what -- I'm going to make the ruling on the evidence or
15 not, so please don't discuss the case amongst
16 yourselves or with anyone else. Be back in the jury
17 room at 9:30 in the morning, and we'll get started at
18 that time. See you in the morning.

19 All right. Let me see what you're trying to put
20 in.

21 (WHEREUPON, the jury leaves the courtroom at
22 5:56 p.m.)

23 THE COURT: All right. You got an objection --
24 they're offering apparently a blank cardiopulmonary
25 resuscitation event form which is commonly -- we have

1 been referring to it as a Mayday form. And you have an
2 objection, is that correct?

3 MR. RANSOM: That's correct, Your Honor.

4 THE COURT: I'll be glad to hear you on the
5 objection.

6 MR. RANSOM: Your Honor, the basis of the
7 objection is the best evidence rule that South Carolina
8 Rule of Evidence 104, which is a codification of a
9 previously well known and almost universally applied
10 common law rule of evidence, typically referred to as
11 the best evidence rule. In our -- and the substance of
12 the objection is set forth in our pretrial brief. I'll
13 try to summarize that for you here.

14 The best evidence of the content of the Mayday
15 record for Mr. Mikell's cardiac arrest is the Mayday
16 record from Mr. Mikell's cardiac arrest. Now, it's
17 interesting that the witness has testified that he
18 doesn't believe that there ever was a Mayday record for
19 Mr. Mikell's cardiac arrest.

20 THE COURT: Well, I don't think he said that. I
21 think he said at the time he offered that testimony, he
22 did not -- was not aware of a Mayday record, because it
23 wasn't in the record. If it was, it had been
24 destroyed --

25 MR. RANSOM: Yes, sir.

1 THE COURT: But it couldn't have been, so
2 there's no way he could have known that --

3 MR. RANSOM: Well, but in any -- in any event,
4 the point is that they're trying to prove that the
5 Mayday record for Mr. Mikell's case doesn't contain
6 this and doesn't contain that. And they're trying to
7 prove the contents of the document by submitting this
8 blank form. We've laid out the law and the evidentiary
9 foundation that is necessary in order to get in this
10 type of secondary evidence of a document, and we don't
11 think that they made the foundation. We don't think
12 that any of this is admissible.

13 MS. FLEMING: The form is not being offered
14 to -- to prove what was in Mr. Mikell's form, it's
15 being offered to --

16 THE COURT: What's the relevance of it? A blank
17 form going into -- going into this trial? I mean, how
18 is there any -- how is there any relevancy to a blank
19 form?

20 MS. FLEMING: Well, the plaintiff argues that
21 there is certain information that would have been in
22 the form, that would have indicated what happened to
23 this patient. And we're using this to establish what
24 actually is the information that's documented in the
25 form.

1 THE COURT: Well, the problem is we don't know
2 what the nurse, or whoever filled out the form, put in
3 it to begin with because it's been destroyed by your
4 clients.

5 MS. FLEMING: And actually --

6 THE COURT: And this -- this goes to the
7 sanctions. I mean, it just seems like you're digging
8 yourself deeper.

9 MS. FLEMING: I -- I would disagree actually,
10 Your Honor --

11 THE COURT: Well, I don't disagree. I mean, I
12 think -- I said I'm going to sanction you. I haven't
13 decided what I'm going to sanction you, and what's
14 going to be the sanctions. But here you are, you've
15 got a Mayday record, and you've got a waste management
16 person -- excuse me -- risk management person
17 destroying the record -- actually -- actually shredding
18 it with a paper shredder.

19 MS. FLEMING: Well, again, Your Honor --

20 THE COURT: So, now -- now, you're here wanting
21 to put in a blank form to insinuate to the jury that
22 there was nothing important in that one that's been
23 destroyed.

24 MS. FLEMING: Let me just clarify --

25 THE COURT: Do you understand where I'm coming

1 from?

2 MS. FLEMING: I do, but -- but I think that the
3 distinction is risk management doesn't have a copy of
4 the record -- she receives a copy. It's not the record
5 that's actually in the patient record. No one knows
6 what happened to the copy that was in the patient
7 record --

8 THE COURT: Well, all I know is I've been told
9 she shredded a Mayday form --

10 MS. FLEMING: She shredded --

11 THE COURT: After she sent it to the American
12 Heart Association, which I think is way out of line.

13 MS. FLEMING: Well, that's -- that's actually
14 what she does in the normal course of business, and
15 she'll testify to that. And that's what they do in her
16 position, in her role as to why she receives that copy.
17 That is typical, usual. That is what she does with
18 that document.

19 It is never -- the copy that she receives is
20 never placed in the patient record, ever. It is a --
21 it is a faxed copy that she receives. And so this
22 information -- I mean, he's alleging that -- his expert
23 is alleging that the negligent act occurred before the
24 arrest. And we want to use this to show and establish
25 the information that would have been documented in the

1 form does not -- is not going to provide any
2 information about why this man arrested at all.

3 That's -- that's the prime reason we want to use
4 this form. And we're not using it to offer what was in
5 that record. I mean, for our -- our -- I mean our
6 position is that the anesthesia record actually
7 contains all that information. We don't --

8 THE COURT: Well, if I -- I understand that,
9 first of all, you wanted to put in an altered form, a
10 narrative. Then you sent apparently a copy of this
11 form that was shredded to the American Heart
12 Association. Now, you want to go to a blank form.

13 MS. FLEMING: So the -- I'm not sure what you
14 mean --

15 THE COURT: And I agree with you as far as the
16 causation issue. I'm not sure what that has to do with
17 it. I understand that argument now. That's the only
18 reason I'm hesitant.

19 MS. FLEMING: Yeah, I don't quite understand
20 what you mean about an altered form. Because I don't
21 think he's alleging that the Mayday form was altered.
22 There's been no evidence or testimony --

23 THE COURT: I think they're talking about the
24 anesthesia records themselves, not the Mayday form.

25 MS. FLEMING: Right.

1 THE COURT: I misspoke. The anesthesia records
2 themselves.

3 MS. FLEMING: Right.

4 THE COURT: Excuse me. That doesn't have
5 anything to do with the Mayday form.

6 MS. FLEMING: I mean, I -- in terms of why the
7 risk manager shredded her copy --

8 THE COURT: All right. Tell me what's the
9 relevancy of letting a blank form in a medical
10 malpractice case?

11 MS. FLEMING: Well, it's relevant to establish
12 the information that ordinarily -- in the ordinary
13 course of business is documented in this particular
14 form. I think that it's prejudicial to not show this
15 to the jury because they are being told --

16 THE COURT: Well, I don't have any problem if
17 you want to ask him what normally goes in these forms,
18 or if you want to call another witness and go into
19 that. But putting a blank form into evidence itself is
20 a different story.

21 If you want to call a nurse or someone -- or
22 this doctor, if he's qualified. I think he's already
23 said the nurses filled it out. If you want to call
24 somebody and ask them about what normally goes into a
25 Mayday card, that's fine. I have no problem with that.

1 But putting the form in itself, I do have a problem
2 with it.

3 MR. COOKE: Your Honor, may I add something?

4 THE COURT: Yes, sir.

5 MR. COOKE: This is -- the purpose of this is to
6 rebut the inference that the plaintiff is going to
7 argue and is going to ask the court for an instruction
8 on this spoliation, but --

9 THE COURT: Let me say this, I -- at this point
10 in time, I don't plan on giving a spoliation charge
11 because I don't think it arises to that level. Okay.

12 MR. COOKE: But he's -- he's already introduced
13 --

14 THE COURT: In -- my sanction, from where I sit
15 today, is the delay in producing it and saying it first
16 didn't occur. That's my sanction for attorney's fees
17 and costs, over a year and a half, two years to get it.
18 Okay?

19 MR. COOKE: I understand.

20 THE COURT: And limited to that.

21 MR. COOKE: But, nevertheless, I think the
22 plaintiff has already argued in opening statements and
23 intends to argue, and that's why he's calling this
24 witness -- because he wants to argue that there must
25 have been something damaging to our case in that record

1 that we destroyed. And by having --

2 THE COURT: But didn't he -- but didn't he
3 speculate? He doesn't know what was in it.

4 MR. COOKE: But he knows that this -- he can
5 identify that this is the form --

6 THE COURT: I understand, but he's assuming
7 that's all they put in it. I mean, one issue could be
8 that the lady that destroyed it, didn't like what was
9 in it, and she's trying to hide something. I'm not
10 saying that's the situation, but that's one assumption
11 you can draw.

12 MR. COOKE: But --

13 THE COURT: And that's a realistic assumption.

14 MR. COOKE: But it would be helpful to the jury
15 to see that they are very specific blocks on here, and
16 there's no place on there where it says, was this your
17 fault, or what caused the arrest. That's not even on
18 the form.

19 THE COURT: Well, I understand, but we don't
20 know what was on the original form is the problem. And
21 that's why I'm very hesitant about it.

22 MR. COOKE: I understand --

23 THE COURT: Okay.

24 MR. COOKE: But if we can -- if we can
25 authenticate that the form at least was this form, it's

1 pretty plain on there what the blanks are that are
2 supposed to be filled out. And that's -- that's the
3 point, is that we don't want to leave it to the jury's
4 imagination, that there must have been something really
5 bad in that form because they shredded it, and so there
6 must be something in there where they say this was all
7 our fault, or we weren't paying attention, or we were
8 busy texting. And we want them to see that there's no
9 place on this form for that kind of information.

10 THE COURT: All right. Well, for now I'm going
11 to sustain the objection. Okay. Now, during the
12 trial, if I hear something that may -- in my opinion
13 make it relevant, I'll tell you and you can reoffer it.
14 Okay?

15 MR. COOKE: All right.

16 THE COURT: All right. But at this point in
17 time, objection is sustained.

18 MR. COOKE: Thank you.

19 THE COURT: Okay. Now, as far as going into
20 what normally goes into these forms, do you have any
21 objection to that?

22 MR. RANSOM: If they can establish a foundation
23 that this witness knows what goes in it --

24 THE COURT: I'm not sure this witness knows
25 that. Okay. Because he's already testified that he's

1 never filled one out. The nurse does. So I'm not sure
2 he would be qualified. But with another witness who is
3 going to establish that, I'm going to let them testify
4 what normally goes into a Mayday form, and I think
5 that's proper. Not what was in that form that was
6 shredded, but what normally goes into a Mayday form.
7 But I'm not -- I've very reluctant to let in a blank
8 copy. Okay?

9 Now, we are on -- what -- cross-examination with
10 this witness?

11 MR. COOKE: Yes, Your Honor.

12 THE COURT: I guess what time -- he'll just have
13 to be back in the morning at 9:30.

14 MR. COOKE: We were going to talk about
15 scheduling anyway. Because you've got your expert
16 coming tomorrow, and we've got Dr. Huggins -- are you
17 going to be able to get him in the morning?

18 THE COURT: I mean, if you want to bring him
19 back at another convenient time for him, that's fine
20 with me.

21 THE WITNESS: If I have to cancel things, these
22 are one of my days to help administer the program, so
23 any -- any Mondays and Tuesdays are the times I'm not
24 actually directly taking care of patients, so this
25 is -- you know, I'll have to cancel some meetings, but

1 I'll -- I'll be here in the morning, sir.

2 MR. COOKE: You probably already put in a full
3 day by 9:30 in the morning anyway, haven't you?

4 THE WITNESS: I start at 5:30, yes, sir.

5 THE COURT: I'll be glad -- you know, work it
6 out with him for his convenience. I'm not saying
7 you've got to come back -- if he wants to come back
8 tomorrow, that's fine. If not, I don't have any
9 problem bringing him back later for cross-examination.

10 MR. COOKE: I think he said tomorrow.

11 THE COURT: He said tomorrow suits him.

12 MR. COOKE: So let's just do that.

13 THE COURT: All right. Doctor, be back here in
14 the morning at -- 9:30 in the morning.

15 THE WITNESS: Yes, sir.

16 THE COURT: And tonight don't discuss this case
17 to anybody; do you understand?

18 THE WITNESS: Yes, sir.

19 THE COURT: Your wife or nobody?

20 THE WITNESS: Yes, sir.

21 THE COURT: Okay.

22 THE WITNESS: She wouldn't want to listen to it
23 anyway.

24 THE COURT: She wouldn't want to listen to it
25 anyhow, would she?

1 THE WITNESS: No, sir.

2 THE COURT: She's probably not even interested.
3 I'll see you in the morning at 9:30. All right,
4 anything from the plaintiff before we break for the
5 evening?

6 MR. RANSOM: Your Honor -- Judge, I think just
7 to protect the record, I would take exception to your
8 ruling. But I'm not going to argue with you about it.

9 THE COURT: Ruling on what?

10 MR. RANSOM: That they can bring in another
11 witness to testify --

12 THE COURT: Pardon?

13 MR. RANSOM: That they can bring in another
14 witness to testify to what --

15 THE COURT: Well, I'm assuming there is enough
16 witnesses to be called, that one of them is going to
17 know about the Mayday card. Okay.

18 MR. RANSOM: Yes, sir.

19 THE COURT: I'm not giving them the right to
20 call somebody that's not on the list. Okay?

21 MR. RANSOM: Yes, sir.

22 THE COURT: And if they qualify them, and know
23 what goes on the form, I'm going to let them testify
24 because I think you made it relevant. Okay? So save
25 your objection to when they try to get into it. All

1 right.

2 MR. RANSOM: Very well, Your Honor.

3 THE COURT: But I'll note at this time it's
4 overruled. Anything else from the defendant?

5 MR. COOKE: Nothing, thank you.

6 THE COURT: All right. Thank y'all very much.
7 See you in the morning.

8 (WHEREUPON, the hearing was concluded.)
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* * * Tuesday, April 19, 2016 * * *

THE COURT: Anything from the plaintiff before we bring the jury?

MR. RANSOM: Your Honor, I just wanted to make the record clear, I intended to offer Plaintiff's Exhibit 9 into evidence. There was some confusion about whether that had actually been done, so I'd like to do that now.

MR. COOKE: No objection.

THE COURT: All right. That's Eric Nelson's -- I'm sorry -- I got the wrong sheet -- number 9, that's the Emergency Response Policy.

MR. RANSOM: Yes, the Emergency Response Medical Policy.

THE COURT: All right. No objection?

MR. COOKE: No objection.

THE COURT: All right. We'll admit Plaintiff's Exhibit No. 9 without objection.

(WHEREUPON, Plaintiff's Exhibit No. 9 was admitted into evidence.)

THE COURT: Anything from the defense before we bring the jury?

MR. COOKE: Nothing. Thank you.

THE COURT: Bring us the jury please. Is the

1 doctor here?

2 THE WITNESS: Yes, sir.

3 THE COURT: Come on around.

4 (The witness returned to the witness stand.)

5 (WHEREUPON, the jury enters the courtroom at
6 approximately 9:37 a.m.)

7 THE BAILIFF: All jurors are present, Your
8 Honor.

9 THE COURT: All right. Thank you very much.
10 All right, Madam Forelady, ladies and gentlemen of the
11 jury, I understand somebody wants to make -- take
12 notes, and that's fine. I've given note pads to
13 everybody. And does everybody have something to write
14 with?

15 All right. If you would put your name on the
16 inside of the note pad, if you would, please. Just
17 write your name on the inside. All right. What I'm
18 going to do with the note pads, is to take notes in the
19 courtroom. When you leave the courtroom, leave the
20 note pads in -- in the chair, and the clerk will
21 collect them and redistribute them when you come back
22 in.

23 And at the end of the case, at the conclusion of
24 the testimony and the charge, and at that time you can
25 take your note pads with you to the jury room. In the

1 meantime, the clerk will maintain control of them.

2 I believe we were at cross-examination. If
3 you'll please proceed.

4 MR. COOKE: Yes, Your Honor. Thank you.

5 MS. FLEMING: Thank you.

6 **CROSS EXAMINATION BY MS. FLEMING:**

7 Q. Dr. Guldan, good morning.

8 A. Good morning.

9 Q. Yesterday we were talking about the code
10 sheet, the Mayday record?

11 A. Yes.

12 THE COURT: Let me interrupt you just a second.
13 Ladies and gentlemen, I forget, Plaintiff's Exhibit No.
14 9, which is the Emergency Medical Response Policy has
15 been admitted into evidence without objection. Please
16 proceed.

17 BY MS. FLEMING:

18 Q. Thank you. Okay. At what point -- you
19 mentioned that the Mayday record is a -- is a document
20 that the nurse in the room would ordinarily document
21 once a Mayday is called; is that correct?

22 A. In situations that are not in the OR or NORA
23 site, which we were in a NORA site for this case.

24 Q. Now, is the record physically kept in the
25 room, or is that something that has to be brought into

DR. GULDAN -- CROSS

1 the room with a crash cart or a defibrillator?

2 A. So in -- in -- when a -- when a Mayday is
3 called on the floor, for instance, the -- the nurse who
4 does the documentation is the charge nurse from the
5 ICU, who is part of the Mayday team. And she's the one
6 who does the documentation, gets the doctors who
7 participated in the code to sign it.

8 The difference in the OR's is the documentation
9 is in the electronic medical record. We document, you
10 know, the -- the attending -- instead of an internal
11 medicine resident running the code, the attending
12 anesthesiologist for the case runs the code for
13 instance. And that's the -- that is documented in the
14 medical record.

15 Q. When -- when does that nurse start documenting
16 in the Mayday record? Is that after the Mayday is
17 called?

18 A. That is correct. When -- when -- whenever the
19 response team arrives in the room, which is usually --
20 depending on where it is in the hospital, can be two
21 minutes, five minutes even, it depends how -- how
22 remote a location is.

23 Q. So is there -- based on your understanding of
24 the Mayday record, is there any information documented
25 in the Mayday record before an actual Mayday is called?

1 A. There is -- there is -- there is no
2 documentation from before a code is called in those
3 records, as far as I understand.

4 Q. And so would it be fair to say that the Mayday
5 record reflects efforts taken to resuscitate a patient?

6 A. It is -- it is a narrative of the actual
7 resuscitation event, who participated and what is given
8 at what times, correct.

9 Q. Now, I think you testified yesterday that when
10 you arrived in response to the Mayday that was called,
11 Mr. Mikell had already returned to spontaneous
12 circulation?

13 A. That is correct. A large part of the
14 resuscitation had been completed, which you know --
15 again, I just really wanted to emphasize the difference
16 between a code in the OR and a code or a Mayday --
17 whatever you would like to call it -- on the floor of a
18 nonanesthesia site. The resuscitation would not begin
19 until a Mayday team arrived, so it would be delayed two
20 minutes, five minutes, however long it takes for the
21 Mayday team to arrive.

22 In this case, because it was in an anesthesia
23 NORA site or an OR, the resuscitation began immediately
24 when the patient was identified to have a problem. And
25 thus, the patient was already well -- well resuscitated

1 when I, and the rest of the team, arrived.

2 Q. And I think you mentioned that you then went
3 to the PACU, which is the Post Anesthesia Care Unit,
4 and instituted or got things ready to start the
5 hypothermia protocol?

6 A. That -- that is correct. The -- the
7 guidelines show that when you have a cardiac arrest,
8 and you're within the first hour of that arrest, if you
9 induce moderate hypothermia, you can reduce organ
10 damage and specifically damage to the brain after the
11 anoxia that happens during any cardiopulmonary arrest,
12 and that can improve the chances of a patient's
13 function returning to baseline.

14 There's always going to be an insult immediately
15 after a cardiac arrest, but you can, you know, improve
16 the likelihood of somebody's function returning to
17 baseline, which happened in this case.

18 Q. Okay. And was the hypothermia protocol a
19 state of the art treatment in 2010?

20 A. That is correct. It was not part of any
21 guidelines as evidenced -- evidence based medicine,
22 excellent standard of care.

23 Q. Were any other hospitals in the Charleston
24 area using the hypothermia protocol in 2010 that you're
25 aware of?

1 A. It was -- it was -- it was pretty new in the
2 literature at that time, so I would seriously doubt it.

3 Q. I don't have any further questions. Thank you
4 very much.

5 A. You're welcome.

6 THE COURT: Any redirect?

7 MR. RANSOM: Yes, sir, Your Honor.

8 **REDIRECT EXAMINATION BY MR. RANSOM:**

9 Q. Good morning, Dr. Guldan.

10 A. Good morning.

11 Q. You -- you testified that the Mayday record,
12 to your understanding, wouldn't contain any
13 documentation of events that occurred before the Mayday
14 took place?

15 A. That -- that is correct.

16 Q. Okay. And let me show you this board here.
17 This is -- you see down in the lower left, it's
18 document control number 611?

19 A. That is correct.

20 Q. Let me see if I can set this up.

21 (Pause.)

22 Q. And this is a part of the anesthesia record
23 from Mr. Mikell's case; correct?

24 A. That is correct.

25 Q. Okay. And I just wanted to point your

DR. GULDAN -- REDIRECT

1 attention to the entry there -- can you see where it's
2 timed 8:00 a.m, and it's under the initials of a Dr.
3 Nelson EWN; do you see that?

4 A. That is correct.

5 Q. Okay. I'll circle it. I apologize. I don't
6 have my marker handy. This entry right here, and it
7 says "Mayday team called at 8 a.m;" correct?

8 A. That is correct.

9 Q. So according to your testimony, the Mayday
10 record would not contain the times or the record of any
11 events that occurred before 8:00 a.m, would it?

12 A. It would not -- it would not have occurred in
13 the events that occurred before the Mayday team arrived
14 on a Mayday sheet.

15 Q. All right. So we wouldn't expect a Mayday
16 record then to provide the times of events that
17 occurred before the Mayday team arrived?

18 A. That is correct, sir.

19 Q. Thank you. Now, you're not really a fact
20 witness in this case, are you?

21 A. No, sir.

22 Q. Right. You don't really know very much of
23 anything about what actually happened during the
24 Mayday?

25 A. Actually I -- I -- I arrived during the

1 resuscitation -- the end of the resuscitation, so I am
2 aware of what happened -- the quality and the -- during
3 the duration of the resuscitation. Before that, I was
4 not present.

5 Q. Well, that's what I mean. I mean, you don't
6 really know what happened during the resuscitation
7 because it was basically over by the time you got
8 there?

9 A. The initial portion of it. The resuscitation
10 doesn't end until the patient is stable. And he was
11 not stable for some time.

12 Q. Instead, your role in this case was you were
13 designated to be the Medical University -- from amongst
14 all the hundreds, if not thousands, of people they've
15 got over there that they selected you -- designated you
16 to talk about -- to explain the Mayday policy; right?

17 A. In -- in -- insofar as it involves the OR's
18 and NORA sites, yes, because I'm an anesthesiologist.

19 Q. Right. But, I mean, your role in this case
20 was to explain to me what this Exhibit 9 means, and how
21 it relates to the events in Mr. Mikell's case; correct?

22 A. Correct.

23 Q. Okay. And I'm curious, I mean did you look
24 over this Mayday policy before you testified in
25 November of 2014?

DR. GULDAN -- REDIRECT

1 A. I did.

2 Q. And I wanted to ask you, did you do anything
3 to investigate whether or not there, in fact, was a
4 Mayday record for Mr. Mikell's cardiac arrest?

5 A. I did look through the electronic medical
6 record. When we transition to the PICIS medical record
7 system, that we've mentioned several times now, all
8 paper entries into a chart are scanned into the
9 electronic record. And that process is a manual
10 process. So I looked for all scanned documents and did
11 not find anything in regards to -- to a Mayday issue.

12 Q. Well, you see one of the things that the
13 Mayday policy requires -- says it must be signed by the
14 designated participants; correct?

15 A. Correct. And that would be -- that would be
16 myself, as well, since I responded. Again, I did not
17 witness a sheet being filled out. I was not asked to
18 sign a sheet. And, again, it is not unusual for there
19 not to be a sheet in the OR, NORA site.

20 Q. Right.

21 A. As the electronic medical record is our
22 official code document for that event.

23 Q. So I wanted to ask you, since the policy
24 requires the record be signed by all the participants,
25 did you do anything to identify who the participants

1 were and then go ask them if they had seen a Mayday
2 record?

3 A. The -- again, the participants are listed in
4 the electronic medical record, and that -- they sign it
5 when they signed into the record.

6 Q. So when you were designated to explain this
7 policy on behalf of the Medical University, you didn't
8 do anything to identify who the people in the record
9 were that had been participating and ask them whether
10 there was a Mayday record, did you?

11 A. Did I speak to the individual -- individual
12 nurses in the room?

13 Q. Right.

14 A. No, I did not. Because I did not expect there
15 to be a medical record. Again in the NORA site or an
16 OR site; there is not.

17 Q. Right. So you didn't ask anything of the
18 participants in the code if there was a Mayday record,
19 you didn't ask any of the nurses in the room whether
20 there was a Mayday record -- let me ask you this: We
21 also know that the policy requires that a copy of the
22 Mayday -- or that rather the Mayday record be faxed to
23 the Risk Management Office; do you see that?

24 A. Again, it does not -- it does not require --
25 there is no form required for an OR or NORA site. So

1 there's -- so the form would not need to be faxed.

2 Q. Did you contact anybody in the Risk Management
3 Office to see if they had received a Mayday record for
4 Mr. Mikell's case?

5 A. I -- I do not recall contacting anybody in
6 Risk Management Office, no, sir.

7 Q. All right. So you can't tell us if the Mayday
8 policy was complied with in this case, can you?

9 A. I can actually. It was complied with because
10 it does not apply to the OR or NORA sites. I've said
11 it once, I'll say it a thousand times.

12 Q. All right. You can't tell us whether there
13 was a Mayday record that was signed by everybody who
14 participated?

15 A. I can tell you there was not a Mayday record
16 signed by everybody that participated, because I would
17 have signed it, as well as Dr. Nelson and Donna Embrey.

18 Q. You can't tell us what the Mayday record
19 contained because you never saw it?

20 A. That's -- that's correct.

21 Q. You don't have any explanation for why the
22 Mayday record isn't in Mr. Mikell's chart?

23 A. Because the Mayday record is the Anesthesia
24 Electronic Medical Record.

25 Q. Did you ever go and look at the paper record

1 for Mr. Mikell to see if it was in his chart?

2 A. Again, the paper record is scanned. This --
3 this -- my involvement was four years after. The paper
4 record no longer exists. All the paper documents,
5 again, are scanned into the electronic system. And
6 that is the complete record for the patients,
7 especially after -- you're two years out, the paper
8 chart doesn't exist anymore. So it's impossible to go
9 back and look at a remote chart.

10 You have to look at the electronic copy and I
11 did. And there was no evidence of a Mayday record,
12 thus my testimony that -- and me not witnessing it,
13 I -- I think reasonably inferred that there was never a
14 Mayday record, especially when it does not apply to an
15 OR or NORA site.

16 Q. And as we sit here today, you don't have any
17 explanation for why there is no Mayday record in this
18 case?

19 A.. Again, there -- it did not need to be, so it
20 never struck my mind as being unusual at all.

21 Q. But you did find out at one point in time that
22 there was, in fact, a Mayday record created; right?

23 A. Very recently.

24 Q. And that that Mayday record was faxed to the
25 Risk Management Office?

1 A. I found that out actually in court.

2 Q. And when you found those things out, did you
3 do anything to notify either my office or my client or
4 anybody in this case that it turned out that what you
5 had testified to was false?

6 A. Again, my -- the -- my testimony was not
7 false. I spoke truly to what I and everyone believed
8 was the case.

9 Q. And it turned out you were wrong?

10 A. You can be wrong and not be false.

11 Q. Thank you. I don't have any other questions.

12 THE COURT: Any recross?

13 MS. FLEMING: No, thank you.

14 THE COURT: Okay. Doctor, you may step down.
15 Any reason the doctor can't be excused?

16 MR. RANSOM: Yes, Your Honor.

17 THE COURT: Yes, he can be, or you have a reason
18 not to excuse him?

19 MR. RANSOM: Yes, he can be excused.

20 THE COURT: All right. Doctor, you may be
21 excused. Thank you very much. Call your next witness,
22 please.

23 MR. RANSOM: The next witness is Sheila
24 Scarborough.

25 (Pause.)

1 MR. COOKE: Judge Nicholson, we told the next
2 witness to be here at 10:00, and she's parking and on
3 her way up now.

4 THE COURT: Well, I guess there's no reason for
5 us to be sitting here looking at each other, so y'all
6 may go to the jury room. When the witness gets here,
7 we'll get back in the courtroom. Leave your note pads
8 in the chairs.

9 (WHEREUPON, the jury leaves the courtroom at
10 approximately 9:54 a.m.)

11 THE COURT: All right. We'll take a break and
12 let me know when the witness arrives.

13 MR. COOKE: I apologize.

14 THE COURT: It's all right. Stuff happens.

15 (WHEREUPON, a brief recess was taken.)

16 THE COURT: Mr. Ransom, you ready?

17 MR. RANSOM: Yes, sir.

18 THE COURT: Bring the jury, please.

19 (WHEREUPON, the jury enters the courtroom at
20 approximately 10:40 a.m.).

21 THE BAILIFF: All jurors are present, Your
22 Honor.

23 THE COURT: All right. Thank you very much.
24 Does everybody have the right book? All right. Mr.
25 Ransom, if you'll call your next witness please.

SHEILA SCARBROUGH -- DIRECT

1 MR. RANSOM: Thank you. The plaintiff calls
2 Sheila Scarbrough.

3 SHEILA SCARBROUGH, after
4 having been duly sworn, testified as follows:

5 THE CLERK: Thank you. Please be seated.
6 Please state your first and last name, and spell your
7 last name loudly and clearly into the microphone.

8 THE WITNESS: Sheila Scarbrough,
9 S-c-a-r-b-r-o-u-g-h.

10 **DIRECT EXAMINATION BY MR. RANSOM:**

11 Q. Good morning, Ms. Scarbrough.

12 A. Good morning.

13 Q. You're employed by the Medical University?

14 A. I am.

15 Q. And I believe that back in October -- well,
16 the late part of 2010, you worked at the Risk
17 Management Office?

18 A. That's incorrect. I worked in the quality
19 department. I was a Critical Interventions Manager.

20 Q. Okay. And what is your position now?

21 A. My position now is the Director of Risk
22 Management and Patient Safety.

23 Q. Okay. But you were in the Risk Management
24 Office in December of 2010?

25 A. No. I was not working in Risk Management at

SHEILA SCARBROUGH -- DIRECT

1 that time. Again, I was working in the quality
2 department. I was a Critical Interventions Manager. I
3 was overseeing our emergency teams, as in code teams,
4 et cetera, and working on patient safety.

5 Q. Now, you were identified by the Medical
6 University to testify on its behalf about its Emergency
7 Medical Response Policy?

8 A. Yes, sir.

9 Q. Okay. We've had that marked as Exhibit 9; are
10 you familiar with that policy?

11 A. Yes, sir. I helped to write it.

12 Q. You testified back in August of 2015?

13 A. Yes, sir.

14 Q. That was about nine months after Dr. Guldan
15 had testified about the same policy?

16 A. I don't know the date he testified, but I
17 remember that I testified in August.

18 Q. Now, you would agree with me that the Mayday
19 Policy, Exhibit 9 there, that does in fact apply to the
20 cardiac arrest that Mr. Mikell suffered on October 1,
21 2010?

22 A. Yes, sir.

23 Q. Okay. And pursuant to that policy, there
24 should be a Mayday record for Mr. Mikell's cardiac
25 arrest?

SHEILA SCARBROUGH -- DIRECT

1 A. That's what's written in the policy.

2 Q. Okay. The Mayday record should be in Mr.
3 Mikell's hospital chart pursuant to the policy?

4 A. That's what's in the policy, yes, sir.

5 Q. Okay. And according to the policy, the Mayday
6 record is something different from the anesthesia
7 record?

8 A. In the policy.

9 Q. Yes, ma'am.

10 A. I don't know that it says that exactly in the
11 policy, but there are -- I don't recall that being in
12 the policy, that it's different.

13 Q. Yeah. You would agree with me that Mayday
14 record is something different than the anesthesia
15 record?

16 A. It's a -- two different things, yes, sir.

17 Q. And something different from the general
18 medical record, too, right?

19 A. The CPR form will be part of the medical
20 record once it's in the medical record, but it is a
21 part of the medical record.

22 Q. And you would agree with me that there -- a
23 Mayday record for Mr. Mikell was, in fact, created?

24 A. I think so, yes, sir.

25 Q. Okay. And it was faxed to the Risk Management

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1 Office some time in late December of 2010?

2 A. No. It probably was faxed right after the
3 code, or sometime around the code is generally when the
4 forms are faxed.

5 Q. Okay. Well, you -- you had the fax in the
6 Risk Management Office?

7 A. It went to the Risk Management fax machine
8 because I couldn't afford a fax machine in my office,
9 and it was the closest fax machine to my office. So I
10 had to walk across the hall to get it. But yeah, it
11 went into that -- that fax machine.

12 Q. Okay. And if you'll look at the policy --
13 well, let me point this out to you -- the policy
14 actually requires that the Mayday record be faxed to
15 Risk Management?

16 A. Yes.

17 Q. You see that -- okay. And so it was --
18 because that's what the policy requires, that's why it
19 was faxed to the fax machine where you picked it up?

20 A. Yes, sir?

21 Q. Do you remember about when it was that -- that
22 you got that fax?

23 A. No, sir. I don't remember that directly.

24 Q. Okay. All right. And what did you do with
25 the Mayday record when you got it off the fax?

SHEILA SCARBROUGH -- DIRECT

1 A. I don't remember this particular record
2 itself. But what my general practice was -- is during
3 that time when I had that job, is to get the records,
4 to review it, to look to see if there were quality
5 issues that needed to be addressed. That's one of the
6 primary functions of that record, is to look to see if,
7 you know, Epinephrine was given in five minutes. If,
8 you know, the patient was defibrillated appropriately,
9 if we were following ACLS protocols.

10 Because that was my primary job, to look to see
11 if there was quality issues that needed to be
12 addressed. So I would look at the -- at the record,
13 and I would do a quick abstraction, to have all the
14 data that I needed to put in the database later. I
15 didn't always put everything in the database
16 immediately. It depended on how busy I was or
17 whatever.

18 But I would want to make sure at the time, when
19 I first got the record, if there was anything that
20 needed addressing, like equipment was missing, or code
21 team members didn't show up or things like that, that's
22 the sort of thing that I would look at on the sheet is
23 to say, okay, did everything seem to go okay.

24 And if something didn't go okay, then I would
25 step it up and go back to the committee and say, you

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1 know, we have a problem with -- the code team didn't
2 respond, or whatever it was that happened on the code,
3 that wasn't a quality piece that we needed to learn
4 from. Because that's we try to do is learn from our
5 quality indicators.

6 Q. And so that's the general process that you
7 would follow?

8 A. Yes, sir.

9 Q. Okay. But you say you don't have any
10 recollection of this --

11 A. Of this particular one, no. We had two or
12 three a day. And so for several years, I did this, so
13 I can't remember this particular date.

14 Q. Okay. And once you were done with your review
15 of the Mayday record from Mr. Mikell's case, what did
16 you do with it?

17 A. Once I finished with the document -- the copy
18 that came off the fax, when I didn't need it any more,
19 then I would put it in the shredder per law. It's a
20 HIPAA violation to leave something like that laying
21 around.

22 Q. Right now, just to be clear, the policy that's
23 on the screen, it doesn't say anything about shredding
24 or destroying the Mayday record?

25 A. No. I wouldn't destroy the record, the one

SHEILA SCARBROUGH -- DIRECT

1 that goes in the chart. No, no one does that. The
2 copy that I get off the fax, that's what's destroyed.
3 And, no, it's not in here, but we do have a policy at
4 the Medical University about HIPAA violations, and how
5 you deal with health information. And so that would be
6 in a policy from that. And I don't remember the actual
7 name of that policy, sorry.

8 Q. Do you have any explanation for why the Mayday
9 record isn't in Mr. Mikell's chart?

10 A. I don't personally know. This particular
11 record, in my experience, sometimes records -- there
12 are pieces of papers. And, of course, during an event,
13 you know, after the event occurs, you know, you
14 resuscitate. And then after the patient is
15 resuscitated and goes to the ICU, or whenever they're
16 going, there's a fair amount of chaos.

17 Sometimes when the nurses fax me the -- the
18 record, they forget to pull it off the fax, and so it
19 stays on the fax. I've seen that happen. I've seen
20 the piece of paper get stuffed into this little folder,
21 that's the medical record. And a piece of paper
22 sometimes can just fall out. But, again, in this
23 particular case, I don't know in this particular case.

24 Q. And you didn't do anything to look for the
25 Mayday record, and try to find out what may have

1 happened to it?

2 A. No, I did not.

3 Q. Okay. So you don't know?

4 A. I do not.

5 Q. Okay. Thank you. I don't have any other
6 questions.

7 THE COURT: Cross-examination.

8 **CROSS EXAMINATION BY MS. FLEMING:**

9 Q. Good morning, Ms. Scarbrough.

10 A. Good morning.

11 Q. Could you tell the jury how long you've been
12 employed by MUSC and a little bit about your
13 educational background?

14 A. Okay. I graduated from nursing school with a
15 Bachelors in Nursing from Radford University back in
16 1986. I did travel nursing for some years, and then
17 came to the Medical University -- first as a traveler,
18 about six months after Hugo. And then traveled a
19 little bit longer, then came back in 1992 permanently.
20 And I've been at the Medical University since then.

21 My background is critical care nursing. And I
22 joined the quality department in two -- about 2005-ish
23 to develop our medical emergency team, which we didn't
24 have before at that time, which was kind of like a code
25 team, but it's for patients who are not coding. The

1 patients are sick on the floor that need critical care,
2 so I developed that team.

3 Q. Okay. Now, you said in 2010, at the time of
4 Mr. Mikell's code, you were in the quality department?

5 A. Yes, ma'am.

6 Q. And you actually developed the policy that we
7 are talking about today?

8 A. Yes. That was actually started back in the
9 '90s, but I did most of the -- I was the chair of the
10 committee, starting in the late -- in the early 2000s,
11 like 2002, 2003, I started being chair. So it was my
12 responsibility to keep that policy up-to-date.

13 Q. Okay. And you said that you -- you actually
14 tracked codes that occurred at the Medical University.
15 And why did you -- why did the Medical University track
16 codes?

17 A. So we could improve. Codes, themselves, you
18 know can be chaotic and difficult, and so we want to
19 make sure that every one of the team members are
20 working appropriately, that we gave the medications
21 that we're supposed to so we can improve. In the
22 last -- since 2005, since I started in the quality
23 department, our return to spontaneous circulation
24 rates, which have gone -- gotten a lot better -- and
25 better than the national average, and so that's what we

1 want to do. We want to save lives.

2 Q. And did -- at the time that this happened, I
3 heard you mention a database?

4 A. Uh-huh.

5 Q. What was the purpose of -- or why did you
6 receive a copy or why was -- why did you receive a copy
7 of -- of the Mayday record or the code sheet?

8 A. As I said before, to look at immediately to
9 see if there was any problems that I needed to be
10 addressing with the code team or equipment, et cetera.
11 The other piece is to put this data in this database so
12 it can be reviewed on the aggregate.

13 As you know, if you're just looking at one
14 event, you may not be able to learn lessons from that.
15 But if you look at 10 or 100, 200, you could see
16 trends. If we have trends of problems with medications
17 or personnel -- or whatever, that would point the
18 quality department in the direction of what we need to
19 do to fix things, and so that's the purpose of the
20 database.

21 Also, to benchmark ourselves with other
22 hospitals in the country. So, you know, how fast can
23 they start CPR, and how fast they do this -- are we in
24 the same -- we're doing the same thing. That's --
25 that's the purpose of that database.

1 Q. And then from a quality standpoint, did you
2 find any issues with regard to quality as it pertains
3 to Mr. Mikell's arrest or the resuscitation?

4 A. I don't recall the actual abstraction, but my
5 normal practice was if I did find any issues, I would
6 have took that back to the committee. And, also, we
7 did learnings, we did meetings. We called M&Ms.

8 So, basically, we went back to the code team and
9 said, hey, this particular thing happened, so let's
10 learn from it. And, you know, we would discuss it.

11 And there's -- I looked at all of those records,
12 you know, in preparation for this deposition -- I mean
13 this witness, and I didn't see that we did that. So I
14 have no evidence that there was anything that was
15 wrong. But, again, I can't actually remember what was
16 in the record.

17 Q. Now, the database that you referenced, what
18 is -- what is the name of that database?

19 A. It used to be called the National Registry of
20 CPR at the time that we were doing this. They changed
21 their name to get with the guidelines, resuscitation.
22 I think they did that about two or three years ago, so
23 that's what it's currently called.

24 Q. And when you say "they", what --

25 A. It's --

1 Q. Is that a database that's maintained by MUSC
2 or is that an independent database --

3 A. That's independent. That's -- I forget the
4 name of the company, I think Hortiles (ph), but it's --
5 it's a vendor of the American Heart Association. So
6 the American Heart Association is the group that hires
7 this -- this -- this database people to keep up with
8 all this data. It's not ours.

9 Q. So the database, is it a -- is it a National
10 Registry of Codes that occur throughout the country?

11 A. Yes, ma'am.

12 Q. And so as part of a participant in that data,
13 MUSC enters data into the database for the purpose of
14 the American Heart?

15 A. That's correct.

16 Q. And did you, in your role as quality
17 coordinator, did you enter data regarding codes into
18 the American Heart Association database?

19 A. Yes, I did.

20 Q. Do you recall whether you entered any data
21 into the database concerning Mr. Mikell?

22 A. I don't recall that. I did look later to see
23 and I did. But I don't technically recall doing it. I
24 did -- like I said, I did many entries.

25 MS. FLEMING: I'd like to mark for

1 identification Defendant's Exhibit 3.

2 (WHEREUPON, Defendant's Exhibit No. 3 marked for
3 identification.)

4 BY MS. FLEMING:

5 Q. Now, Ms. Scarbrough, when you -- did you --
6 did you at any point go back into the database and look
7 to see if you entered information on Mr. Mikell?

8 A. Yes. At a request for my deposition -- for
9 the deposition, I did look at that, yes.

10 Q. Okay. And I'd like to go ahead and show you
11 what's been marked for identification as Defendant's
12 Exhibit 3.

13 A. Okay.

14 Q. Can you identify that document?

15 A. This is a PDF that I pulled off -- I think
16 this last Fall -- about what was entered into the
17 database for Mr. Mikell.

18 Q. And when you it's say a PDF, can you
19 explain -- so did you go back into the database and
20 look for information concerning Mr. Mikell's --

21 A. So, when I was originally asked back in August
22 to look to see if anything had gone into the database
23 -- and, again, you have to -- the way I see the data is
24 in the aggregate, so I have an Excel -- so I don't look
25 at -- I never go back and look at individual patients.

1 I look at aggregate data, like a bunch of data.

2 And so when I was asked to look for it, I looked
3 in the big Excel database. And I did find the medical
4 record that was associated with Mr. Mikell in that
5 database. And so I pulled that to start off with,
6 which was very unwieldy to be able to read, because it
7 was an Excel -- a long thing, and it turned out to be
8 like 20 something pages -- and it was hard to read, so.

9 I went back to get with the guidelines and
10 looked on their website for help to see if there was a
11 better way to pull individual patients, because I've
12 never done it before. And I found that the best way to
13 pull it is a PDF, which actually shows it in a more
14 organized fashion to be able to read.

15 Q.. Okay. And so the document that's been handed
16 to you, that we were talking about, is that a printout
17 of the information from the database that you entered
18 concerning Mr. Mikell?

19 A. Yes, it is.

20 Q. And when did you create this -- the entry in
21 the database for Mr. Mikell?

22 A. When did I create the entry in the database --
23 it was the last week of -- of December -- December 29,
24 2010 at 5:00 in the afternoon.

25 MS. FLEMING: I'd like to move to enter

1 Defendant's Exhibit 3 into evidence at this time.

2 THE COURT: Any objection?

3 MR. RANSOM: Yes, Your Honor, we object.

4 THE COURT: Let me see what -- what we're
5 talking about, please, ma'am.

6 (Pause. Document handed to Court.)

7 THE COURT: All right. What is your legal
8 objection?

9 MR. RANSOM: Two objections, Your Honor. The
10 first is relevance of the information contained in the
11 document. And the second is the best evidence rule
12 objection.

13 THE COURT: All right. Madam Forelady, and
14 ladies and gentlemen of the jury, I'm going to ask you
15 to go to the jury room. Please don't discuss the case
16 amongst yourselves. Please leave your note pads in
17 your chairs.

18 (WHEREUPON, the jury leaves the courtroom at
19 11:00 a.m.)

20 THE COURT: All right. Ms. Fleming, tell me
21 exactly what this is.

22 MS. FLEMING: Yes. Your Honor, it is --

23 THE COURT: I -- wait a minute -- I assume it's
24 what she put into the database, based upon a copy of
25 the Mayday card; is that correct?

1 MS. FLEMING: That she received, yes.

2 THE COURT: Pardon?

3 MS. FLEMING: Yes. Yes. That she received,
4 yes.

5 THE COURT: And this was in December, 2010, and
6 was produced to the defendant when?

7 MS. FLEMING: Produced to me in --

8 THE COURT: I'm sorry -- produced to the
9 Plaintiff when?

10 MR. RANSOM: I think it was in December of 2015.
11 It may have been a month or two earlier. We took her
12 deposition in August -- you remember we had a printout
13 that we couldn't understand --

14 THE COURT: And she put this in when? In
15 December of 2010? Six -- six years later it was
16 produced to the Plaintiff, right?

17 MS. FLEMING: It --

18 THE COURT: I'm sorry, not -- five years later
19 --

20 MR. RANSOM: Five years, yes, sir.

21 MS. FLEMING: That's when we learned that there
22 was information.

23 THE COURT: And the information that she put in
24 is off of the missing Mayday card; is that correct?

25 MS. FLEMING: Yes, that's correct.

SHEILA SCARBROUGH -- CROSS

1 THE COURT: All right. Let me hear you on --
2 on -- first of all, let me hear Mr. Ransom on the issue
3 of relevance. I understand your argument about the
4 Best Evidence Rule, but let me hear you on your --

5 MR. RANSOM: Well, Judge, Ms. Scarbrough has
6 testified just a moment ago that she doesn't have any
7 personal knowledge of what was actually in Mr. Mikell's
8 Mayday records. She just can't recall. I don't think
9 then that she could testify that this exhibit that's
10 been marked is -- contains all of the information that
11 would have been in the Mayday card.

12 And more importantly, since we don't know
13 whether or not it -- you know, it is representative of
14 all the information that was in the original record,
15 the question is, well, what is it that they're trying
16 to prove? How is that relevant to one of the medical
17 issues in the case?

18 And, again, we think -- we take the position
19 that this is just a backdoor effort to try to provide
20 secondary evidence of a Mayday record, in an effort to
21 convince this jury that there's --

22 THE COURT: I mean, it's relevant because you've
23 put it into issue in your case so far. And it's in
24 response to what you've raised, ie, the -- the missing
25 Mayday card.

1 MR. RANSOM: Well, that's true. We've raised --

2 THE COURT: Which as I've said before, that
3 doesn't necessarily go to your theory of liability. A
4 Mayday card is just about the resuscitation, not about
5 what happened when they put him to sleep.

6 MR. RANSOM: Well, and this is -- again, Judge,
7 so I'm following --

8 THE COURT: I mean, this whole -- this whole
9 process we're going through about this Mayday card, I
10 question the relevancy as to your case in chief, but
11 I've allowed it primarily from a standpoint of
12 credibility. But what does it actually have to do to
13 your case in chief as far your theory of liability?

14 MR. RANSOM: Well, I think that's best explained
15 when we come to the testimony of another witness who is
16 going to be talking about what she claims to have done
17 when she had the Mayday record in her possession. And,
18 you know, she's going to talk about how she used it to
19 accurately complete the anesthesia narrative. And what
20 I'm trying to do is lay a foundation with these other
21 witnesses to show that that's nonsense.

22 THE COURT: All right. Ms. Fleming, let me hear
23 you -- and I'll just tell you my concerns. My concern
24 is twofold. Number one, she says she has no
25 independent knowledge of Mr. Mikell and what was in the

1 original Mayday card. And she testified she took
2 that -- that information, the Mayday card, and put it
3 into the computer system, retrieved it from the Excel
4 spread sheet, which you have produced here today. But
5 how -- the only thing she could say is she did put this
6 in evidence, but I don't -- if she doesn't have
7 independent knowledge of what was on the Mayday card,
8 how can it be -- how could I let it in, since we don't
9 have the original Mayday card?

10 MS. FLEMING: Well, Judge, it's a business
11 record in and of itself, the data entry into the
12 American Heart Association database, which is something
13 that MUSC --

14 THE COURT: Well, I understand that.

15 MS. FLEMING: -- in their normal course of
16 business.

17 THE COURT: I understand it's a business record,
18 and I understand she pulled it out, but it still hasn't
19 been authenticated because she doesn't know what the
20 original -- was on the original document, that she
21 theoretically produced this document from.

22 MS. FLEMING: Well, I think -- I think that's
23 the nature of all business records. And she actually
24 can authenticate what's in this document, which is
25 information that she entered into the database.

1 THE COURT: Well, if it was a business record,
2 why did it take five years to produce it?

3 MS. FLEMING: I -- I can -- I can tell you what
4 we've said all along, which is she's never asked to --
5 this isn't a part of the patient's medical record, and
6 so it wasn't something that we knew to look --

7 THE COURT: All right. I'm going -- I'm going
8 to sustain the objection primarily because this witness
9 cannot prove that it's accurate because she doesn't
10 remember the case, she doesn't remember what was in the
11 original card. Therefore, I don't think under any
12 theory, business records or whatever theory you want it
13 under, she can authenticate the document properly
14 because all it is, is a transaction or a -- a passing
15 of information from an original Mayday card into the
16 computer.

17 And if she doesn't remember what was on the
18 Mayday card, she can't sit here today and say that's
19 accurate. All she can say is, that's what I think I
20 put in. That's my normal course. And I'm not going to
21 let it in with that testimony. The motion is denied --
22 excuse me -- the motion is sustained. All right. Is
23 there anything else we can take up while the jury is
24 out concerning any other documents that we're going --
25 you're going to try to get in with this witness?

SHEILA SCARBROUGH -- CROSS

1 MS. FLEMING: Yes, actually. We're going to --
2 we'd like to move to enter the code sheet, the Mayday
3 record through this witness.

4 THE COURT: The which one?

5 MS. FLEMING: The blank code.

6 THE COURT: Show me what you're talking about.
7 I'm not sure I have it. Okay. Do we have it -- oh,
8 this is the blank. I thought we ruled on that
9 yesterday.

10 MS. FLEMING: But I think you left --

11 THE COURT: I said you can ask her questions
12 about it, but I'm still not going let the blank copy
13 in.

14 MS. FLEMING: I thought you said that if we
15 could lay a foundation through another witness, that we
16 would address that.

17 THE COURT: I would reconsider it.

18 MS. FLEMING: Yeah.

19 THE COURT: All right. How are you going to --
20 let's hear the foundation. Let's just do this while
21 the jury is out.

22 MS. FLEMING: Right. Right. She actually
23 created this document.

24 MR. COOKE: Ask her the questions.

25

1 BY MS. FLEMING:

2 Q. Ms. Scarbrough, I'd like to show you what's
3 been identified as Defendant's Exhibit 2 for
4 identification; could you please identify that
5 document?

6 A. This is a Cardiopulmonary Resuscitation Event
7 Form, as it has been called, quote, really the Mayday
8 form or the code form.

9 Q. And have you seen this document before?

10 A. Yes, I have.

11 Q. And under -- under what circumstances have you
12 seen this document?

13 A. Again, I created it to start off with. And
14 then I looked at many, many, many filled out cardiac
15 forms, and I actually -- we still use this form, so I
16 still see it.

17 Q. And when you say you still see it, is this --
18 is what's been marked as Defendant's Exhibit 2
19 representative of the form or the version that was
20 being used in 2010?

21 A. Yes, it was.

22 Q. Okay. And does it -- when you said that you
23 developed it, did you make a determination of what
24 information should be or would be documented in an
25 actual Mayday record code sheet?

1 A. Part of that came from American Heart
2 Association, part of the purpose of this tool is to get
3 quality data to put into the database. And so that's
4 what this form was based on, what they asked for the
5 database information. We wanted to make sure that that
6 was being collected at the time of the code. So that's
7 one of the reasons that we developed this sheet.

8 And, of course, the other reason is because
9 generally during codes, nurses give medications not
10 doctors, anesthesia is the only people that give meds.
11 And so this had to be a physician's order as well.

12 Q. And so was this form designed to be completed
13 by a nurse or a physician? Because you just mentioned
14 something about --

15 A. Generally nurses fill this out.

16 Q. And you'll notice that -- obviously you
17 drafted this, so did the labels on the document and
18 each of the various sections describe accurately the
19 data that is recorded during a Mayday or a code?

20 A. I'm sorry. I didn't understand the question.

21 Q. Sure. You'll notice that there are different
22 sections where data is entered on the code sheet?

23 A. Yes.

24 Q. Okay. Do those sections represent the
25 information that is supposed to be recorded in the form

1 during a code or a Mayday resuscitation?

2 A. Yes.

3 MS. FLEMING: Nothing further.

4 THE COURT: Do you have any cross-examination
5 you would like -- let me see the form you're actually
6 trying to put in for a second, please. I know I've got
7 a copy of it. I want to make sure it's --

8 MS. FLEMING: The same. Okay.

9 THE COURT: All right. Before I even would
10 consider it, down where it says PWPA, file number,
11 Mikell vs. MUSC, that's going to be redacted if I let
12 in; do you understand?

13 MS. FLEMING: Uh-huh.

14 THE COURT: All right. Cross-examination
15 concerning this witness, if you so desire before I
16 rule.

17 MR. RANSOM: Yes, Your Honor. I would like to
18 ask a couple of questions.

19 THE COURT: Now, my understanding is they are
20 offering this simply to show that this is what we've
21 been referring to as the Mayday card. It's really a
22 Cardiopulmonary Resuscitation Event form, which we've
23 been referring to as the Mayday form which MUSC uses --

24 MR. RANSOM: Correct.

25 THE COURT: -- is my understanding -- is that

1 correct? Ms. Fleming, is that correct?

2 MS. FLEMING: I'm sorry. I didn't hear what you
3 said.

4 THE COURT: I'm sorry.

5 MS. FLEMING: I didn't hear --

6 THE COURT: I said you're offering this for the
7 purpose of showing this is what MUSC uses, and this is
8 what a blank Mayday card is; is that correct?

9 MS. FLEMING: That is correct.

10 THE COURT: Okay. All right.

11 BY MR. RANSOM:

12 Q. Ms. Scarbrough, with respect to this blank
13 form, which is marked as Defendant's Exhibit 2, in your
14 experience, have you ever seen these forms when they
15 aren't fully completed?

16 A. Yes.

17 Q. And have you ever seen a circumstance where
18 information is written on the form other than just
19 the -- to fill out the form itself?

20 A. I'm sorry? What other information?

21 Q. So have you ever seen -- you know, there are
22 boxes to check and places to write in medications and
23 so forth. I mean, have you ever seen information
24 written in one of these forms that isn't according to
25 the template, that somebody wrote in something in the

1 margin or up here at the top?

2 A. I can't recall, sir.

3 Q. So you can't tell us that that hasn't
4 happened?

5 A. That's accurate. I don't recall 100 percent.
6 I can't remember every single form right now, so yes.

7 Q. And you don't have any specific recollection
8 of Mr. Mikell's Mayday record to be able to tell us
9 that it didn't have stray marks, added notes, extra
10 information?

11 A. I don't remember that. And I don't remember
12 ever seeing it, so I think I probably would remember it
13 if it was something that strange.

14 Q. But when you say you don't remember --

15 A. But I don't. I don't.

16 MR. RANSOM: Thank you, Your Honor. That's all
17 I have on the form.

18 THE COURT: Okay. All right. Let me hear your
19 argument on why -- why it shouldn't be admitted
20 primarily just to show this is the form that MUSC uses?
21 And I will so instruct the jury.

22 MR. RANSOM: Judge, the blank form doesn't prove
23 or disprove anything in the case.

24 THE COURT: Well, I understand that. But my
25 arguments -- why shouldn't I allow it?

1 MR. RANSOM: Because I think it's, again, it's a
2 back door to beat the best evidence rule and provide
3 secondary evidence of what was in Mr. Mikell's form.
4 The argument is going to be --

5 THE COURT: Well, we haven't gotten to Mr.
6 Mikell yet, because she says she doesn't remember.
7 Now, if it is somehow fill in the blanks, that's a
8 different story; okay?

9 MR. RANSOM: Well, and again, I think the
10 filling in of the blanks is going to come in the
11 argument of counsel at the close of the case.

12 THE COURT: Well, I don't know. But I -- I
13 think it's -- I'm going to overrule your objection.
14 I'm going to allow it in simply based upon the fact
15 that this is a -- what the parties have been referring
16 to as a Mayday card, used by MUSC when this occurred --
17 when did it occur -- October 1, 2010. And it's
18 referred to as a Cardiopulmonary Resuscitation Event
19 Form. I'm going to allow it in for that purpose and
20 that purpose only.

21 Now, assuming the part down here, this Mikell
22 vs. MUSC is redacted --

23 MS. FLEMING: May we use a black marker to
24 redact that?

25 THE COURT: I don't have a black marker.

1 MS. FLEMING: We do. We do.

2 THE COURT: Okay. Do you have one?

3 MS. FLEMING: Yes. Yes.

4 THE COURT: Then mark it. Redact it.

5 MS. FLEMING: Okay. I wanted to make sure that
6 that was acceptable.

7 THE COURT: Okay. Get it marked. It's not
8 going in unless you get it marked.

9 MS. FLEMING: Thank you.

10 THE COURT: Thank you very much.

11 (WHEREUPON, Defendant's Exhibit No. 2 admitted
12 into evidence.)

13 THE COURT: All right. Ms. Fleming, you
14 understand you're going to have to go -- jump through
15 this hoop again when we bring the jury in.

16 MS. FLEMING: Okay.

17 THE COURT: Okay. Bring us the jury. Any other
18 forms you're going to try to get in with this witness
19 that we need to discuss now?

20 MS. FLEMING: No, I don't think so.

21 THE COURT: Okay. Thank you very much. Bring
22 us the jury.

23 (WHEREUPON, the jury enters the courtroom at
24 approximately 11:15 a.m.)

25 THE BAILIFF: All jurors are present.

1 BY MS. FLEMING:

2 Q. Ms. Scarbrough, could you please identify this
3 document for the jury?

4 A. This is the Cardiopulmonary Resuscitation
5 Event form, which is also known as the Mayday form.

6 Q. And I'm sorry -- is it -- how -- are you
7 familiar with this form?

8 A. Yes. I helped to create it.

9 Q. Okay. And is the -- is this the version of
10 the form that MUSC was using in 2010?

11 A. Yes, it was.

12 Q. And the information on the form -- there are
13 various places to record information; is that correct?

14 A. That's correct.

15 Q. Okay. Is this representative of the
16 information that was documented in the form during
17 resuscitation after a Mayday was called?

18 A. Yes. This is the type of information that is
19 documented for Maydays.

20 Q. And you said that you helped to create this
21 form; why did -- why did MUSC create this form that's
22 called the Cardiopulmonary Resuscitation Event --

23 A. There's a couple of reasons. First and
24 foremost, from the quality standpoint, we wanted to
25 make sure that at the time of resuscitation, when

1 people are busy saving lives, they don't think a lot of
2 the data points that we want to capture to put in the
3 database, so this helps to remind them to write these
4 things down.

5 The other piece is that -- unlike anesthesia,
6 who those doctors give their own medicines, most
7 doctors don't give medications. They order nurses to
8 do it. And in a code situation, you know, there's not
9 time to write something down, like a normal physician's
10 order, so we made this a physician's order so that
11 nurses would be covered for giving medications.
12 Because nurses can't give medications without a
13 physician's order, so that's what this is.

14 MS. FLEMING: I would like to move Defendant's
15 Exhibit 2 into evidence at this time.

16 THE COURT: I'm sorry?

17 MS. FLEMING: I said, I would like to move
18 Defendant's Exhibit 2 into evidence at this time.

19 THE COURT: All right. The defendant (sic) has
20 an objection, is that correct -- what's your legal
21 objection?

22 MR. RANSOM: The same objection that we
23 discussed when the jury was out, Your Honor.

24 THE COURT: All right. That objection is
25 overruled. I'm going allow the Defendant's Exhibit --

SHEILA SCARBROUGH -- CROSS

1 is it number 2 or number 3?

2 MS. FLEMING: It's number 2.

3 THE COURT: Number 2. Defendant's Exhibit No. 2
4 admitted to show that this is the form that the parties
5 have been referring to as a Mayday card.

6 (WHEREUPON, Defendant's Exhibit No. 2 was
7 admitted into evidence.)

8 BY MS. FLEMING:

9 Q. Ms. Scarbrough, I'm going to put a copy of
10 this form up so the jury can see it. Now, Ms.
11 Scarbrough, what information is -- is documented in the
12 resuscitation form? And when I say that, I'm really
13 referring to -- is it information that's -- that occurs
14 after a Mayday is called?

15 A. After the Mayday is called, yes. After it's
16 determined that the patient is in cardiopulmonary
17 arrest.

18 Q. Does -- is anything that occurs, generally
19 speaking, prior to the time of the Mayday, recorded in
20 this document?

21 MR. RANSOM: Your Honor, I'm going to object.

22 THE COURT: What's the legal objection?

23 MR. RANSOM: Well, on relevance grounds. This
24 doesn't have anything to do with Mr. Mikell's care.

25 THE COURT: Overruled. Go ahead.

1 BY MS. FLEMING:

2 A. No. It's actually about the resuscitation,
3 but it's what the patient's condition was at the time
4 that he went into cardiac arrest. Like there's a
5 question about was it witnessed or not. So when he
6 went into cardiac arrest, was someone there. Because
7 sometimes we have patients that we find, you know, in
8 the bed that has cardiac arrest that we didn't know
9 about. Those sort of things.

10 Yeah, it's all about at the time of cardiac
11 pulmonary arrest on -- until the patient is
12 resuscitated or not, that's what the information is in
13 the form is all about.

14 Q. And I think you mentioned that the nurse
15 actually -- the nurses actually document in this form,
16 not physicians?

17 A. That's correct.

18 Q. So the anesthesiologists might be asked to
19 sign the form at the completion of a Mayday, but they
20 generally don't fill out the boxes and the information
21 that's contained on this?

22 A. They do not. They usually -- they don't even
23 sign it. It's a doctor -- it's not -- unless the
24 anesthesiologist is running the code, it's the other
25 doctors that sign it, so anesthesia very rarely ever

1 see this form.

2 Q. Okay. Now, the copy of the code -- I'll refer
3 to it as a code sheet, but we would call it the
4 Cardiopulmonary Resuscitation Event form, or the Mayday
5 form, the copy that you receive in your office, is that
6 copy ever placed in the patient's medical record?

7 A. No. It's a fax. So that doesn't go back into
8 it. It's a fax.

9 Q. And after you -- what do you do with -- with
10 the form that you -- the copy that you receive after
11 you enter the data in the database?

12 A. After I enter the data in the database, I
13 throw the form away into the confidential bend.
14 Because it is confidential information. You just don't
15 leave health information laying around.

16 Q. And you said that -- that to leave it lying
17 around would be a violation of HIPAA?

18 A. HIPAA, it's against the law.

19 Q. And HIPAA was -- could you explain just
20 generally speaking what HIPAA is?

21 A. HIPAA, actually it's the Health Affordability
22 Act, but basically it's about health information, so
23 that your medical records are not found by people that
24 don't need them. So in the quality department, we do
25 look at patient's medical records. We're not actually

1 taking care of them, but we use the medical records for
2 quality purposes. No one should be looking at your
3 medical records except for your doctor, or for quality
4 insurance or insurance purposes. It's protection of
5 information.

6 Q. And so do you ever maintain a copy of the form
7 that you receive in the ordinary course of business?

8 A. After I -- after I finish the abstraction, no.

9 Q. Now, Mr. Ransom asked you some questions about
10 why a code sheet or a -- one of these forms might go
11 missing. Could you -- could you explain -- have you
12 had circumstances where the actual form that is
13 supposed to be placed in the medical record cannot be
14 found?

15 A. Yes.

16 Q. Is that something that has happened?

17 A. It happens -- it happens several times a month
18 at least that, you know, there's -- I try to find the
19 code sheet, and nobody can find the code sheet.
20 Because, again, it may have gotten destroyed about the
21 time of the code when there was chaos, or it fell out,
22 or it fell into medical records, and we lost the
23 medical records. So it's not unheard of at all for the
24 code sheet to -- to be missing.

25 Q. Now, I think you said that you entered the

SHEILA SCARBROUGH -- CROSS

1 data concerning Mr. Mikell's code into American
2 Heart -- or the database maintained by the American
3 Heart Association at the end of the year of 2010?

4 A. That's correct.

5 Q. Okay. Did you know that Mr. Mikell had passed
6 away -- did you know any circumstances related to his
7 health at the time that you entered the data into the
8 database?

9 A. So, for the database, you put in all the
10 resuscitative data, but you also put in when a patient
11 is admitted and discharged. And so I would have waited
12 until after he was discharged, and then put in the date
13 of discharge. After someone is discharged, I don't
14 know what happens to them after that.

15 Q. Okay. And so when you entered this data into
16 the database, would it be fair to say that you didn't
17 know whether he had died or not?

18 A. That's correct.

19 Q. And did you -- do you know whether a lawsuit
20 had been filed?

21 A. That's correct -- I didn't know anything about
22 it.

23 Q. And when did you come to learn that he
24 actually passed away?

25 A. I guess when I was asked about this form last

1 summer. I didn't know anything about it. I had
2 nothing to do with it.

3 Q. Ms. Scarbrough, did you know when you
4 discarded the copy that you received, that the original
5 Mayday form had been lost?

6 A. I did not.

7 MS. FLEMING: That's all I have. Thank you.

8 THE COURT: Redirect.

9 MR. RANSOM: Yes, Your Honor.

10 **REDIRECT EXAMINATION BY MR. RANSOM:**

11 Q. Ms. Scarbrough, you said that once it's in the
12 file, the Mayday record is generally pretty safe?

13 A. In the file?

14 Q. In the patient's record, in the patient's
15 chart?

16 A. It should be. They punch the holes and stick
17 it in the chart.

18 Q. All right. Did Dr. Guldan ever come and ask
19 you if you knew anything about the Mayday record?

20 A. No.

21 Q. Can you think of any reason why if Dr. Guldan
22 was part of the resuscitation effort, he wouldn't have
23 signed the Mayday record as the policy requires?

24 A. He -- I don't think he was the leader of the
25 code team. I think it was another physician that was

1 actually leading the resuscitative effort. So the
2 policy doesn't say that everyone signs it. The policy
3 says that it's reviewed, but it's not signed by all.

4 The only people that sign the code sheet are the
5 person -- the nurse that fills it out, and the code
6 team leader that -- the doctor who orders medications.
7 But, again, if the doctors aren't ordering medications,
8 then they don't necessarily need to sign it because
9 they're not -- because the signature is for a
10 physician's order.

11 Q. They are all supposed to review it though?

12 A. They are supposed to make sure that what's in
13 the sheet is accurate.

14 Q. So --

15 A. The team.

16 Q. So Dr. Guldan was supposed to review this
17 record?

18 A. Either Dr. Guldan or the other
19 anesthesiologist that was there.

20 Q. Now, you testified that the Mayday records
21 themselves, they might actually reflect whether
22 everyone was doing what they were supposed to do?

23 A. That's correct.

24 Q. You don't have any specific knowledge of what
25 was on the Mayday record for Mr. Mikell's cardiac

1 arrest that you shredded; right?

2 A. All I know is what's in the database.

3 Q. And it's no longer in the medical record for
4 Mr. Mikell, is it, the Mayday record?

5 A. It's -- from what -- that's my understanding.

6 Q. Even though the MUSC policy requires that it
7 be in his medical record?

8 A. That's correct.

9 MR. RANSOM: I don't have any other questions.

10 THE COURT: Any recross?

11 MS. FLEMING: No, Your Honor. Thank you very
12 much.

13 THE COURT: All right. Ms. Scarbrough, you may
14 step down. Thank you very much. Any reason she can't
15 be excused?

16 MR. RANSOM: No, Your Honor. She can be
17 excused.

18 THE COURT: Ms. Scarbrough, you may be excused.
19 Thank you so very much. Call your next witness,
20 please.

21 MR. RANSOM: The plaintiff calls Dr. Terrill
22 Huggins.

23 DR. JOHN HUGGINS, after having
24 been duly sworn, testified as follows:

25 THE CLERK: Please state your first and last

DR. HUGGINS -- DIRECT

1 name, spell your last name loudly and clearly into the
2 microphone.

3 THE WITNESS: Okay. John, J-o-h-n, last name is
4 Huggins, H-u-g-g-i-n-s.

5 **DIRECT EXAMINATION BY MR. RANSOM:**

6 Q. Good morning, Dr. Huggins. Thank you for
7 coming.

8 A. Good morning.

9 Q. You're employed by the Medical University?

10 A. I am.

11 Q. What type of physician are you?

12 A. I am a Pulmonary Critical Care physician.

13 Q. Okay. And how long have you been employed by
14 the Medical University?

15 A. I have been employed right out fellowship in
16 2004 through 2006. I subsequently have been in private
17 practice from 2006 to 2008 at Conway Medical Center. I
18 returned back to the Medical University in 2008 and
19 currently.

20 Q. So except for the two years that you were down
21 at Colleton (ph), your whole career has been at the
22 Medical University?

23 A. That is correct.

24 Q. Where did you go to medical school?

25 A. Medical University of South Carolina,

DR. HUGGINS -- DIRECT

1 Charleston.

2 Q. Are you originally from Charleston?

3 A. I'm from the Loris, South Carolina, Conway
4 area.

5 Q. Yeah. That's up in Horry County?

6 A. Yes.

7 Q. Now, you were the attending physician for --
8 or one of the attending physicians for Mr. Mikell when
9 he was admitted to the hospital after his cardiac
10 arrest?

11 A. That is correct.

12 Q. Okay. And let's make sure that the jury
13 understands what we mean when we say an attending
14 physician; can you sort of explain that role to them?

15 A. So I am a board certified Pulmonary Critical
16 Care physician. I've been in the academic center. We
17 have obviously medical students who are obtaining their
18 doctorate of medicine. We have -- we have -- once they
19 have graduated from medical school, are in training.
20 So we have interns and residents and fellows who are
21 trained to be like my subspecialty is, that will be
22 part of our ICU team makeup.

23 Q. Okay. And when Mr. Mikell was in the
24 hospital, it's true he had a number of physicians that
25 were taking care of him?

DR. HUGGINS -- DIRECT

1 A. That is correct.

2 Q. And he had quite a number of problems that
3 were being attended to?

4 A. That is correct.

5 Q. And your role as the -- as the attending
6 physician was to be sort of in charge of all that?

7 A. That is correct.

8 Q. That's an accurate statement. Okay. And the
9 reason that I wanted you to testify today, Dr. Huggins,
10 is because I need the jury to understand some of the
11 problems that Mr. Mikell had after the cardiac arrest
12 that he experienced on October 1st; do you feel as
13 though you can do that?

14 A. I can do that.

15 Q. All right. Now, I've got a number of medical
16 records from his chart that have been marked as
17 exhibits. And we've got defense counsel looking over
18 them right now.

19 A. Okay.

20 Q. As soon as they give me the okay, I want to
21 start asking you about them.

22 A. Okay.

23 Q. All right. Now, have you had an opportunity
24 to sit down and review Mr. Mikell's medical chart?

25 A. I have reviewed my deposition. And in that

DR. HUGGINS -- DIRECT

1 time -- reviewed the medical records at that time. And
2 I've actually reviewed pieces of the medical records in
3 preparation for today.

4 Q. Okay, good. Because I want to try to be able
5 to be efficient and move -- be efficient and move
6 through this.

7 A. Yes.

8 Q. All right. So let's start with what I have
9 marked as Plaintiff's 15 -- and if you don't mind, I'm
10 going to kind of stand close to you. And you'll see
11 that that is a document from his record, can you tell
12 us generally what that record is?

13 A. This is listing the diagnosis codes at the
14 time of discharge. So this is a summary of all the
15 medical -- medical diagnosis at discharge.

16 Q. Okay. And that's a part of Mr. Mikell's
17 medical record?

18 A. That is correct.

19 MR. RANSOM: Judge, I'd like to publish this on
20 the overhead and offer these things into evidence.

21 THE COURT: What -- what -- what exhibits do you
22 have; 15 and what else?

23 MR. RANSOM: Plaintiff's 15 and then plaintiff's
24 17 through 31.

25 THE COURT: Okay, 17 through 31.

DR. HUGGINS -- DIRECT

1 MR. RANSOM: Yes.

2 THE COURT: Does the defendant have any
3 objections to any of those exhibits?

4 MS. FLEMING: No objections.

5 THE COURT: All right. Plaintiff's Exhibit No.
6 15, and 17 through 31 are admitted without objection.
7 Thank you so very much.

8 (WHEREUPON, Plaintiff's Exhibits Nos. 15 & 17 -
9 31 admitted into evidence.)

10 BY MR. RANSOM:

11 Q. All right. So, what I want to do -- you see
12 I've got a couple of things highlighted here in Mr.
13 Mikell's record. And, again, this is up at the top, it
14 says "Diagnosis and Procedure Summary", Dr. Huggins?

15 A. That is correct.

16 Q. Now, is this an effort by the record keepers
17 there to try to capture all of the various problems
18 that he's had while he's in the hospital?

19 A. That is correct. So we have coders that go
20 through the medical records and review, and list these
21 for -- as a summary of the medical records.

22 Q. Okay. So, the first one that you see that
23 I've got highlighted, it looks as though -- and I'm
24 going to take the liberty of trying to translate some
25 of this -- it says "ventilator associated pneumonia";

1 is that right?

2 A. That is correct.

3 Q. Okay. Can you explain to the jury what
4 ventilated associated -- ventilator associated
5 pneumonia is?

6 A. Okay. So that's basically a developing of a
7 lung infection, a lower respiratory track infection in
8 a place of mechanical ventilation in -- on a mechanical
9 ventilator.

10 Q. Okay. And a mechanical ventilator is what?

11 A. So a mechanical ventilator is basically
12 providing assisted breathing through typically an
13 artificial airway. That artificial airway can be an
14 endotracheal tube or a tracheostomy, and so it's
15 providing assistance with ventilation and oxygenation
16 for a patient.

17 Q. Okay. So would it be fair to say that for a
18 period of time Mr. Mikell was breathing through a
19 machine?

20 A. That is correct.

21 Q. Or rather a machine was doing the breathing
22 for him?

23 A. Assisting, right.

24 Q. All right. And at one point in time, the
25 machine was hooked up to him through an endotracheal

DR. HUGGINS -- DIRECT

1 tube?

2 A. That is correct.

3 Q. That's placed through his mouth, down into his
4 lungs?

5 A. Yeah, either through the mouth or through the
6 nares, or through the nose and goes down into the
7 trachea.

8 Q. Now, at one point in time, that tube was
9 removed and he got a tracheostomy?

10 A. That is correct.

11 Q. Okay. We'll come to that in a minute. Now,
12 the other thing that you'll see that's highlighted is
13 it says -- well, tell us, can you read what this second
14 highlighted entry is?

15 A. I'm -- I'm not sure what A.C.C.I.D. is in a
16 resident institution -- I assume this is identifying
17 that Mr. Mikell at that time was in a teaching
18 hospital, would be my assumption, but I'm -- I'm not a
19 hundred percent correct on that.

20 Q. Do you know if that stands for "accident" in a
21 residential institution?

22 A. No, I did not.

23 Q. Okay. On the second page of Exhibit 15, we
24 also see a couple of entries that he's satisfying
25 hemodialysis; can you explain to the jury what

1 hemodialysis is?

2 A. Hemodialysis is a support mechanism that we
3 use for patients when their kidneys are impaired, so if
4 we need to filter their blood or -- or remove volume,
5 we use it through a hemodialysis machine, which is
6 connected to a catheter. It's inserted into like a
7 large vein to do that.

8 Q. Okay. So one of the functions that the kidney
9 plays in the human body is it filters stuff out of the
10 blood?

11 A. Right.

12 Q. Okay. And Mr. Mikell had to have the machine
13 perform that function for him?

14 A. That is correct.

15 Q. All right. And the way that this was arranged
16 was actually a line was placed in through one of his
17 blood vessels?

18 A. That is correct.

19 Q. An invasive line?

20 A. That is correct.

21 Q. There was a surgical procedure to place a
22 port, they call it, in order for that to be hooked up?

23 A. We placed a temporary hemodialysis, which we
24 do bedside in our critically ill patients. And then
25 when patients may foresee a potential need of ongoing

DR. HUGGINS -- DIRECT

1 dialysis, we will place a -- what we call a permacath,
2 which is a more tunneled catheter that would have lower
3 risk of infection.

4 Q. Did Mr. Mikell receive a permacath?

5 A. From my recollection, I believe that is
6 correct.

7 Q. Can you indicate to the jury where on his body
8 the permacath was placed?

9 A. Typically the permacath would be placed up in
10 here (indicating), so going into the subclavian area.

11 Q. So it's placed on your chest?

12 A. Right.

13 Q. And that's where they then hook the
14 hemodialysis machine up to?

15 A. That's correct.

16 Q. And then the blood in his body goes out
17 through the machine?

18 A. Right.

19 Q. And back in?

20 A. That is correct.

21 Q. Okay. Why was it necessary for Mr. Mikell to
22 undergo hemodialysis?

23 A. For to manage his electrolyte dysfunction, his
24 acid base. Because at the time of post cardiac arrest,
25 and during that period of time, his -- he has acute

1 renal failure on -- on a background setting of chronic
2 kidney disease.

3 Q. So he had some problems with his kidneys
4 before the cardiac arrest?

5 A. That is correct.

6 Q. The cardiac arrest made him worse?

7 A. Yeah. In the event of a cardiac arrest, when
8 that happens, we're typically left with two outcomes.
9 And one outcome is -- if we're not able to resuscitate
10 the patient, that results in death.

11 And then if we're able to resuscitate the
12 patient, then there can be consequences as a result of
13 that cardiac arrest. And those insults can be
14 temporary and improve, or they can remain with lower
15 levels of function related to those organ function. So
16 Mr. Mikell did clearly have, as a result, acute renal
17 failure set in chronic kidney disease as a result of
18 that.

19 Q. And the reason he had the acute renal failure
20 was because when he went into cardiac arrest, the blood
21 supply to his kidneys was reduced?

22 A. Yes.

23 Q. And so those organs suffered an injury?

24 A. That is correct. As well as other factors
25 that could contribute as well when -- infections and so

DR. HUGGINS -- DIRECT

1 forth that may have occurred following the cardiac
2 arrest could cause kidney impairment as well.

3 Q. Such as the infection that you said he
4 developed from being on the ventilator?

5 A. Correct.

6 Q. Okay. Now, do you know whether or not Mr.
7 Mikell had ever required hemodialysis before the
8 cardiac arrest?

9 A. To my knowledge, he did not require
10 hemodialysis before.

11 Q. The next record that I've marked as Exhibit
12 17, I'll put this up on the screen for you -- up at the
13 top, you'll see it says "Critical Care Services,
14 Induced Hypothermia, Post Cardiac Arrest, Physician's
15 Orders"; that's a mouthful, isn't it?

16 A. Yes.

17 Q. Okay. And tell us now when we see what --
18 you'll see what I've got highlighted here on Exhibit
19 17, it says -- there's a box that's checked that says
20 "Comatose within six hours of cardiac arrest, unable to
21 follow verbal commands"; am I reading that correctly?

22 A. That is correct.

23 Q. All right. Now, is this an accurate
24 description of the condition that Mr. Mikell was in at
25 the time that this form was completed?

1 A. Yes. So post resuscitation, he was
2 unresponsive and therefore initiated a hypothermia post
3 cardiac arrest protocol --

4 Q. Okay.

5 A. Which is this.

6 Q. Now, explain to the jury what comatose means.

7 A. Coma means you're not responding to external
8 stimuli, so that's speaking, or rubbing, or touching
9 patients, so they're unresponsive.

10 Q. Okay. So if you grab ahold of Mr. Mikell, and
11 you shake him, he doesn't respond?

12 A. That is correct.

13 Q. All right. Now, this doesn't mean he's
14 asleep; right? It means he's unconscious?

15 A. He's unconscious, right.

16 Q. Okay. And he's unconscious because of the
17 cardiac arrest?

18 A. In this setting the -- the likelihood of that
19 state could be induced by that.

20 Q. Okay. Now, this induced hypothermia that this
21 document refers to, can you explain to the jury what
22 that's about?

23 A. So, basically, in post cardiac arrest, when
24 your heart is not pumping and your body is deprived of
25 oxygen, our most sensitive organ for oxygen is our

DR. HUGGINS -- DIRECT

1 brain. And what we've learned is actually patients who
2 sustain Vfib or Vtach arrest, and are resuscitated, if
3 they don't show signs of, you know, they're not
4 responding post resuscitation, and -- we know that
5 lowering the body temperature for a defined period of
6 time actually improves neurological outcome.

7 Q. Okay. How is the body temperature lowered?

8 A. Different protocols we predominately -- I'm
9 not sure exactly in 2010, I think we were using this,
10 it's called an Arctic Sun. So this is an external
11 blanket that we put on the patient, and we can actually
12 just put in the actual temperature that we want the
13 hypothermia to be. And typically it's 32 degrees
14 Celsius.

15 Q. So you've got sort of a plastic thing that you
16 put over him and run an ice water through it?

17 A. Basically, in essence.

18 Q. Okay. So you iced him down. It says over
19 here in the highlighted part on the second page of this
20 Exhibit 17, that you cooled the body temperature to 32
21 degrees Celsius?

22 A. That is correct, 32 to 34 degrees.

23 Q. Now, can you help us make a conversion to
24 Fahrenheit?

25 A. This would be probably around 90 degrees

1 Fahrenheit.

2 Q. Okay. Now, his normal body temperature,
3 normal average body temperature is going to be what
4 range?

5 A. Around 98.6.

6 Q. Okay. So you've lowered him down seven or
7 eight degrees?

8 A. Right.

9 Q. Now, if you were in that condition -- like if
10 I jumped in cold ocean water and started swimming, and
11 the water was say 50 degrees, I would get hypothermia
12 and die, right?

13 A. Potentially, yes; and potentially, no. You --
14 your organ and cardiovascular system will try to shunt
15 blood to preserve core temperature. But, yeah, as you
16 become cooler, you can lose consciousness and so forth.

17 Q. Okay. Now, how long is Mr. Mikell kept in
18 this hypothermia state?

19 A. So we do it for 24 hours. And then we allow
20 for passive rewarming, so we don't actively rewarm the
21 body or the patient. We actually remove the Arctic Sun
22 and allow his body to rewarm back to normal thermia, or
23 normal body temperature.

24 Q. Okay. And then did you cool him again a
25 second time?

DR. HUGGINS -- DIRECT

1 A. No, we did not.

2 Q. Okay. So it was just the one time?

3 A. One time.

4 Q. Twenty-four hours?

5 A. Correct.

6 Q. Then come back. Excellent. All right. Now,
7 the next record is what I've got marked as Exhibit 18.
8 And this is another part of the induced hypothermia
9 record. It's a neurological assessment worksheet; do
10 you see that?

11 A. I see this.

12 Q. And you'll see the highlighted part, it says
13 that "there's no eye movement noted"?

14 A. That is correct.

15 Q. So this is kind of what I want to try to help
16 the jury understand. When you're talking about
17 Mr. Mikell being unresponsive in a coma, that's --
18 tests are done to see whether or not that's actually
19 his condition; right?

20 A. Yes, that is. And this is what it goes over.
21 It gives kind of a level of the calmness scale, the
22 more the number, the more unresponsive. We look at
23 pupillary -- we look at reflexes up in the head area.
24 We look for purposeful eye movements. And as you go
25 through, you can kind of see in terms of motor, verbal

1 and so forth, and we look at as well..

2 Q. Yes. So one of the things that you do is you
3 open his eyes and you shine a flashlight?

4 A. That is correct.

5 Q. And if a person is in a normal condition, then
6 the pupils will be dilated?

7 A. They will actually constrict, right.

8 Q. Right.

9 A. Right, so.

10 Q. And so what does this record indicate when
11 this test is performed by Mr. Mikell?

12 A. So he has an intact pupillary response.

13 Q. And that's a good thing, right?

14 A. That is a good thing.

15 Q. Okay. But when it says that there's no eye
16 movement noted, what does that mean?

17 A. Well, that's maybe reflecting the level of
18 the -- the brain does -- there's two functions to the
19 brain that are -- these are reflections of our brain
20 stem. Our brain stem helps control our normal
21 functions, you know, like pupil -- pupillary response,
22 regulator cardiovascular system. It tells us to
23 breathe, but we're not thinking about it consciously.
24 The cognitive ability or thoughts or emotions reside in
25 our cortex, so -- and that's -- we're able to

DR. HUGGINS -- DIRECT

1 communicate and so forth. So this is assessing that
2 lower brain stem function, and the other is getting --
3 reflecting more of our cortical function.

4 Q. Okay. So the cortical function has been
5 interfered with, but his brain stems function looking
6 like it's --

7 A. Right. And the interference can occur for
8 many reasons, because when patients are critically ill
9 and we have support lines, and we're got endotracheal
10 tubes and so forth, then they'll -- we don't want
11 patients to suffer. So -- so our ability to provide
12 comfort measures are medications, obviously, that
13 affect our cognitive functioning.

14 Q. And one of the things that was done with
15 Mr. Mikell, for example, when he was placed in this
16 hypothermic state, you're actually giving him a drug to
17 keep him unconscious?

18 A. Yes. Because our goals of care at that time
19 are not to excavate him at that time point or liberate
20 him off of the ventilator.

21 Q. All right. And when he's actually gotten the
22 tube down his throat and he's breathing with the
23 machine --

24 A. Right.

25 Q. -- you want him asleep or unconscious during

1 that, too?

2 A. Exactly. We want him -- we want him -- our
3 patients comfortable, right.

4 Q. Because if he's got that tube down his throat
5 and he's not unconscious, he'll start to gag and that
6 kind of creates all kinds of problems?

7 A. That can create problems and that can create
8 complications where we get dyssynchronous patients on
9 ventilators.

10 Q. The document here, Exhibit 18, also indicates
11 no motor response, no sounds on the verbal side, and no
12 eye opening?

13 A. That's what reflected, correct.

14 Q. So he's in a coma? He's unconscious?

15 A. At this time, yes.

16 Q. Right. The next document that has been marked
17 is Exhibit 19, this says up at the top -- it's the
18 adult history and physical form?

19 A. That is correct.

20 Q. Okay. Now, any time that a patient is
21 admitted into the hospital, the attending physician has
22 to complete this history and physical form?

23 A. Yeah. So being in a teaching hospital, our
24 residents, fellows or interns may be the original
25 author of this, but the attendings always provide

DR. HUGGINS -- DIRECT

1 comments or -- and sign a review of the patient
2 history --

3 Q. Right. You've got students and residents, and
4 they're learning how to be doctors, and one of the ways
5 they learn is by doing?

6 A. That's right.

7 Q. So they'll be tasked with the exciting
8 prospect of filling out these documents, but then an
9 attending physician like you, you'll review it and make
10 sure --

11 A. Review it for accuracy, correct.

12 Q. And completeness. All right.

13 A. Yeah.

14 Q. And this document is intended to reflect what
15 Mr. Mikell's condition is when he first comes in to be
16 admitted to the hospital; correct?

17 A. That is correct?

18 Q. All right. And it's got a history of the
19 present illness, which simply explains how it is that
20 he comes to be in the hospital; right?

21 A. That is correct.

22 Q. So what we see in his case is, it says "a 49
23 year old black male, who was undergoing a colonoscopy
24 today for constipation, during the procedure he became
25 hypoxic, then bradycardic with a junctional rhythm, and

DR. HUGGINS -- DIRECT

1 then went into cardiac arrest with ventricular
2 fibrillation"; is that --

3 A. That is correct.

4 Q. -- an accurate description of what took place?

5 A. At that time, yes.

6 Q. Okay. Now, when it says he became "hypoxic";
7 explain what hypoxic means.

8 A. Hypoxia is low oxygen in our blood.

9 Q. Okay. And how does he get low blood oxygen?

10 A. It could be through multiple mechanisms. You
11 know, the patients can develop blood clots that go to
12 the lungs. The lungs can fill up acutely with water --
13 water from acute congestive heart failure. It could be
14 a result of -- a patient could aspirate it, so the
15 gastric contents come up and goes down our trachea, and
16 can cause the lungs to be damaged and can't participate
17 in gas exchange. So there -- there -- you know, many
18 reasons why in this setting you get acute hypoxia.

19 Q. Would respiratory arrest be a cause of
20 hypoxia?

21 A. Yes. So -- yes, so if we're -- if -- if our
22 -- if we arrest, then we can't -- we can't circulate
23 the blood to the lungs, to pick up the oxygen to
24 deliver it to our tissue or eliminate carbon dioxide.

25 Q. Okay. And if somebody developed an

DR. HUGGINS -- DIRECT

1 obstruction of their airway from sleep apnea, could
2 that cause hypoxia?

3 A. That could be -- yeah, a precipitating factor.

4 Q. And that's what happened to Mr. Mikell; right?

5 A. I was not present during the code, so I -- it
6 would be very difficult for me to know exactly what
7 precipitated that hypoxemia at that time.

8 Q. And in terms of the treatment that you
9 provide, it's not really necessary for you to know
10 that, is it?

11 A. Well, at the -- at the time -- at the time of
12 the care that I rendered, we obviously look into many
13 reasons why and -- and obviously correct the conditions
14 that's resulted in the hypoxia. But I did not recall
15 exactly what was felt to be, at the time of the code,
16 the true cause of the hypoxemia although --

17 Q. Now -- are you comfortable, are you confident
18 when you say that this -- this sequence of events, it
19 becomes hypoxic, then bradycardic, a junctional rhythm,
20 and then underwent cardiac arrest --

21 A. Yes --

22 Q. Is --

23 A. Yes --

24 Q. So --

25 A. Yeah, so that could be a consequence of

1 hypoxemia that would result in --

2 Q. Well, my point is, you said that you did some
3 investigating and this is the sequence of events as you
4 determined them to have occurred?

5 A. Right. So the hypoxia led to the bradycardia,
6 to the junctional rhythm, to the cardiac arrest, that
7 is correct.

8 Q. Now, tell the jury real quickly, what is
9 bradycardia?

10 A. A slow heart rate. So when our heart rate is
11 less than 60 beats per minute, that's bradycardia.

12 Q. Okay. And can hypoxia cause bradycardia?

13 A. It can.

14 Q. Okay. And what is a junctional rhythm?

15 A. A junctional rhythm is basically where the
16 conduction system of the heart now is -- instead of
17 getting the conduction occurring from heart chambers,
18 where electricity comes down to our -- what we call our
19 AV Node, which is sort of -- like a little internal
20 pacemaker so -- so all of a sudden, there's this
21 regulation where only the -- the AV Node is causing the
22 ventricle to contract. And usually it's a reflection
23 of a junctional rhythm, a heart will be bradycardic or
24 have a slow heart rate.

25 Q. So, now, so that the jury understands it, so I

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1 mean the heart is just a muscle that pumps by
2 squeezing, by contracting?

3 A. Yes. Squeezing, but it's eclectically
4 influenced because it's the muscle. So we have our own
5 intrinsic pacemakers or sinus node, which conducts --
6 it helps regulate our heart rate.

7 Q. Well, right, it's an electrical impulse that's
8 generated by a part of the heart itself?

9 A. Right.

10 Q. Okay. So when you say that it goes into a
11 junctional rhythm, what you're saying is that the
12 electrical impulses that the heart itself generates to
13 control its contraction, have been thrown off kilter?

14 A. That's correct.

15 Q. Okay. And it says then he underwent cardiac
16 arrest; now what is that relative to a junctional
17 rhythm?

18 A. Well, junctional rhythm, you would probably be
19 alert or potentially awake. You may feel light headed
20 or may be completely asystematic, but you'll have a
21 blood pressure and you'll have a pulse. Cardiac arrest
22 is now -- you're pulseless.

23 Q. Pulseless?

24 A. You do not have a pulse.

25 Q. Okay. So let's talk about that real quickly.

1 When I put my fingers on my wrist, I can feel my pulse;
2 right?

3 A. Correct.

4 Q. And that's because as my heart contracts and
5 sends blood down into my hand, that blood vessel
6 contracts and --

7 A. And generates some pressure and that's the
8 pulse.

9 Q. So when you say that he's gone into pulse
10 electrical activity, that means he doesn't have a
11 pulse; right?

12 A. He does not have a pulse. But pulseless
13 electrical activity would mean if we put something to
14 monitor that electrical activity, we would see that he
15 could be in like a normal size rhythm, for example.

16 Q. Okay.

17 A. Or a junctional rhythm.

18 Q. So blood is not flowing through his system any
19 more, but the electrical impulses are still coming out
20 of the heart?

21 A. That is correct.

22 Q. Just not in a way that makes it pump
23 effectively?

24 A. Correct.

25 Q. So, then that's followed by what you've

DR. HUGGINS -- DIRECT

1 identified as a ventricular fibrillation; can you tell
2 us what that is?

3 A. So, basically, now it's escalated. So cardiac
4 arrest could be pulseless electrical activity as we
5 described. It could be the result of the ventricular
6 fibrillation where basically now the ventricles are
7 beating excessively, but not able to generate any form
8 of -- of flow or pressure when you get a pulse.

9 So what we see on this screen is this very
10 chaotic EKG where -- when we see that first therapeutic
11 decision to treat V fib, is to electrically cardiovert
12 the patient.

13 Q. And that's what we see on television when they
14 shock him with paddles to restore the proper electrical
15 pulse?

16 A. That is correct.

17 Q. So that's what was done with Mr. Mikell. All
18 right. I'm turning to -- I think it's the seventh page
19 of the Exhibit 19. And this is where certain
20 examinations are being performed. Do you see over here
21 they're doing a neurologic exam, and they're indicating
22 he shrugs his shoulders minimally with pain, but he
23 doesn't respond otherwise or follow commands; am I
24 reading that correctly?

25 A. That is correct.

1 Q. Now, explain to us what is it about shrugging
2 your shoulder -- what does that tell you? I mean, how
3 -- what kind of a test is being done down here and what
4 does it tell you?

5 A. You know, I -- I was not the admitting
6 physician for Mr. Mikell. You know, this could be as a
7 result -- one of the maneuvers we do -- actually do a
8 very firm sternal rub, so we really rub the sternum,
9 the breast plate right here.

10 Q. And that hurts; right?

11 A. It hurts. And it could -- but I'm not sure
12 what maneuver was done to elicit this response.

13 Q. Okay. So the purpose of the test is to try to
14 inflict a modest amount of pain on the patient. And if
15 they are neurologically intact, they're going to have
16 some biological response to that pain?

17 A. Yes, potentially.

18 Q. Okay. So when it says that he shrugs his
19 shoulders minimally when that pain is put on him -- I
20 mean, a shoulder shrug? I mean, there's nothing
21 special about that; right?

22 A. Nothing.

23 Q. All right. And then it says he doesn't
24 respond otherwise or follow commands, meaning if you
25 tell him, wake up, Mr. Mikell, wake up -- he didn't

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1 respond in any way?

2 A. That is correct.

3 Q. Okay. The last page of Exhibit 17, I've got a
4 couple of things highlighted. But what I want to point
5 your attention to is this part right here, it says
6 "acute respiratory failure". Do you see that?

7 A. I see that.

8 Q. Can you tell us what acute respiratory failure
9 is?

10 A. So acute means it happens very quickly.
11 Respiratory is -- is our lungs. And failure means
12 he's -- the patient has an inability to breathe
13 adequately; and, therefore, their lungs are impaired.

14 Q. So in lay terms, does that just mean he quit
15 breathing?

16 A. Well, it could because in this setting, post
17 cardiac arrest, you're obviously going to be in
18 respiratory failure, so it could have different
19 meanings as well depending if -- you know, based upon
20 the evaluation of the data that is known. But at this
21 point, obviously, he would be in acute respiratory
22 failure.

23 Q. You know, we're to the point in time where
24 he's now being admitted to the hospital --

25 A. That is correct --

1 Q. To --

2 A. Right.

3 Q. Up at the -- in the upper part of the record
4 here it says "decreased 0.2 sats" -- and then there's
5 an arrow pointing to the word "bradycardia". Am I
6 reading that correctly?

7 A. Yes, that is correct.

8 Q. Okay. So that means that his oxygen
9 saturation dropped, and that led to bradycardia?

10 A. This -- this was basically summarizing that
11 first page so it's -- you know, it's basically saying
12 the decrease in 0.2 sats, hypoxemia, bradycardia and
13 then cardiac arrest.

14 Q. And, again, this is the effort by one of the
15 physicians to give a history of why it is that he's
16 coming into the hospital, it says on the history --
17 under comments -- under history?

18 A. Right.

19 Q. And history, I mean, it's not like what
20 happened during the civil war, it's what happened to
21 Mr. Mikell?

22 A. Right. Right. So this is actually the --
23 this is actually filled out by the attending at the
24 time.

25 Q. Okay. And down here at the bottom real

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1 quickly, we see that this is being completed on October
2 1, 2010 at about 5:20 p.m.?

3 A. That is correct.

4 Q. Okay. So that's the day that he's admitted to
5 the hospital?

6 A. That's right. That was -- that's actually the
7 time in which the documentation was done by the
8 attending physician.

9 Q. Now, he was actually put into the Intensive
10 Care Unit initially; right?

11 A. That is correct.

12 Q. Okay. And tell -- explain to the jury what
13 the Intensive Care Unit is?

14 A. So Intensive Care Unit is probably our highest
15 level of monitoring that we can provide for patients.
16 So these are, you know, our critically ill patients.
17 So this is where we take care of our sickest patients.

18 We have better support because they typically
19 require a much higher level of care, so our nursing
20 ratios in the ICU can -- are typically, you know, two
21 patients to one nurse. And sometimes it could be one
22 nurse to one patient. And so that's where we would
23 manage our -- our patients -- patients who have low
24 blood pressure, who need support through different
25 types of medications, might need that high level of

1 care.

2 Q. So there's no question that when Mr. Mikell is
3 admitted to the ICU, the Intensive Care Unit, he is a
4 critical care patient?

5 A. That is correct.

6 Q. Okay. And you're a critical care specialist,
7 and that's how you came to be his attending physician?

8 A. That is correct.

9 Q. Okay. All right. Now, Exhibit 20 is another
10 record that I want to show you. You'll see up at the
11 top it says "adult ventilator flow sheet"?

12 A. That is correct.

13 Q. Again, explain to us -- well, tell us a little
14 bit about what you're doing -- when the patient is on
15 the ventilator, that ventilator has to be managed by a
16 physician such as yourself?

17 A. Managed by a physician, but also by a
18 respiratory therapist.

19 Q. And what are the types of concerns that you
20 have with a patient who is on a ventilator, what is it
21 that actually has to be managed?

22 A. A lot of different things. And this actually
23 is a flow sheet of all the things that the respiratory
24 therapist looks at. So that basically it goes over,
25 you know, what mode of ventilation. So what -- how is

DR. HUGGINS -- DIRECT

1 the air flow program sat, so we -- we also want to know
2 things like, you know, what the respiratory rate is,
3 what the I.O.2 is, like -- you know, how high are the
4 peak airway pressures. And -- and ventilators are very
5 sophisticated, so they have built in alarms and so
6 forth that would allow us to know when a patient may be
7 in trouble.

8 Q. And part of the point is, when you have a
9 patient who's on a ventilator, you've got to pay very
10 close attention; right?

11 A. That's correct.

12 Q. Okay. Now, the thing that I've got
13 highlighted over here on the right -- and this is what
14 I wanted to ask you about. Do you see that date right
15 there, October 22nd of 2010?

16 A. That is correct.

17 Q. Okay. So that's now three weeks after he's
18 been admitted to the hospital?

19 A. Yes.

20 Q. Okay. And is it safe for us to infer from
21 this record then that as of October 22nd, 2010, three
22 weeks after his admission, he's still breathing on a
23 ventilator?

24 A. He is breathing on his own through TC, which
25 stands for trach collar, at a respiratory rate of 14

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1 and -- and how much oxygen is 35 percent. So -- so in
2 essence what's happened here is he's off of the
3 ventilator, breathing on his own with a tracheostomy
4 tube still here. And so he has oxygen delivered at 35
5 percent. So it's kind of a blow-by, that the patient
6 is not getting assisted with mechanical ventilation.

7 Q. I see. And the ventilator itself, it's got
8 sort of a bellows that expands and contracts and will
9 actually force air --

10 A. Right.

11 Q. -- in and out of the lungs?

12 A. Yeah. So, in essence, all we're doing is
13 taking their oxygen from the wall, that goes through --
14 just, you know, a corrugated piece of pipe that
15 actually just sits there and is breathing this
16 concentration of air --

17 Q. So he's still got the tube surgically placed
18 through his throat, and that's hooked up to a oxygen
19 line coming out of the wall?

20 A. That is correct.

21 Q. Okay. Good. The next one that I wanted to go
22 over with you, doctor, this has been marked as Exhibit
23 21. A couple of highlights here. You'll see -- this
24 is a document -- it's dated October 12th of 2010, and
25 it relates to a tracheostomy that was performed on Mr.

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1 Mikell?

2 A. Yes. This is the surgical op report performed
3 by the ear, nose & throat surgeons who performed the
4 procedure on that date.

5 Q. Okay. So this is an actual surgical procedure
6 that's performed in the operating room?

7 A. It could be performed in the operating room or
8 at bedside. But at this time, I think he was -- this
9 was performed in the operating room, but I don't know
10 exactly.

11 Q. Now, can you just give a basic description to
12 the jury of what a tracheostomy is.

13 A. So, basically, it's making a small incision
14 here in the trachea. And they go in a -- go directly
15 into the trachea, make a small incision, and then take
16 a balloon and actually dilate, and insert basically a
17 piece of plastic that kind of goes into the trachea.
18 And a small piece of plastic actually sticks out here,
19 where we can attach to -- to the ventilator or whatever
20 we need to do.

21 Q. Okay. Now, when you say "trachea", this is
22 what we would commonly refer to as a windpipe?

23 A. This is a windpipe, right.

24 Q. And so you've got your Adam's Apple here?

25 A. Right.

DR. HUGGINS -- DIRECT

1 Q. At least the men do. So you're making a
2 surgical incision underneath there?

3 A. That is correct.

4 Q. And you're poking a hole in the windpipe?

5 A. Yes.

6 Q. And sticking a plastic tube in there?

7 A. Correct.

8 Q. Now, why does he need to have that done?

9 A. Well, he's currently -- is still with
10 respiratory failure, and standards -- kind of standard
11 practice is if we're having difficulties weaning after,
12 you know, 10 to 14 days, we will proceed with a -- with
13 a tracheostomy at that point.

14 One, it's a more stable airway to facilitate our
15 ability for him to start participating in physical
16 therapy, getting stronger. Because a lot of factors,
17 you know, in this case with -- you know, a prolonged
18 respiratory failure often can be a result of muscle
19 weakness, so we try to get patients stronger again.

20 Q. Now, being on a ventilator is sometimes
21 necessary to support life, but it's not an ideal
22 circumstance for the human body to be in; right?

23 A. No. We're doing everything we can to liberate
24 this patient off of the ventilator --

25 Q. You want to get him off the ventilator?

DR. HUGGINS -- DIRECT

1 A. Right.

2 Q. And the way that you get him off the
3 ventilator is you -- you sort of do a little trial to
4 see if you take them off the machine, are they able to
5 breathe on their own?

6 A. Right. So after -- after we feel like
7 patients are getting into a weaning period, that is
8 their blood pressure is stable and their -- their
9 mechanical ventilatory settings are appropriate, we do
10 daily spontaneous awakenings and -- and daily trials
11 and weaning parameters.

12 Q. Okay. And what this record indicates, you'll
13 see the highlighted portion down here, there had been a
14 couple of efforts to try to get him off of the
15 ventilator?

16 A. That is correct.

17 Q. And he hadn't been able to breathe on his own,
18 or he hadn't been able --

19 A. Yes --

20 Q. -- to tolerate it twice?

21 A. Right. Right. So two times to remove the
22 endotracheal tube. He subsequently had to be
23 re-intubated.

24 Q. Okay. When we talk about that with respect to
25 Exhibit 15, where he had developed a ventilator

1 associated pneumonia?

2 A. Uh-huh.

3 Q. All right. This is fluid that builds up in
4 his lungs, is one of the consequences of being on the
5 ventilator for so long?

6 A. Well, one of the complications, a one to two
7 percent risk per day with patients who have an
8 endotracheal tubes in, is developing pneumonia. So
9 unfortunately, when you've got things down that are
10 helping to support, that become sort of a conduit for
11 bacteria to get down --

12 Q. Right --

13 A. -- can cause infection.

14 Q. -- got a tube from the outside going to the
15 inside --

16 A. Right.

17 Q. -- and bacteria just goes right on in?

18 A. Right.

19 Q. Okay. So he develops an infection in his
20 lungs?

21 A. That is correct.

22 Q. Now, does this infection in his lungs in any
23 way impair the ability of his lungs to provide oxygen
24 to his body?

25 A. It -- it can.

DR. HUGGINS -- DIRECT

1 Q. Okay.

2 A. As a result of the inflammation and infection
3 within the lung tissue.

4 Q. And would a patient like Mr. Mikell, if he's
5 not getting adequate oxygen in his blood, can this have
6 a bad impact on his heart?

7 A. It potentially could have consequences related
8 to his heart.

9 Q. Okay. And one of the things to having an
10 infection in your lungs will make you do is cough;
11 right?

12 A. Make you -- repeat that question?

13 Q. Cough?

14 A. Yes.

15 Q. Okay. So if I've got an upper respiratory
16 infection, that's what the doctor calls it, what that
17 really means is I've got an infection in my lungs;
18 right?

19 A. Well, a lower respiratory track infection, so
20 upper respiratory wouldn't be necessarily in the lungs.

21 Q. But one of the things that happens to you when
22 you have a lung function is you get (indicating)
23 hacking cough?

24 A. You can cough as a -- a symptom.

25 Q. All right. And that's the the kind of

1 infection that Mr. Mikell has, that can produce a
2 cough?

3 A. According to the coders at some point in this
4 hospitalization, they -- he was treated for possibly
5 ventilator associated pneumonia.

6 Q. Okay. And that would be something that could
7 cause him to have a bad cough?

8 A. Yes.

9 Q. Okay. All right. The next document that I've
10 got -- the next exhibit rather is Exhibit 22, and this
11 relates to a procedure that was done -- and I think
12 this is a radiological procedure on October 15th of
13 2010. And it says "fluoroscopic and ultrasound guided
14 right arm central venous line placement", and then it
15 says "PICC line placement" -- okay. So this means that
16 on October 15th, he had a PICC line placed?

17 A. That is correct.

18 Q. All right. Explain to the jury what a PICC
19 line is and how it's done.

20 A. So, typically, as described here so
21 fluoroscopy is using X-ray, ultrasound is using sound
22 waves, so they used the ultrasound to find the vein.
23 Okay. They use -- so we know where the vein is. Then
24 they insert a central venous line, which comes up and
25 comes through -- the vein is here. And basically under

DR. HUGGINS -- DIRECT

1 the X-ray, we can see where the tip is as it relates to
2 where the heart is.

3 Q. Okay. So they're taking a wire, and they're
4 feeding it through the main blood vessel in his arm
5 into his heart, and then they're sliding a catheter
6 over the top of that?

7 A. That is correct.

8 Q. And then they pull the wire out?

9 A. Yeah.

10 Q. Okay. And then what is left is what they call
11 a PICC line?

12 A. That is correct.

13 Q. And that PICC line is to used to administer
14 certain medications?

15 A. Yeah, intravenous medications.

16 Q. In the way that's most effective?

17 A. That is correct.

18 Q. Now, what was it that he needed the PICC line
19 for?

20 A. We typically -- PICC lines are -- may be
21 associated with lower risk infection of the typical
22 catheters that we place in our critically ill patients.
23 So after a period of time, the patients are going to
24 potentially need on-going care, being in the ICU, we'll
25 take out some of these lines that we put in initially,

1 and place a PICC line.

2 Q. Okay. And when you talk about lines, like IV
3 lines that might be in the back of his wrist, in his
4 forearm?

5 A. Right. Or in the femoral vein, you know, what
6 we call more central veins, right.

7 Q. Okay. All right. And this is done for a
8 patient that you anticipate is going to require a lot
9 of medication intravenously over a long period of time?

10 A. Yes, that's correct.

11 Q. Okay. Now, Exhibit 23 is another document.
12 This relates to a central venous catheter procedure.
13 And it's got a date down at the bottom of October 16th.
14 Now, it seems to indicate that he's received some kind
15 of a line in the left femoral vein; is that right?

16 A. That is correct.

17 Q. Okay. And tell us what's going on here,
18 please.

19 A. Can you move the document up just a little
20 bit, so I can see?

21 Q. Yes.

22 A. Can you go --

23 Q. Would you like me to hand it to you?

24 A. Yeah, that would be great. Thank you.

25 (Handed to witness.)

DR. HUGGINS -- DIRECT

1 A. I don't see the type of catheter, but I assume
2 this may be a Quinton catheter that may be used for --
3 yes, so the indication here was renal failure, so this
4 is a dialysis catheter.

5 Q. Okay. So this is what they used to hook him
6 up to the dialysis machine?

7 A. That's correct.

8 Q. Now, is this femoral line, is this done in the
9 operating room?

10 A. This is done typically at bedside.

11 Q. Okay. Can you tell us, do you know without
12 looking at the specific record, Dr. Huggins, how many
13 times was Mr. Mikell taken back into the operating room
14 after he was admitted to the hospital? We know they
15 did that with the tracheostomy; right?

16 A. Yes, I think at the time, it probably was done
17 in the OR. Outside of that, I'm not aware of any other
18 timing it back to the OR.

19 Q. Now, are you aware of any other incidents that
20 he had where there was a problem with the anesthesia?

21 A. In terms of during his clinical course in the
22 ICU?

23 Q. Well, while he was admitted to the hospital.

24 A. No. I was not aware of any issues related to
25 the anesthesia.

1 Q. Okay. They didn't have any other problems
2 once he was admitted in the hospital?

3 A. Once he was admitted in the hospital, we had
4 to deal with issues related to pneumonia, respiratory
5 failure, and his acute kidney injury, correct.

6 Q. But nobody had any problems with airway
7 obstruction, nobody had any problems with desaturation,
8 no more hypoxia, no more cardiac arrest?

9 A. No -- no -- no cardiac arrest, but he did fail
10 two times of getting extubated, which probably was due
11 to -- and I'm not -- I think was due to some
12 desaturations at the time from what I recall.

13 Q. But now those desaturations didn't result in
14 cardiac arrest --

15 A. Did not. That was a one time event.

16 Q. Okay. The next exhibit -- has been marked as
17 Exhibit 24?

18 THE COURT: Before we get to 24, let's take a
19 short break. Okay?

20 MR. RANSOM: Yes, sir.

21 THE COURT: Madam, Forelady, I know y'all have
22 been in and out, but we've been in here since about
23 10:00, so we're going to take a short break at this
24 time. If you need anything, let the bailiff know.
25 Please don't discuss the case amongst yourselves. And

DR. HUGGINS -- DIRECT

1 I'll get you back in 15 or 20 minutes.

2 All right. We'll take about a 20 minute break.
3 Doctor, don't discuss your testimony during the break.

4 (WHEREUPON, the jury leaves the courtroom at
5 12:15 p.m.)

6 (WHEREUPON, a brief recess was taken.)

7 THE COURT: Is the plaintiff ready to proceed?
8 Anything from the plaintiff before we bring the jury?

9 MR. RANSOM: Nothing, Your Honor. We're ready
10 to proceed.

11 THE COURT: Anything from the defendant?

12 MR. COOKE: Nothing, thank you.

13 THE COURT: Bring us the jury, please.

14 (WHEREUPON, the jury enters the courtroom at
15 approximately 12:40 p.m.)

16 THE BAILIFF: All jurors are present, Your
17 Honor.

18 THE COURT: Okay. Thank you very much. You may
19 proceed please, sir.

20 MR. RANSOM: Thank you, Your Honor.

21 BY MR. RANSOM:

22 Q. Dr. Huggins, we were with Exhibit 24.

23 A. Okay.

24 Q. And you'll notice that this is -- it's dated
25 October 17, 2010?

1 A. Correct.

2 Q. And it says "OT General Acute Evaluation", am
3 I reading that correctly?

4 A. That is correct.

5 Q. Can you tell us what means?

6 A. This is an occupational therapy evaluation, so
7 these are occupational therapists who assess levels of
8 functioning.

9 Q. Okay. And why is it that Mr. Mikell is being
10 referred for occupational therapy?

11 A. Because of a perceived need that he's not
12 functioning independent at the time.

13 Q. Okay. So is he weak?

14 A. Weak, could be motor activity in -- in walking
15 and so forth, although we have physical therapists who
16 do that. So these occupational therapists are looking
17 at ability to feed yourself and doing -- doing those
18 things.

19 Q. And I wanted to ask you about that. During
20 this period of time that Mr. Mikell was in the
21 hospital, how is he being fed?

22 A. During the acute time in which he was on the
23 mechanical ventilator, he was receiving enteral feeds,
24 so this is through an NG tube that goes in the stomach.
25 And we -- we put the -- the feeds directly into stomach

1 via an NG tube.

2 Q. And an NG tube, it's a plastic tube, small --

3 A. That's right.

4 Q. -- tube that's set up through his nose, back
5 down his throat, and into his stomach?

6 A. That is correct.

7 Q. Okay. And it's sort of liquid nutrition --

8 A. Liquid nutrition.

9 Q. -- that's pumped in?

10 A. Pumped in.

11 Q. Okay. Now, how long was it that he was
12 receiving that parenteral nutrition; is that what that
13 is?

14 A. Yeah. He would receive that up until the time
15 in which his speech therapist would do an evaluation to
16 assess for his swallowing. Once his swallowing was
17 clear, then he would be placed on a diet at that point.

18 Q. Okay. Could he eat solid food while he's got
19 the tracheostomy?

20 A. He -- he could. But we typically don't start
21 with solid foods initially. We start with clear
22 liquids and advance the diet up accordingly.

23 Q. Can you tell us, do you remember -- or have a
24 general sense of how long it was before he was able to
25 return to eating solid food?

1 A. I think in the -- from what I recall -- in the
2 discharge summary, there was a note in which -- in
3 which that time may have occurred.

4 Q. Okay. We're coming to that. We'll look for
5 that there. Okay. So the thing that's noted here in
6 this occupational therapy evaluation -- since he was
7 independent with ADL prior to admission -- that means
8 he's able to do his activities of daily living?

9 A. That is correct.

10 Q. He can dress himself?

11 A. That's correct.

12 Q. He can use the bathroom, take a shower, those
13 types of things?

14 A. That is correct?

15 Q. All right. It also says he's working a full
16 time job as a bus driver?

17 A. That is correct.

18 Q. All right. And that the condition that's
19 described by them at the time he's being evaluated, is
20 highlighted next -- it says, "he's trach" -- that's
21 tracheostomy?

22 A. That is correct.

23 Q. It says he can "mouth words" -- does that mean
24 that he's not being able to speak?

25 A. It depends on what type of -- well, actually,

DR. HUGGINS -- DIRECT

1 to be able to speak with a trache -- with a trache in
2 place, we actually had to put on a Passy Muir valve,
3 which basically allows the air now not to go out
4 directly here, but allows it to go across the vocal
5 cords to create a voice.

6 Q. Got you. So the air is coming in at a place
7 lower than the vocal cords?

8 A. That is correct.

9 Q. So he's got to cover that hole then he can
10 speak --

11 A. Cover it, right.

12 Q. It says "inconsistently followed commands for
13 movement, however was shutting down later on in the
14 evaluation. Said he was tired and had impaired
15 attention". All right. Now, can you explain what's
16 going on there?

17 A. You know, typical problems in the patients who
18 are critically ill, one of the problems that can be
19 transient is what we call delirium. And delirium is
20 basically a time in which you're not in a coma, but you
21 have impaired attention which is -- can be a
22 complication of someone who's critically ill.

23 Q. And do you remember Mr. -- whether Mr. Mikell
24 still had any sort of neuro cognitive deficits? I know
25 that's a big sounding term, but I mean -- if his higher

DR. HUGGINS -- DIRECT

1 executive brain functions, ability to think, speak,
2 communicate, reason abstractly; had all that returned
3 to normal when he left the hospital?

4 A. I think he -- at the time of my knowledge and
5 -- it would be reflected more toward a discharge time,
6 I think he was obviously getting back to his baseline
7 neurological function.

8 Q. Getting back, but not already there?

9 A. Probably not fully there, but I would have to
10 see the documentation at that time.

11 Q. Okay. Okay. All right. Now, it's indicating
12 that he's got one of five strength in shoulders, two of
13 five in his elbows, three of five grasp, two of five in
14 his fingers, so that just means he's weak; right?

15 A. He's weak.

16 Q. And the explanation for that is since he's
17 been hospitalized in a bed, he's just become
18 debilitated?

19 A. That is -- that is one mechanism.

20 Q. All right. Down here, endurance, it says
21 "poor, he tolerates less than five minutes of
22 activity"?

23 A. Yeah, zero to five minutes.

24 Q. And that activity could be just getting up and
25 walking; right?

DR. HUGGINS -- DIRECT

1 A. That could be -- right or -- that is correct.

2 Q. All right. Here on the second page of Exhibit
3 24, they give a description of what he's able to do, so
4 grooming with moderate assistance -- that means he can
5 brush his teeth, comb his hair kind of thing?

6 A. That is correct.

7 Q. And he needs help with that?

8 A. He needs moderate assistance, right.

9 Q. Feeding it says "total assistance"; what does
10 that mean?

11 A. Probably using a spoon or fork to assist with
12 eating at the time.

13 Q. Okay. Meaning someone has got to actually
14 feed him, like I did with my baby?

15 A. That is correct.

16 Q. Okay. Bathing is total assistance; what does
17 that mean?

18 A. He needs complete assistance on bathing.

19 Q. Okay. Now, he's not getting out of bed and
20 going and taking a shower, is he?

21 A. I don't know how that assessment is made on
22 that.

23 Q. But he can't do that if he's on a ventilator,
24 can he?

25 A. Well, I'm not sure if he's on -- when was this

1 actually --

2 Q. I think it's October 17th was the date of the
3 record.

4 A. Okay. Yeah. Yeah, he wouldn't be able to do
5 that if he's on -- on a ventilator.

6 Q. Down at the bottom, it says October 17th.

7 A. Okay.

8 Q. All right. So upper extremity, dressing;
9 lower extremity, dressing. Total assistance, right?
10 He can't do any of that?

11 A. That is -- yeah, that is what's reflected.

12 Q. And he can't go to the bathroom without help
13 either?

14 A. Yes.

15 Q. Okay. So there's a sense then in which --
16 he's pretty much completely dependent upon the medical
17 care providers to do just about everything for him;
18 right?

19 A. That is correct.

20 Q. Okay. Down here, the last thing we've got
21 highlighted is "decreased ability to perform ADL's" --
22 we just talked about that -- "functional transfers",
23 meaning if he wants to get out of bed, sit in a chair,
24 move around in any way, he needs help with that; right?

25 A. That is correct.

DR. HUGGINS -- DIRECT

1 Q. It says "decreased gross motor and fine motor
2 coordination, decreased cognitive skills"; what is that
3 referring to?

4 A. So decreased gross motor would be like walking
5 or lifting something. Fine motor coordination would
6 be, you know, fine motor control with fingers and
7 holding a pencil, writing, those activities.

8 Cognitive would be, you know, high level of
9 thinking. So -- so doing complex task or -- is
10 reflected as decreased cognitive skills.

11 Q. Okay. And that's reflective of -- well, what
12 is it that's causing him to have those decreased
13 cognitive skills?

14 A. Well, with not -- you know, not seeing a
15 physician assessment at that time, it could be some
16 issues related to the delirium, because his attention
17 span seemed to be impaired at that time, which we would
18 be concerned with.

19 Q. Is it fair to say that it's related to the
20 injuries that he's suffered in the treatment that he's
21 receiving?

22 A. This -- this would be normal findings of
23 someone who's been critically ill for sometime.

24 Q. Right. In other words, this wasn't the
25 cognitive impairment that he had before he went in for

1 the colonoscopy?

2 A. I would not assume, no.

3 Q. Okay. All right. Now, very quickly, the next
4 one that I have is Exhibit 25, this relates to the
5 placement of the right internal jugular, tunneled
6 central venous catheter placement on October 25th.
7 This is another one of these lines that they use to
8 give medications?

9 A. Yes. So this is probably -- I'm not -- this
10 is another central venous catheter for hemodialysis
11 support, I think.

12 Q. Okay. So we talked about --

13 A. And it's tunneled, so it's more of a -- what
14 we call permacath. So it's going to have a lower risk
15 of infection as -- you know, compared to the previous
16 hemodialysis catheter.

17 Q. So he's had one, and you're saying this is on
18 his upper chest?

19 A. This is -- right.

20 Q. And he also had the PICC line that was through
21 his arm?

22 A. Right.

23 Q. And then he had that line, the femoral line as
24 well?

25 A. Yeah. And that one probably would have been

DR. HUGGINS -- DIRECT

1 removed after this one was placed.

2 Q. Okay. Thank you. Now, Exhibit 26 is a
3 record, an Adult Critical Care Progress Note, and it
4 indicates that he's now --

5 A. Twenty six days in the ICU.

6 Q. That's it. He spent 26 days in the ICU. And
7 if you look over there in the right, it says he's
8 developed renal failure and on HD, that means
9 hemodialysis?

10 A. That is correct.

11 Q. So he's developed this renal failure as a
12 consequence of the injuries he suffered in the --
13 during the colonoscopy?

14 A. Yeah. So he developed acute renal failure
15 during his -- during his clinical course at MUSC.

16 Q. Okay. And that's an injury to his kidneys?

17 A. That is an injury to his kidneys.

18 Q. And it's different than whatever problems he
19 may have had with his kidneys before the colonoscopy?

20 A. Yeah. This was new -- in the setting in --
21 you have impaired renal function at baseline.

22 Q. All right. Now, the -- the next exhibit I
23 wanted to show you was marked as 27, this is a transfer
24 form?

25 A. That is correct.

1 Q. And it's dated October 26th of 2010. Where is
2 he being transferred?

3 A. He is getting transferred to our local long
4 term acute care facility to facilitate ongoing physical
5 therapy, occupational therapy, so trying to improve
6 strengthening and conditioning. In addition, he had a
7 -- he needed to be decannulated, so that's basically
8 removing -- safely removing the piece of plastic that
9 was here --

10 Q. The tracheostomy?

11 A. The tracheostomy.

12 Q. Okay. Good. Exhibit 28 is what's -- it says
13 a hemodialysis treatment record?

14 A. Yes.

15 Q. This is a record that's made each time he
16 undergoes dialysis?

17 A. That is correct.

18 Q. Okay. And I've got a number of pages that are
19 affixed to this. The first one you see is dated
20 October 16th?

21 A. That is correct.

22 Q. So it means he had dialysis on that date?

23 A. That is correct.

24 Q. All right. And then the next page is October
25 17th?

DR. HUGGINS -- DIRECT

1 A. That is correct.

2 Q. Okay. And then the next page is October 18th?

3 A. That is correct.

4 Q. October 19th?

5 A. That is correct.

6 Q. October 20th?

7 A. That is correct.

8 Q. And then October 22nd -- so it looks like he
9 was able to skip the 21st?

10 A. Yeah, that is correct.

11 Q. And then the last date that he undergoes
12 dialysis is October 23rd?

13 A. That is correct.

14 Q. Right. So with the access lines that he's
15 had, these ports that have been placed in order to hook
16 him up to the hemodialysis machine, what happens to
17 those once he no longer needs to have dialysis?

18 A. When there's no longer a need for dialysis, we
19 remove them.

20 Q. Okay. How is that done?

21 A. Simply cutting the suture, and pulling out the
22 catheter, and applying a little bit of pressure to stop
23 the bleeding, and typically a bandaid.

24 Q. That's just done in the patient's room?

25 A. That can be done in the patient's room.

1 Q. Does it hurt?

2 A. No.

3 Q. All right. Now, the next is Exhibit 29. And
4 this is the hospital discharge summary. I think you
5 had mentioned that this may contain the answers to some
6 of the questions I asked you a little bit ago; right?

7 A. That is correct.

8 Q. Okay. So it indicates that he was admitted to
9 the hospital on October 1st, discharged on October
10 26th; right?

11 A. That is correct.

12 Q. Once again, we see a little bit of history
13 information that's provided?

14 A. Yes.

15 Q. Now, I wanted to focus your attention -- get
16 it to move up. We see discharge laboratories, that
17 means that some lab work was done in order to make sure
18 that he's A-OK to be discharged?

19 A. That's correct.

20 Q. And one of the laboratory values is
21 Creatinine?

22 A. That's correct.

23 Q. And it comes back at 5.8?

24 A. That is correct.

25 Q. Now, the Creatinine test tells us how well his

DR. HUGGINS -- DIRECT

1 kidneys are functioning?

2 A. That is correct.

3 Q. And we don't need to get into all the
4 chemistry about that, 5.8 is that low, normal, high --
5 where does that fall?

6 A. That's high.

7 Q. High.. Okay. So what does that tell us about
8 his kidney function at the time that he's leaving the
9 hospital?

10 A. Well, this tells me he's got significant
11 kidney impairment at the time.

12 Q. Okay. Now, are you aware of some of the
13 medications that Mr. Mikell was taking before the
14 colonoscopy that were being used to treat his heart
15 condition -- his heart failure and his hypertension?

16 A. Yes, I was -- yeah..

17 Q. Okay. Now, are any of those medications
18 things that when you got a kidney injury, you can't
19 keep taking it?

20 A. Some of them may need to be renal adjusted.
21 In other words, we may have to reduce the dose of the
22 medications, because the kidneys may be responsible for
23 the clearance of those medications. So we may need to
24 dose modify those medications.

25 Q. Now, you would agree that there were some of

DR. HUGGINS -- DIRECT

1 his medications that had to be stopped; right?

2 A. That would probably be correct.

3 Q. Okay. There were other medications that the
4 dosages needed to be adjusted?

5 A. Right.

6 Q. And in view of those two things, there were
7 even more medications that he had to be started on?

8 A. That is correct.

9 Q. On page two of Exhibit 29, we see this
10 statement that as of October 12th, at least, it says
11 "he continued to be in acute renal failure despite
12 management"?

13 A. That is correct.

14 Q. And when it says "management", what are they
15 referring to there?

16 A. It's typical supportive care that we provide
17 to improve renal profusion or kidney profusion or -- or
18 just antibiotics -- whatever we're doing, it's in -- in
19 order to support. And despite, you know, things that
20 we were doing at the time, his renal failure at that
21 period persisted. And probably that was the point in
22 which they consulted our kidney specialist or
23 nephrology renal.

24 Q. So, there is some things that you, as a
25 physician, can do -- medications that you can do, other

DR. HUGGINS -- DIRECT

1 therapy you can proceed to try to rehabilitate his
2 kidneys. But that wasn't working, and that's why he
3 ends up on dialysis?

4 A. That is correct.

5 Q. Okay. He also received a blood transfusion.
6 It says he was given one unit of packed red blood
7 cells; is that correct?

8 A. That is correct.

9 Q. Okay. So tell us what's happening there.

10 A. So he probably met -- he actually required a
11 blood transfusion of one unit. Based on this, he had
12 some oozing from around his trach site. And typically,
13 we give Heparin, which is a blood thinner to prevent
14 blood clots. So it kind of will increase our risk of
15 bleeding. So he probably, at the point, reached a
16 hemoglobin level threshold, probably less than seven
17 milligrams per deciliters, which we at that point
18 transfused one unit of red cells.

19 Q. Okay. So it's true that because of his
20 underlying heart failure, he's taking a blood thinner
21 medication, right -- before the colonoscopy?

22 A. I don't -- I would have to review his
23 pre-existing medicines.

24 Q. We'll come to that. And when he gets a
25 tracheostomy, he's got some bleeding that's associated

1 with that?

2 A. We have some more oozing. I think we would
3 de-script it as significant bleeding -- we would
4 describe significant bleeding, and that typically would
5 require numerous units.

6 You know, also he's in the ICU. And he actually
7 has anemia, a chronic disease, pre-existing. So his
8 hemoglobin, it's already -- he's at an anemic level.
9 And then all the blood orders that we have to -- yet to
10 determine, his hemoglobin, all that processes. And
11 being critically ill suppresses our bone marrow, which
12 actually helps make our red cells. So a lot of
13 processes here involved that would cause him to be more
14 anemic.

15 Q. Okay. And it says there -- I don't have this
16 highlighted -- it says "after discontinuing his
17 heparin" -- that's a blood thinner; right?

18 A. This is a blood thinner.

19 Q. And when a guy has got some oozing going on,
20 you don't really want him to be taking a blood thinner?

21 A. Yeah. Typically, we will stop it --

22 Q. So he was actually given a unit of now packed
23 red blood cells, is that the kind of blood -- if I get
24 in a car wreck, and they give me a transfusion --

25 A. Yeah --

DR. HUGGINS -- DIRECT

1 Q. -- is that what it is?

2 A. That is correct.

3 Q. Okay. So they give me a unit of blood. Then
4 you'll see, as we talked about it a little bit ago, on
5 October 25th, he passed his swallow study. All right.
6 That was where they were seeing whether or not he was
7 safe to start eating on his own?

8 A. That is correct.

9 Q. Okay. And it says so he was advanced to an
10 ADA clear liquid diet? What does that mean?

11 A. That's a diabetic -- clear liquid means
12 like -- well, it's basically, water. Okay. So
13 anything clear -- clear liquids, Ginger Ale, so forth.

14 Q. So he can't eat a sandwich? He can't have a
15 pizza?

16 A. No, not yet.

17 Q. Okay. And he can't even really eat pudding at
18 this point?

19 A. Not yet.

20 Q. Okay. When he was discharged from the
21 hospital, they wanted him to continue to seek treatment
22 for his kidney injury; right?

23 A. That's correct.

24 Q. And to continue to receive physical therapy
25 and occupational therapy, to try to strengthen him;

1 right?

2 A. That's correct.

3 Q. Okay. Now, Exhibit 30 is a history in
4 physical from when he came into that next level of care
5 that you referenced -- and that's actually a place
6 called the Kindred Hospital?

7 A. That is correct.

8 Q. Now, is that -- where is the Kindred Hospital
9 located relative to MUSC?

10 A. At this time, it was located on the third
11 floor of the old Charleston Memorial Hospital.

12 Q. Okay. Is that like across the street, down
13 the block?

14 A. It was basically one block over, yeah.

15 Q. So it's still sort of there on the MUSC
16 campus?

17 A. Yeah. Well, yeah, but this is not an MUSC
18 affiliated hospital.

19 Q. No, I understand.

20 A. All right.

21 Q. And they specialize in Kindred Hospital, in
22 rehabilitating patients who are coming out of these
23 critical illnesses?

24 A. Right. So these are acute care medical
25 centers like us, but they're long term.

DR. HUGGINS -- DIRECT

1 Q. Okay. And so they're describing in this
2 Exhibit 30 what his condition is when he comes into
3 their facility?

4 A. That is correct.

5 Q. All right. So we talked about in the other
6 exhibit, we had his history and physical that was
7 recorded --

8 A. Right.

9 Q. When he came into the Medical University, that
10 was Exhibit 19. And this is now what his condition is
11 when he comes into Kindred?

12 A. That's correct.

13 Q. Okay. So he says he had acute kidney injury,
14 superimposed on chronic kidney disease requiring
15 hemodialysis; correct?

16 A. That's correct.

17 Q. Okay. And they've also given us this
18 description, probably taken directly from the earlier
19 record of what actually led to him being hospitalized?

20 A. That's correct.

21 Q.. Down here, we actually see a statement by the
22 physician at Kindred commenting on what it was that
23 brought all this about. He says, "it's possible the
24 hypoxia triggered this event", meaning the cardiac
25 arrest?

DR. HUGGINS -- DIRECT

1 A. That is correct.

2 Q. Okay. But she says that she hasn't actually
3 reviewed the records to be able to draw any conclusion
4 about that?

5 A. That is correct.

6 Q. Okay. All right. So he's being identified as
7 having anemia. You talked about that. Anemia is just
8 a low number of red blood cells in the blood?

9 A. Yeah, you know, it's low hemoglobin. So --
10 hemoglobin is a molecule that allows us to bind oxygen
11 and transport it to our tissue.

12 Q. Okay.

13 A. So anemia is -- is -- I said anemia is --

14 COURT REPORTER: I'm sorry.

15 A. I said amenia is basically -- it's hemoglobin.
16 So hemoglobin is the -- is basically found in the red
17 cells, so we're just measuring the hemoglobin
18 concentration. So anemia would refer to low
19 hemoglobin.

20 Q. And that just affects the ability of his blood
21 to effectively carry oxygen to all of the tissues in
22 his body?

23 A. It would be -- right. That's -- it carries
24 oxygen to -- to our body.

25 Q. It says "marked debility from prolonged

DR. HUGGINS -- DIRECT

1 hospitalization and critical illness" -- that just
2 means he's out of shape?

3 A. Yes, potentially.

4 Q. Yes. I mean, he's got no strength; he's got
5 no endurance?

6 A. Yeah, severely deconditioned.

7 Q. And the dysphagia, that means he can't
8 swallow?

9 A. He has difficulty swallowing.

10 Q. Okay. Because he's still got that
11 tracheostomy tube?

12 A. Yeah. And that can be -- that can definitely
13 cause that.

14 Q. All right. The last exhibit that I have is
15 number 31. And this is the transfer summary that's
16 dated November 19, 2010. And you'll see that you're
17 listed as the referring physician; correct?

18 A. That is correct.

19 Q. Okay. And this transfer summary tells us
20 about his condition when he's finally sent him from
21 Kindred; right?

22 A. That is correct.

23 Q. And you'll see up in the upper right, Kindred?

24 A. Yes.

25 Q. All right. So November 19th is the day that

DR. HUGGINS -- DIRECT

1 he finally goes home?

2 A. That is correct.

3 Q. All right. And one of the things that he
4 indicates is -- on the second page -- it says, he needs
5 to call for an appointment with Dr. Van Bakel for
6 further recommendations, whether to resume and the need
7 for resumptions of anticoagulin therapy; right?

8 A. Correct.

9 Q. Can you explain to us what that's about?

10 A. So, Dr. Van Bakel is one of our heart
11 transplant cardiologists and congestive heart failure
12 cardiologists at MUSC. So I assume they are
13 identifying Dr. Van Bakel was a prescribing physician
14 for a blood thinner. So they -- to infer the
15 recommendations -- someone who's got more expertise.

16 Q. Right --

17 A. -- on his condition --

18 Q. -- Dr. Van Bakel had been his doctor before
19 the colonoscopy; right?

20 A. That is correct.

21 Q. And so they're saying, hey, you need to go see
22 Dr. Van Bakel?

23 A. Uh-huh.

24 Q. Because while you've been in the hospital,
25 we've done some stuff with your medications?

DR. HUGGINS -- DIRECT

1 A. Right.

2 Q. Specifically, your anticoagulation therapy,
3 the blood thinners; right?

4 A. Correct.

5 Q. And it's important for a patient with a heart
6 condition like Mr. Mikell's, to be on those blood
7 thinners so that he doesn't develop certain serious
8 fatal problems; right?

9 A. Well, I -- it's -- you know, I'm not a
10 cardiologist, so I'm not the expert on that. But --
11 and I'm not really sure what the indication for --
12 for -- for the blood thinner was. There are many
13 indications for blood thinners.

14 Q. Okay. So we've gone through his medical
15 history in some detail, talking about the injuries that
16 he suffered, the treatment that he received. Now, I
17 want to kind of draw on all of that foundation, Dr.
18 Huggins, and just sort of ask you a generalized
19 question. Can you explain to us, as a critical care
20 specialist, I mean what are the -- some of the
21 recognized problems that people can have when they've
22 been through this type of a critical care illness?

23 A. In terms of having a cardiac arrest that led
24 to this particular problem?

25 Q. Well, all of the things that we see in these

1 records, that identify the particular details of Mr.
2 Mikell's journey --

3 A. Right.

4 Q. -- through the --

5 A. Right.

6 Q. To the illness -- I'm asking you, in your
7 experience, what are the kinds of problems that people
8 like this can have?

9 A. These are very common problems in patients
10 with critical illness. The delirium, cognitive
11 dysfunction, acute kidney injury, organ impairment,
12 respiratory failure.

13 Q. And what about once he gets released from the
14 hospital, what are the long term effects?

15 A. Well, that would be sort of determined by
16 where things are -- you know, do things improve and
17 come back to baseline. And can -- we can measure organ
18 dysfunction for -- you know, by echocardiograms. We
19 can look at the heart, pre-imposed, no event.

20 Measure where -- because patients can continue to
21 improve after they're discharged from the hospital.

22 Q. Okay. But these types of problems that are
23 indicated in these records, can they actually lead to
24 future trouble down the road?

25 A. Well, they can lead to permanent impairment

DR. HUGGINS -- DIRECT

1 where the need for hemodialysis or need for renal
2 transplant may -- may exist permanently.

3 Q. Okay. Now, you mentioned something about his
4 heart function. And while he was in the hospital, he
5 actually had a test done on his heart function?

6 A. Yeah. We do multiple different tests. But,
7 you know, for assessing for how well the heart is
8 squeezing, you know, what we call ejection fraction
9 contract of the heart -- we use an ultrasound of the
10 heart. And one test, EKGs, you can look at the rhythm
11 of the heart.

12 Q. Okay. And the test that was done for his
13 ejection fraction, I think it was done in early October
14 of 2010?

15 A. I think that is correct, from what I recall.

16 Q. And it's true that the findings were that his
17 ejection fraction, at that point in time, was more or
18 less the same as it had been when it had been tested
19 last before the colonoscopy?

20 A. That is correct.

21 Q. And I think there was also a CT scan done of
22 his brain?

23 A. That is correct.

24 Q. Because at one point in time, there was
25 concern that he had suffered a brain injury from lack

DR. HUGGINS -- DIRECT

1 of oxygen?

2 A. That is correct.

3 Q. And that the findings did not show any injury
4 that you would expect to see on a CT Scan?

5 A. We did not see any detectable evidence of
6 injury.

7 Q. And just because it doesn't show up on a CT,
8 doesn't mean it's there? It just means the CT doesn't
9 detect it?

10 A. Well, the CT -- right. So the head CT may not
11 give us all the information.

12 Q. All right. Thank you, Dr. Huggins. Those are
13 all the questions I have right now.

14 A. Thank you.

15 MR. RANSOM: Your Honor, we would move to have
16 the exhibits entered into evidence.

17 THE COURT: Okay. I think you've already done
18 that.

19 MR. RANSOM: Okay. Thank you.

20 THE COURT: They have already been admitted.

21 MR. RANSOM: Very good.

22 THE COURT: It's 15, 17 through 31.

23 MR. RANSOM: Thank you, Your Honor.

24 THE COURT: All right. Madam Forelady, ladies
25 and gentlemen, it's 1:00. We're going to take a lunch

1 break at this time. Please don't discuss the case
2 amongst yourselves. And if you'll be back in the jury
3 room at 2:30, we'll get started at that time.

4 MR. COOKE: Could we approach for a second
5 before you do that?

6 THE COURT: Yes, sir.

7 (WHEREUPON, a bench conference was had.)

8 THE COURT: All right. Madam Forelady,
9 disregard. We're going to try to complete the cross.

10 **CROSS EXAMINATION BY MS. FLEMING:**

11 Q. Dr. Huggins, throughout your testimony, you
12 used the term "acute". Are you using the word "acute"
13 to describe a short term injury or illness?

14 A. Yes. So acute means -- right, so this could
15 be -- typically, we use that term to describe the
16 insult occurred in a very short period of time versus
17 chronic where the condition has been chronically there
18 for a much longer duration. You know, having an acute
19 injury or organ dysfunction doesn't mean that there can
20 be permanent damage -- you know, our organs can improve
21 back to their normal state of health.

22 Q. And Mr. Ransom asked you about an
23 echocardiograph that was performed?

24 A. That's correct.

25 Q. And what does the -- you mentioned the

1 ejection fraction of the heart. Can you explain why
2 you look at the ejection fraction of the heart?

3 A. So -- so the heart does two things. One,
4 it's -- it's a muscle. So to generate its pulse and
5 our blood pressure, it's got to contract. And so we
6 can measure this contractility or how strong our heart
7 muscle is and describe it in terms of ejection
8 fraction. So the higher the ejection fraction, the
9 stronger our heart is.

10 MS. FLEMING: And I'd like to go ahead and mark
11 for identification Defendant's Exhibit 3 -- 4.

12 (WHEREUPON, Defendant's Exhibit No. 4 was marked
13 for identification only.)

14 BY MS. FLEMING:

15 Q. Dr. Huggins, would you identify that document
16 for the jury?

17 A. So, this is an echocardiography report that a
18 cardiologist did on October 9, 2010.

19 Q. Okay. And does that echocardiogram provide
20 any information regarding Mr. Mikell's heart function
21 after the cardiac arrest?

22 A. Yes, it does. It is noted on the second page
23 where ventricular ejection fraction is calculated to be
24 at 43 percent. And since the last echo that was
25 performed, prior to the event in January 22nd of 2010,

1 there's been no -- no changes relative to valve or
2 function, and all other functions -- measurements they
3 would do based upon this echocardiography.

4 Q. Okay. And so does that indicate to you that
5 Mr. Mikell had no damage to his heart muscle as a
6 result of the cardiac arrest?

7 A. That would tell me that there is no damage to
8 the heart as a result of a cardiac arrest at that time.

9 Q. And he didn't have a heart attack or an acute
10 myocardia infarction?

11 A. He did not have an acute myocardia infraction.

12 Q. Now, he also asked you about the CT scan of
13 the brain that was performed?

14 A. That's correct.

15 MS. FLEMING: I would like to go ahead and mark
16 this for identification as Defendant's Exhibit 5,
17 please.

18 THE COURT: What number?

19 MS. FLEMING: Five.

20 THE COURT: Does Plaintiff have any objection to
21 Defendant's Exhibit 4 and 5?

22 MR. RANSOM: No objection, Your Honor.

23 THE COURT: All right, 4 and 5 admitted without
24 objection.

25 (WHEREUPON, Defendant's Exhibits 4 & 5 admitted

1 into evidence.)

2 THE COURT: What's five?

3 MS. FLEMING: It's a CT scan of the brain.

4 THE COURT: CT scan?

5 MS. FLEMING: Uh-huh.

6 THE COURT: Okay.

7 BY MS. FLEMING:

8 Q. And I think we previously discussed that the
9 CT scan revealed no acute injuries to Mr. Mikell's
10 brain?

11 A. That's the impression, no evidence of acute
12 intracranial abnormality.

13 Q. Now, when Mr. Mikell was discharged from MUSC
14 on October 26th of 2010, transferred to Kindred
15 Hospital, was he awake and responsive at that time?

16 A. He was.

17 Q. Okay. Was he -- was he on the ventilator at
18 the time?

19 A. He was not.

20 Q. Was his overall condition improving at that
21 time?

22 A. His overall condition was improving at that
23 time which facilitated our ability to move him to long
24 term acute care.

25 Q. Okay. And you were asked some questions about

1 Mr. Mikell's discharge from Kindred Hospital. And if
2 we look under paragraph one, it indicates "the patient
3 did well during this hospitalization and advanced to
4 capping trials, and was he capped successfully using
5 his CPAP machine at night. He was subsequently
6 decannulated on November 11, 2010"; do you see that?

7 A. I see that.

8 Q. And what does that mean?

9 A. So, basically, he -- you know, capping trials
10 basically is -- basically including the trach, so
11 he's -- now has to breathe normally like we do. And
12 that's just assessed that he can do that without this
13 artificial airway. And so he demonstrated he could do
14 that, and was capped -- and cap -- or removed -- or
15 taken out or decannulated.

16 He had preexisting sleep apnea, which CPAP is
17 Continuous Positive Airway Pressure, which allows him
18 not to obstruct his airway when he's breathing. So
19 it's kind of an artificial bridge to -- for the
20 treatment of sleep apnea.

21 Q. So decannulation means that his tracheostomy
22 was removed?

23 A. It -- it's simply removed, and that hole or
24 stoma closes off by secondary intent.

25 Q. And then under paragraph 2 it says, "He did

1 not require any further hemodialysis, and per Dr.
2 Browder's recommendation, permanent cap was
3 discontinued prior to discharge. Most recent
4 Creatinine on November 15, 2010 was 3.1." Does that
5 indicate that he's no longer receiving hemodialysis as
6 of the time that he's discharged from Kindred?

7 A. Not -- that is correct.

8 Q. And his Creatinine had actually come down?

9 A. Yeah from -- it was --

10 COURT REPORTER: I'm sorry --

11 A. Yeah, it was initially -- I think at discharge
12 from MUSC, it was 5.8. Now, it's 3.1 improvement.

13 Q. So his kidney function is improving?

14 A. That is correct.

15 Q. No further questions. Thank you very much.

16 A. Thank you.

17 THE COURT: Any redirect?

18 **REDIRECT EXAMINATION BY MR. RANSOM;**

19 Q. The 3.1 Creatinine that is identified there,
20 that's not normal, is it? That's still elevated?

21 A. That is still elevated.

22 MR. RANSOM: Thank you. I don't have any other
23 questions.

24 THE COURT: All right, Doctor. You may step
25 down. You may be excused. Thank you very much.

1 THE WITNESS: Thank you.

2 THE COURT: Madam Forelady, ladies and gentlemen
3 of the jury, we're going to take a lunch break at this
4 time. Leave your note pads. Please don't discuss the
5 case. Be back in the jury room at 2:30, and we'll get
6 started at that time. Thank you very much. See you
7 then.

8 (WHEREUPON, the jury leaves the courtroom at 1:18
9 p.m.)

10 THE COURT: Anything from the plaintiff before
11 we break for lunch?

12 MR. RANSOM: No, Your Honor.

13 THE COURT: Anything from the defendant?

14 MR. COOKE: Nothing, thank you.

15 THE COURT: All right. See you at 2:30.

16 (WHEREUPON, a lunch break was taken.)

17 THE COURT: Anything from the plaintiff before
18 we bring in jury?

19 MR. RANSOM: Yes, Your Honor. The next witness
20 will be Dr. Kofke. And you had indicated a desire to
21 make a ruling on the defense's motion. And I'm not
22 quite sure what you wanted to hear.

23 THE COURT: Well, once you start getting to the
24 opinion as to causation of death, if you go there, I'm
25 going to listen to it in camera.

1 MR. RANSOM: Okay.

2 THE COURT: And I'll just send the jury out at
3 that time.

4 MR. RANSOM: Okay. That's fine.

5 THE COURT: Okay. Just let me know when you're
6 going there, and I'll send the jury out, and we'll just
7 do it in camera.

8 MR. RANSOM: Yes, sir.

9 THE COURT: Okay?

10 MR. RANSOM: Yes, sir.

11 THE COURT: All right. Anything else from the
12 defense?

13 MR. COOKE: Nothing, Your Honor.

14 THE COURT: All right. Bring us the jury,
15 please.

16 (WHEREUPON, the jury enters the courtroom at
17 approximately 2:38 p.m.)

18 THE BAILIFF: The jury is all seated, Your
19 Honor.

20 THE COURT: Thank you very much. Call your next
21 witness, please.

22 MR. RANSOM: Thank you, Your Honor. The
23 plaintiff calls Dr. Kofke.

24 THE CLERK: Thank you, sir. Please be seated.

25 WILLIAM ANDREW KOFKE, after

DR. KOFKE -- DIRECT

1 having been duly sworn, testified as follows:

2 THE CLERK: Please state your first and last
3 name, and spell your last name loudly and clearly into
4 the microphone.

5 THE WITNESS: William Andrew Kofke, K-o-f-k-e.

6 **DIRECT EXAMINATION BY MR. RANSOM:**

7 Q. Good afternoon, Dr. Kofke. How are you?

8 A. Fine.

9 Q. Good. I want to spend just a little bit of
10 time just briefly introducing you to the jury, going
11 over your qualifications. So you live in Media,
12 Pennsylvania?

13 A. Yes.

14 Q. That's one of the suburbs of Philadelphia?

15 A. Yes.

16 Q. Okay. You are a medical doctor?

17 A. Yes.

18 Q. A professor of Anesthesia and Critical Care at
19 the University of Pennsylvania?

20 A. Yes.

21 Q. All right. Just to go over your education
22 very quickly, you graduated from Bucknell University in
23 1974 with a degree in Chemistry?

24 A. Yes.

25 Q. You graduated from medical school at the

DR. KOFKE -- DIRECT

1 University of Pittsburgh in 1978?

2 A. Yes.

3 Q. You received a Masters in Business
4 Administration from West Virginia University in 1999?

5 A. Yes.

6 Q. You did your internship training at Mercy
7 Hospital in Pittsburgh, Pennsylvania?

8 A. Yes.

9 Q. You then spent four years in Boston at Harvard
10 University Massachusetts General Hospital?

11 A. Yes.

12 Q. Okay. Following that, you spent five years on
13 the Anesthesia Faculty at Penn State University?

14 A. Yes.

15 Q. You then went and spent the next eight years
16 on the Anesthesia Faculty at the University of
17 Pittsburgh?

18 A. Yes.

19 Q. And you then spent four years on the faculty
20 at West Virginia University where you were vice chair?

21 A. Yes.

22 Q. And then for the last 15 years, you've been on
23 anesthesia faculty at the University of Pennsylvania
24 there in Philadelphia?

25 A. Yes.

DR. KOFKE -- DIRECT

1 Q. Okay. Now, you are board certified in
2 Anesthesia?

3 A. Yes.

4 Q. And you also have a subspecialty certification
5 in Neurocritical Care?

6 A. Neurocritical Care and in Critical Care.

7 Q. Okay. You've been licensed to practice
8 medicine in the states of Massachusetts, Pennsylvania
9 and West Virginia?

10 A. Yes.

11 Q. And you've actually testified as an expert at
12 a trial in an Anesthesia case which went to a verdict
13 here in Orangeburg, South Carolina?

14 A. Yes.

15 MR. RANSOM: Your Honor, I would offer Dr. Kofke
16 as an expert in the areas of Anesthesia and Critical
17 Care.

18 THE COURT: Does the defense agree, or do you
19 want to ask some questions?

20 MR. COOKE: No questions at this time.

21 THE COURT: All right. Do you agree -- do you
22 object to his qualifications?

23 MR. COOKE: No, Your Honor.

24 THE COURT: All right. The court finds -- as
25 offered, the court finds he's qualified as an expert.

DR. KOFKE -- DIRECT

1 MR. RANSOM: Thank you, Your Honor.

2 BY MR. RANSOM:

3 Q. Dr. Kofke, what experience do you have either
4 supervising or training nurse anesthetists or CRNAs?

5 A. Since my residency on and off, I have been
6 involved with CRNA's supervision. I prefer to call it
7 a team, being a part of a team.

8 Q. Okay. And is a CRNA part of the team that you
9 work with when you're providing anesthesia services to
10 patients?

11 A. Sometimes.

12 Q. Okay. And do you have any experience doing
13 anesthesia for colonoscopies?

14 A. Yes.

15 Q. All right. Over the course of the many years,
16 that you have been an anesthesiologist, can you give us
17 some idea of how many colonoscopies you've attended?

18 A. It -- it isn't something I do every day, so I
19 would put it in the hundreds I guess. Do -- I'm not
20 going to count my colonoscopy.

21 Q. Okay. That's good. Now, let me ask you this
22 -- are there certain procedures that need to be
23 followed in order for the provision of anesthesia to be
24 safe for a patient?

25 A. Yes. We all learn it the first week of

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1 training.

2 Q. Okay. And we refer to those procedures as
3 standards of care?

4 A. That's part of the standard of care.

5 Q. Okay. Can we also call them like safety rules
6 or rules for keeping patients safe?

7 A. Sure, yes.

8 Q. All right. And in the context of anesthesia,
9 if you've got a patient that stops breathing, are
10 minutes important in responding to that?

11 A. Minutes or seconds, yes.

12 Q. And if you have a patient who has had a
13 cardiac arrest or their heart stops functioning
14 properly, are minutes and seconds important in
15 responding to that?

16 A. Yes.

17 MR. COOKE: Your Honor, I am going to ask that
18 he not lead this witness.

19 THE COURT: I'm sorry. What?

20 MR. COOKE: I am going to ask that he not lead
21 the witness.

22 THE COURT: All right. Don't lead your witness,
23 please, sir.

24 BY MR. RANSOM:

25 Q. Dr. Kofke, are there any medical conditions

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1 that Mr. Mikell had that you're aware of that were
2 particularly important in the anesthesia that he
3 received when he underwent his colonoscopy?

4 A. The primary factors that made him a
5 challenging -- a somewhat challenging case, all though
6 like common cases actually these days, is his -- he was
7 significantly obese. Whenever -- whenever you're
8 significantly obese, you're prone to have your oxygen
9 levels fall very quickly. It's very hard to keep
10 oxygen levels up just with routine things.

11 And whenever you're very large, then you're
12 prone to having sleep apnea -- obstructive sleep apnea
13 from all the extra tissues and stuff that come with
14 that. So are those two -- two important ones.

15 Then you also had what was labeled as having
16 heart failure, and had an arrhythmia, atrial
17 fibrillation for which he was on an anti-arrhythmic drug
18 -- I've forgotten off hand -- but he had an arrhythmia
19 problem.

20 But an arrhythmia problem is where the heart
21 starts to beat funny or fast or, you know, and -- you
22 know, a problem which -- the chart indicated that he
23 was supposed to have life anticoagulation, so his
24 anticoagulation was also an issue to manage that, you
25 know, peri-operatively, you know, before -- before the

DR. KOFKE -- DIRECT

1 procedure, the test to be turned down. And then has
2 the procedure, then it's put back on, because it's on
3 for a reason.

4 Q. Okay. Now, I've got a couple of graphics that
5 I want to show the jury that may help us to explain
6 some of these conditions that he had.

7 The first one you mentioned, obstructive sleep
8 apnea -- bear with me -- are you able to see that on
9 the screen?

10 A. Yes, yeah, I see it. It looks just like that.

11 Q. Okay. So, we see that we've got blue arrows
12 that represent oxygen going in?

13 A. Yes. Yes.

14 Q. And the yellow arrows representing carbon
15 dioxide coming out?

16 A. Yes.

17 Q. Okay. Now, what does that -- what does that
18 particular picture show taking place?

19 A. Right there, it's showing that his -- this
20 patient's -- or this individual's tongue is forward.
21 And thus on -- there's easy passage of oxygen to and
22 fro from the nose down into -- down into the lung. You
23 know, so this is the -- the normal -- the normal state.

24 Q. Okay. Good. The next one I want to show
25 you -- okay. And here we've got the next one, what

DR. KOFKE -- DIRECT

1 does this show?

2 A. So this shows an airway that becomes occluded,
3 that's -- that's easy -- easy to see compared to the
4 one before. Now the tongue has fallen back, which is
5 typical for someone who has obstructive sleep apnea
6 whenever they fall asleep. And then they start -- if
7 anyone around here, or anyone in the jury, or in the
8 courtroom knows anyone with it, you know it because
9 they snore so much. And that's part of the -- part of
10 the story -- part of the story that you get whenever
11 you're screening someone for obstructive sleep apnea.

12 So you're inclined to get normal physiologic
13 sleep, but then whenever you get hypoxemic -- that was
14 a word that was used this morning -- you wake up and
15 you clear it. But if you're under anesthesia, the same
16 thing happens, but you don't just wake up because
17 you're under a chemical anesthesia.

18 Q. I see. So, for example -- well, is this
19 representative of the type of condition that Mr. Mikell
20 was suffering from?

21 A. Yes. Yes.

22 Q. Okay. So you're saying when your airway
23 closes off and you're at home asleep in bed, you wake
24 up?

25 A. Almost all the time. You know, and you do

1 have a bit of hypoxemia, but it's not enough to -- you
2 know, and it is enough long term to cause chronic
3 problems in the lungs and the -- the other organs. But
4 in the acute sense, however, whenever it immediately
5 happens, you wake up.

6 Q. Okay. So his airway closes off when he's
7 asleep?

8 A. Or under anesthesia.

9 Q. Now, if the patient's airway starts to close
10 off while he's under anesthesia, how is that managed?

11 A. So there's a variety of choices that the
12 anesthesiologist has. One is just to give a higher --
13 a higher oxygen concentration. Of course, if there is
14 no gas moving to and fro, that obviously won't do
15 anything.

16 So then the next maneuver is simply to put a
17 hand under the chin and lift it up. And that -- and
18 that helps pull -- pull the tongue off -- the tongue up
19 a little bit. And if you can't do that, then you put
20 your fingers behind the -- behind the jaw, and you push
21 it forward, and I'll demonstrate that (indicated) like
22 so, so the jaw goes forward. It pulls the tongue off
23 and then -- and then the patient is able to -- is --
24 makes it easier to get some gas exchange. So these
25 aren't all one hundred maneuvers, but there's a --

DR. KOFKE -- DIRECT

1 typically the things that are done.

2 And then if that doesn't work, then you go into
3 putting an oral airway in -- an airway into the mouth,
4 which goes in and pulls the tongue forward, or into the
5 nose, called a nasopharyngeal airway or an oral
6 pharyngeal airway. It is just airway for short.

7 And if that doesn't work, then there's
8 another -- there's a device that you can put in called
9 a laryngeal mask airway, which can -- which can take --
10 which can take away the obstruction. And if that
11 doesn't work, then you put a breathing tube in.

12 Q. Okay. So there's sort of a progression?

13 A. Yes. A progression of things to do to prevent
14 it or attenuate it.

15 Q. Now, one of things that you've done in your
16 career is you've done some work in a simulator center?

17 A. Yes.

18 Q. All right. Where you simulate various
19 problems that anesthesiologists might encounter?

20 A. Yes.

21 Q. A teaching process?

22 A. Yes.

23 Q. Okay. And you've got a video that shows this
24 head maneuver?

25 A. Well, you've got it.

DR. KOFKE -- DIRECT

1 Q. Yeah. Okay. Let's take a look at it.

2 (Whereupon, a video was played.)

3 BY MR. RANSOM:

4 Q. So that's it, that's the airway maneuver?

5 A. Can you put that back on, back on again?

6 (Whereupon, a video was played.)

7 A. Yeah, there -- this is a nasal airway, which
8 can go in the nose and -- and goes in the nose, it's a
9 little tube and it'll get behind the tongue so that air
10 can go through the nasal airway into -- into the
11 windpipe.

12 Q. And the idea with this airway maneuver, I
13 think, is demonstrated in this next graphic -- right
14 here -- so does that demonstrate or does that graphic
15 represent what takes place when you do that --

16 A. Right, when you --

17 Q. Chin maneuver?

18 A. Yes. Whenever you -- this is flexion -- it
19 extends ahead -- the tongue tends to go forward off
20 the -- of the back.

21 Q. Okay.

22 A. Not all 100 percent, but it just tends to.

23 Q. So, if you've got a patient that has
24 obstructive sleep apnea, and they start to obstruct
25 during a procedure, this is the first thing you do?

DR. KOFKE -- DIRECT

1 A. Right.

2 Q. Okay. Now, how many hands does it take to
3 execute that maneuver?

4 A. Well, I can do it with one hand, but if -- but
5 if it's really difficult, two hands are sometimes
6 needed.

7 Q. Now, let me show you this board here. And I
8 don't know that everybody can see this, so we're going
9 to try to put it where everyone can see it. So this is
10 a part of the anesthesia record from Mr. Mikell's case.
11 You can see down in the corner, it's got an MUSC page
12 504 for the record. Okay. Okay. So we look at this V
13 shaped part of the graph right here -- can you see
14 that, Dr. Kofke?

15 A. Yes. Yes.

16 Q. Okay. What does that V shape represent?

17 A. So that blank line there is the -- is the
18 oxygen saturations that is based off -- I assume off of
19 the finger. But anyways -- it's a non-evasive
20 indicator of oxygen levels in the blood. Normal is
21 over 90. And you see that in this record, it doesn't
22 -- at the start of the record, it is not even 90.

23 After -- you'll -- we'll get into this, because
24 after the cardiac arrest and being on the ventilator,
25 it is over 90. And that V there indicates an acute

DR. KOFKE -- DIRECT

1 drop in his saturations to 47 or so, which is quite
2 a -- quite a dramatic drop. And if you think about the
3 oxygen concentration in the blood, that would be a PO2
4 in the 20s. I don't know if you're familiar with that,
5 but PO2 in our atmosphere is 150. So it drops the PO2
6 in the blood down into the 20s if the sats are 50
7 percent. And most -- most people with normal
8 hemoglobins so --

9 Q. Let me see if I can dial this in for you a
10 little bit.

11 A. So -- so right about here -- whoops -- right
12 about here is where this -- where there was quite a
13 dramatic drop in sats. And there -- and that's about
14 the time that there was a drop in heart rate, which
15 incidentally is a classic, a classic presentation for
16 someone who has hypoxemia with a cardiac complication.
17 They will -- their sats will fall. The heart rate will
18 fall. And then the blood pressure will fall with it.
19 And then things -- things just go down the drain.

20 But a slow heart rate -- a slow heart rate and
21 his pulseless electrical activity that you saw
22 described this morning is -- is just classic -- and I
23 know it's classic from what I've read, but also what
24 I've seen in my 30 years of practice, where I've had
25 patients get bradycardic and not get -- I've had one or

DR. KOFKE -- DIRECT

1 -- one go to PEA actually, this pulseless electrical
2 activity and it --

3 COURT REPORTER: I'm sorry, Judge. If he can
4 just slow down just a little bit.

5 BY MR. RANSOM:

6 Q. Dr. Kofke, you're from Philadelphia, so we
7 realize that you speak sort of quickly. The court
8 reporter is trying to take down what you are saying.

9 A. All right. I was getting involved in the
10 description. Do I need to say it again?

11 Q. Okay. So, go ahead.

12 A. So it indicates a significant drop in
13 saturations, which are reversed. They are reversed.
14 You know, so it drops off. But it's -- they're not --
15 they don't reverse up into the 90 percent range. They
16 reverse up into the 80s.

17 Q. Okay.

18 A. So it's even -- so it's even still a problem
19 after it's -- being -- being attended to.

20 Q. Okay. Now, what should Mr. Mikell's
21 anesthesia care providers have done when this
22 desaturation that's depicted on that graph started to
23 occur?

24 A. Well, before the big desaturation, their --
25 the sats were already in the 80s, so that -- I don't

DR. KOFKE -- DIRECT

1 remember offhand, but I expect that they were -- his
2 sats were okay beforehand. Otherwise, I don't think
3 that they would have started the case. But by okay, I
4 mean over 90 -- 90 percent -- are the preop areas.

5 So the first sat that we have here is in the
6 80s, so at that point, even to prevent that drop in the
7 40s, there should be these maneuvers -- there should be
8 these maneuvers that I discussed which entail the
9 various things to do in the airway, you know, a chin
10 lift; opening the mouth. You know, various things to
11 support -- get the tongue -- get the tongue off. And
12 if it's due to anesthesia, you know, these folks are
13 known to be sensitive to anesthesia, then you've got to
14 turn the anesthesia down or off.

15 Q. And what is the anesthesia that he's being
16 given in this case?

17 A. He got some Versed or Midazolam, which is like
18 a short acting Valium at the very beginning, which
19 wouldn't produce the anesthesia, just kind of chill
20 out -- you know, settles his nerves down a little bit.

21 And then at some point before 7:42, a Propofol
22 infusion was started. So instead of giving just a slug
23 of the stuff, which I'm sure many of you have
24 experienced yourselves with a little burning, and
25 suddenly you're waking up. Instead, you know, that --

DR. KOFKE -- DIRECT

1 in someone who is really fragile, that can cause a
2 significant drop in blood pressure. It can be, you
3 know -- you know, fragile. So you -- so you -- and the
4 plan that they -- that they elected was to start it
5 slow, and just let it gradually increase. And then as
6 they started to get an effect -- adjust the dose, I
7 think that was the plan.

8 So he was on a Propofol infusion at a dose of 75
9 mites per kilo per minute, which eventually will -- at
10 that dose will eventually produce anesthesia, but
11 (snaps finger) not like that. It takes five, ten,
12 fifteen minutes to fully -- to fully level out.

13 Q. Okay. So what you're saying is that before
14 the graphs start showing up there on the -- on the --
15 well, before the line starts plotting on the graph,
16 he's already received the anesthesia?

17 A. It -- it -- it well -- yes. Sometime before
18 7:42 -- at 7:42 is whenever they put the colonoscopy
19 in -- that's the time that I'm confident about. And
20 they couldn't have done that unless the Propofol was
21 working already. So sometime before that, it had been
22 started. And I'm not sure exactly when, because the
23 records are kind of inconsistent.

24 Q. Now, the oxygen saturations that are
25 represented on that graph there, you said that they

DR. KOFKE -- DIRECT

1 were already in the 80s?

2 A. Right.

3 Q. So what does that indicate to you?

4 A. That even before they had the life threatening
5 drop, they were in trouble. I mean the 80s is a
6 warning, but the -- but the 47 is a life -- is an
7 alarm.

8 Q. And so what should the anesthesia providers
9 have been doing?

10 A. They should have been supporting the airway --
11 focusing on the patient, supporting the airway, and you
12 know, getting up -- getting the sats back up.

13 Q. Now, if they had done those things, would his
14 sats continued to have fallen?

15 A. I don't think so.

16 Q. All right. If they had done those things,
17 would his heart have gone into pulseless electrical
18 activity?

19 A. No.

20 Q. Okay. And if they had done those things, do
21 you believe Mr. Mikell would have ended up a Critical
22 Care Patient in the hospital?

23 A. If they had done those things, that would not
24 have happened.

25 Q. Now, do you have any understanding of why the

DR. KOFKE -- DIRECT

1 anesthesia care providers weren't effective in managing
2 this?

3 A. There were multiple reasons. One, is the
4 nurse was basically in the room by -- by herself from
5 the beginning of this infusion until they got into
6 trouble -- perhaps a -- a drop-in visit by the
7 attending anesthesiologist. And, number two, is that
8 there were a lot of distractions going on related to
9 the electronic record.

10 Q. Yes. So you're aware that there was a problem
11 with the electronic record?

12 A. There was a problem with the record. I
13 don't -- I haven't read that there was any problems
14 with the machine or the equipment required to support
15 life, but just with the record keeping electronics.

16 Q. Okay. Bear with me. I'm looking a document.
17 So I want to show you now a document -- I think this is
18 marked, and I'll have to find where it is. Okay.
19 We've got this -- an exhibit, and once we find it,
20 we'll actually put it into the record. But have you
21 seen this record?

22 A. Yes.

23 Q. All right. Tell the jury what that is.

24 A. This is a record of recipient -- recipient
25 messages -- message ID from Annette Thompson, who is

DR. KOFKE -- DIRECT

1 the -- as I understand it, was the information
2 technology person who was at the end of the phone or a
3 beeper to help with problems with the -- with the
4 anesthesia record or electronic record.

5 It indicates a message that was sent to her --
6 it started at -- the first one here is at 7:39 a.m, and
7 it says, "message tech, hey, call me, re" -- I guess
8 that's not OR -- "anesthesia patient not in transfer
9 bucket, Donna".

10 So I have come to learn that "transfer bucket"
11 means that the patient's -- when they go from one spot
12 in the hospital to another, they put them in a thing
13 called a transfer bucket. So when the patient
14 transfers, the record follows. So the record didn't
15 follow the patient. So this is at 7:39. And I'm quite
16 confident that Propofol had started before then.

17 So it started being a little bit of a fix with
18 the Propofol already starting as an infusion in this
19 guy with sleep apnea, and having to put in this text
20 that says "call" -- "call me".

21 So then a phone call presumably followed to
22 either her -- either the CRNA's cell phone, or the
23 phone in the room. I'm not sure. And something is
24 done that she has to do in response to that -- given
25 some instruction.

DR. KOFKE -- DIRECT

1 And then there's another text then at 7:46 from
2 the OR to the -- to the IT lady. And it says, "Hey,
3 can you call me back. Thanks, Donna." And there's a
4 -- there's a -- you know, a URL -- or a web page
5 address for that computer.

6 So, now we're at 7:46. The colonoscopy has
7 started already. "Hey, can you call me back?" So that
8 means that whatever the fix was down here, didn't work.
9 So there's another call, which has another return --
10 return message, and some instruction undoubtedly to fix
11 something. And I think it did get fixed eventually.

12 So while he's desaturating, there's two phone
13 calls -- two texts, two phone calls, two instructions
14 to fix the problem, six distractions going on either
15 before or during the desaturation episode. So you ask
16 what -- one of the things that are going on that
17 undoubtedly contributed to this, is -- this, I think,
18 was a large contributor.

19 And I've seen the ergonomics of the system. And
20 in order to send these texts, the anesthesia provider
21 has to turn his or her back on the person in order
22 to -- to go like so (indicating) and type -- and type
23 in the text. They weren't long texts, but it's -- you
24 know, it's a turn around. And the phone is behind
25 the -- is behind the anesthesia provider also. So

DR. KOFKE -- DIRECT

1 that's again another turn around to pick up the phone,
2 you know, and deal with this stuff.

3 And then -- then you've got to go back to the
4 computer and do the fix, which is again putting your
5 back to the -- to the patient while he's -- while the
6 sats are in 80s to 40s. So that -- that's what I think
7 is -- I think your question was the cause.

8 Q. Right. So what was going on -- Dr. Kofke,
9 what is your understanding of what was happening with
10 the patient's blood oxygen saturation levels during
11 the -- it looks like seven minutes that are spent with
12 text messages, phone calls trying to fix this computer
13 problem?

14 A. Well, it's -- it's on there, that the sats
15 were starting in the 80s, and were already making all
16 these phone calls, and then they're dropping into the
17 40s. And then -- and then they come up, which I assume
18 is from starting to pay some attention to the patient.
19 But the initial whole minute was started, I think --
20 it's like texting and driving, texting and doing
21 anesthesia. Not on a phone but, you know, it's the
22 same sort of thing.

23 Q. Now, the airway maneuver that you showed in
24 the video, is that something that you would -- the
25 anesthesia care provider would have been able to

DR. KOFKE -- DIRECT

1 execute while they're sending text messages?

2 A. It's kind of gymnastics that I don't think is
3 impossible -- is possible, because it means the patient
4 is in front of me. He's on his side. So I've got to
5 pull up his airway. And then I've got to go back here
6 and -- wait a minute -- I think it may have been back
7 here. So you can see how -- you know, and it -- it's
8 further -- and I'm not sure of the distance, but I
9 think -- it's enough to indicate that full attention
10 was not able to be given to the -- to the patient. And
11 the ergonomics demanded that the airway was not going
12 to be properly supported with all these maneuvers that
13 I discussed earlier.

14 Q. Okay. So the text messages -- and I
15 apologize, folks, I found the piece of paper I was
16 looking for.

17 MR. RANSOM: The text messages are marked as
18 Plaintiff's Exhibit 12, Your Honor, and I'd offer those
19 into evidence.

20 MR. COOKE: No objection.

21 THE COURT: Plaintiff's 12 admitted without
22 objection.

23 (WHEREUPON, Plaintiff's Exhibit No. 12 was
24 admitted into evidence.)

25 MR. RANSOM: All right.

DR. KOFKE -- DIRECT

1 THE COURT: I'm sorry, did you say 12?

2 MR. RANSOM: Yes, sir, Your Honor, 12.

3 THE COURT: Okay. Thank you, sir.

4 MR. RANSOM: And then I've also got Plaintiff's
5 Exhibit 46, a photograph that I'd like to publish and
6 put it in evidence.

7 MR. COOKE: No objection.

8 THE COURT: Forty-six?

9 MR. RANSOM: Yes, sir.

10 THE COURT: All right, 46 admitted without
11 objection.

12 (WHEREUPON, Plaintiff's Exhibit No. 46 was
13 admitted into evidence.)

14 BY MR. RANSOM:

15 Q. Now, you're talking about ergonomics, and what
16 you mean by that is a reference to the way that the
17 room is laid out; correct?

18 A. Yes.

19 Q. Okay. So we've got this photograph that has
20 been marked as Exhibit 46, and this depicts generally
21 speaking the way that the procedure room was laid out
22 at the time of Mr. Mikell's colonoscopy. If you can
23 please help the jury to understand what you were
24 explaining about the location of the key board relative
25 to the patient.

DR. KOFKE -- DIRECT

1 A. So, the patient's here, and he's on his side.
2 I think he's facing this direction, but he's on his
3 side. He's a large man, 300 pounds or so. I think
4 they have the head of the bed up a little bit to help
5 with the airway and so on. And there's a mask on the
6 -- well, I think they started with a nasal cannula --
7 no -- they started with just a nasal cannula. And
8 whenever he started to go bad, he -- there's a mask
9 over here somewhere.

10 There's a mask here. This mask, on the end of
11 the anesthesia circuit, is put on the patient so that
12 it hooks to the anesthesia circuit, and you squeeze
13 this bag to squeeze air into the patient, you know, to
14 make the sats get better.

15 So you can see how that's a one hand on the
16 patient, another hand on this bag. And then during all
17 this, which is what would be required normally --
18 during all this, over here is the electronic anesthesia
19 machine. And here is the keyboard where the texting
20 presumably is -- or the keyboarding is presumably going
21 on. So you can see how -- how difficult it would have
22 been.

23 But it may have been even more advantageously
24 arranged for this specific case, but you can still see
25 that's it a -- turning your head away from -- from the

DR. KOFKE -- DIRECT

1 patient to the -- you know, to the -- to the computer.
2 And then -- then while -- if you want to -- enter this
3 text, it's not going to be built into the anesthesia
4 records, so you've got to minimize the anesthesia
5 record and then find the web page where you type in --
6 type in the web page, you know, what -- type in the
7 text.

8 So there's a lot of little things that
9 ordinarily are nothing, but in this context where
10 you've got to have one hand on the -- on the patient's
11 airway, and another hand on the mask, that's -- that's
12 a significant distraction. And I think the phone --
13 I'm told -- is behind this thing here, but I'm not
14 sure.

15 Q. Okay. So all of those things would have been
16 very, very difficult to undertake at the same time?

17 A. It would have been a very distracting day,
18 yes.

19 Q. Now, in terms of the desaturation that's --

20 A. I -- I think I do have this -- I think this is
21 backwards. Because over here is the colonoscopy
22 equipment, so I think he's probably facing in the other
23 direction, so perhaps not quite as disadvantaged, but
24 still -- still difficult.

25 Q. Now, looking over here at the board, Dr.

DR. KOFKE -- DIRECT

1 Kofke, with this V shaped desaturation, what happens to
2 a patient like Mr. Mikell, when his blood oxygen levels
3 drop like that?

4 A. Every patient is a little bit different. But
5 to -- but his -- his response clearly is to get
6 bradycardiac and hypertensive, and that means slow
7 heart rate, low blood pressure, you know. And at some
8 point in there, there's a cardiac arrest which isn't
9 clearly indicated on the anesthesia record.

10 So it was probably a short arrest which it's
11 classic -- again, another reason why I'm confident that
12 the arrest is caused by the hypoxia, is that once the
13 hypoxia is improved, the arrest goes away. You know,
14 so it was probably -- and as I say, this Mayday record
15 isn't available for us to say for sure, but probably
16 was just a relatively short arrest. But, nonetheless,
17 enough to cause all these problems.

18 Q. Okay. Would it useful to you to indicate that
19 Dr. Kofke, sort of switching back and forth on these
20 exhibits -- okay. So with respect to the V shaped
21 desaturation, where is it that you're telling us that
22 he actually gets into the cardiac arrest?

23 A. It's probably right around here (indicated).
24 This looks like it's an arrest, but I think this is
25 transport to the -- to the PACU because of the timing.

DR. KOFKE -- DIRECT

1 Everyone said that around 8:00 is when the breathing
2 tube was put in and the CPR was being done, and all --
3 and all that stuff.

4 Q. Okay. Well, the PACU, meaning after they've
5 rescued him, they transported him to another area of
6 the hospital?

7 A. Yes.

8 Q. And it's at that point in time that it's
9 unhooked, and that's why --

10 A. Right. Right. And then their electronic
11 system continued as if it's the same anesthesia record.
12 But over here, it's out of the OR.

13 Q. Okay. Now, what I wanted to ask you to see if
14 you could explain it to the jury is so when we look at
15 that V that goes down and then comes back up, when they
16 brought his oxygen saturations back up, why wasn't
17 that -- why didn't that take care of everything?

18 A. I think that he was -- was starting to have
19 his arrest already. And, you know, you see this high
20 blood pressure here is probably from the Epinephrine
21 that they give him as a part of the ACLS, so he's
22 arresting in here somewhere (indicated).

23 Q. Now, have you ever had one of your patients
24 desaturate and go into a cardiac arrest during a
25 colonoscopy, Dr. Kofke?

DR. KOFKE -- DIRECT

1 A. No, not during a colonoscopy.

2 Q. All right. And have you ever had a patient
3 with sleep apnea desaturate and go into cardiac arrest
4 when they -- when their airway obstructed?

5 A. No.

6 Q. Okay. Have you ever encountered this type of
7 computer system issue while you were doing a procedure?

8 A. In fact, it happened to me last week. I put
9 in six safety things into the UPenn system, because our
10 anesthesia record wasn't collecting -- wasn't -- our
11 physiology wasn't transmitting to the anesthesia
12 record.

13 Q. Okay.

14 A. You know, so it's -- it's part of the sign of
15 our times, to have them try to learn how to do all this
16 federally mandated, you know, electronic record stuff,
17 you know. We're all kind of how learning how to deal
18 with it.

19 Q. Well, when that happened, do you -- did your
20 patient go into cardiac arrest?

21 A. Well, those patients had -- they were
22 undergoing other -- other procedures in radiology, but
23 I -- I was working with nurses that day. And I said,
24 screw the record. I said, we're going to do paper
25 today. And, you know, and -- and we just -- just focus

DR. KOFKE -- DIRECT

1 on the patient, and then kept the record by hand -- by
2 the way we did it for a hundred years.

3 Q. Okay. But your -- your patients didn't go
4 into cardiac arrest?

5 A. Correct.

6 Q. All right. Now, have you been able to reach
7 any conclusions about, you know, the state of the
8 record from Mr. Mikell's procedure since we see there
9 are some gaps -- and we also look at other parts of the
10 record, you're aware that there is some data that's
11 missing?

12 A. Yes. Yes.

13 Q. Now, have you drawn any conclusions about the
14 effectiveness of the anesthesia care provider's conduct
15 if this desaturation process took place at various
16 times relative to these text messages and phone calls?

17 A. So, there's three possible times it occurred,
18 before, during, or after the text messages. So if
19 the -- if the text messages occurred before the
20 desaturation, then I am confident that they contributed
21 to the desaturation. Because the original sats were in
22 the 80s and -- and that dropped down into the 40s. It
23 was then permitted by the lack of attention to the
24 airway.

25 If the text messages occurred during the -- the

DR. KOFKE -- DIRECT

1 sats in the 40s, well, you know, that's like the worst
2 -- the worst situation because the patient is in crisis
3 and you're worried about the anesthesia record whenever
4 you've got to be focusing on the patient.

5 And if -- if the text messages occurred after
6 all the dust had settled, well, then -- there's -- then
7 there's still the issue of why -- why couldn't they
8 just manage the airway if that -- if that wasn't an
9 issue -- I'm sorry.

10 If the text messages were before, and they had
11 settled everything and now -- then they had the desats
12 after all the text messages, you know, then you show a
13 focus on the patient and it's a fairly straight forward
14 technique to keep the airway open. Because, as I said,
15 this is -- in America today, this is very common.

16 Q. What's very common?

17 A. Obstructive sleep apnea and obesity.

18 Q. Okay. So in other words, this is a patient
19 that they should have been prepared to be able to
20 manage?

21 A. Right. Right. If the text messages didn't
22 interfere, then they should have been able to manage
23 it. And if the text message -- or the anesthesia
24 record wasn't taking attention away from the patient,
25 then the -- then the anesthesia record should have been

DR. KOFKE -- DIRECT

1 ignored and focusing on the patient.

2 Q. Now, do you have any -- do you have
3 information and conclusions about whether or not the
4 anesthesia providers met the standard of care in
5 Mr. Mikell's case?

6 A. Yeah, I've come to a conclusion, yes.

7 Q. What is it --

8 MR. COOKE: Your Honor, may I?

9 THE COURT: Yes, sir.

10 MR. COOKE: I object to the form of the
11 question. He asked "anesthesia providers" plural, and
12 I think he needs to be specific as to which anesthesia
13 provider he's speaking of. Otherwise, it's not
14 relevant.

15 THE COURT: Specify who, what.

16 MR. RANSOM: Well, I'm starting out general and
17 then we'll become more specific.

18 THE COURT: All right. Let me hear your
19 question. He made the objection before I heard the
20 entire question.

21 BY MR. RANSOM:

22 Q. Dr. Kofke, have you reached any conclusions as
23 to whether or not the anesthesia care providers in
24 Mr. Mikell's case met the standard of care?

25 THE COURT: All right. Doctor, hold on just a

DR. KOFKE -- DIRECT

1 second. Now, what's your legal objection?

2 MR. COOKE: The objection --

3 THE COURT: He said, does he have an opinion.

4 MR. COOKE: Correct. I was really objecting to
5 the next question, which is if you give your opinion --

6 THE COURT: Well, let me find out if he has an
7 opinion first.

8 MR. COOKE: All right.

9 THE COURT: Okay?

10 MR. COOKE: Yes.

11 THE COURT: Doctor, please answer the question.

12 A. Yes, I have an opinion.

13 THE COURT: All right.

14 BY MR. RANSOM:

15 Q. And what conclusions have you reached?

16 THE COURT: All right, now what's your legal
17 objection?

18 MR. COOKE: The objection is relevance. Because
19 he's lumped the health care providers together rather
20 than specifying which one he's referring to or asking
21 about.

22 THE COURT: Let me see the attorneys up here
23 without sending the jury back a second -- without
24 sending the jury out.

25 (WHEREUPON, a bench conference was had.)

DR. KOFKE -- DIRECT

1 THE COURT: All right. As to that question,
2 I'll sustain the objection. Be specific about what
3 anesthesia provider -- or assistant or providers,
4 please, sir.

5 BY MR. RANSOM:

6 Q. Dr. Kofke, now what is your understanding of
7 the number of anesthesia care providers that were
8 involved in providing this anesthesia to Mr. Mikell?

9 A. A CRNA and an attending anesthesiologist.

10 Q. Okay. And you've had access to the complete
11 medical record that's been provided by the Medical
12 University for this procedure?

13 A. Yes.

14 Q. All right. You've reviewed a number of
15 depositions?

16 A. Yes.

17 Q. Would that include the testimony of the nurse
18 anesthetist and the anesthesiologist?

19 A. Yes.

20 Q. All right. Are you able to reach any
21 conclusion as to who was present in the room during the
22 various times that these events were playing out?

23 A. Well, the CRNA was there the whole -- the
24 whole time. And then up until the time that he
25 arrested, we have documentation -- a memo -- a memo

DR. KOFKE -- DIRECT

1 kind of notes that were entered indicating that the
2 anesthesiologist was -- was present briefly, because
3 there's said to be an increase in sats. And he was
4 okay with that. And then -- then they left, but it had
5 to be very brief because it's not reflected in any of
6 the electronic records.

7 Q. Okay.

8 A. So -- so his involvement was -- was -- to be
9 in there briefly. He attested to being present for
10 induction, although she -- she said he wasn't there for
11 induction.

12 Q. Well, what's induction? Explain that.

13 A. Oh, induction is the start of anesthetic.

14 Q. Okay.

15 A. That's jargon, I'm sorry. So you have to --
16 you know for -- for administrative and billing
17 purposes, you know, the anesthesiologist is expected to
18 attest to being there -- being present for critical
19 parts of the procedure, typically induction or
20 procedure -- lines and things are put in, and being
21 present for the end of the case, things like that.

22 Just like a surgeon has to attest to being present --

23 Q. So -- so if we look at this part of the graph
24 over here, before the desaturation shows, can you tell
25 at what point in time Dr. Nelson, the anesthesiologist,

DR. KOFKE -- DIRECT

1 is or isn't present in the room?

2 A. No. I can't tell from the -- from the --
3 from -- from this -- this record. It's only from the
4 typed in notes.

5 Q. Well, I mean, from any of the material that
6 you've reviewed, have you been able to determine when
7 it was that he was actually physically present in the
8 room?

9 A. When exactly is difficult to tell because this
10 record has been -- it's -- from one spot to another
11 spot in the record, the times are a little different
12 and people's memories are different. And some things
13 got changed after the fact. So I'm a little -- I'm a
14 little unsure exactly, so that's why I -- there's only
15 three times -- three times during this case that I'm
16 confident of, and that's the two times of the text, and
17 then the time that the colonoscopy was put in. Other
18 than that, I speak relative to things.

19 So I think -- after -- after the colonoscopy was
20 put in, I think the doctor -- the anesthesiologist
21 probably looked in, you know, briefly and then got
22 called back when they were in trouble.

23 Q. So what I want to ask you in order to meet Mr.
24 Cooke's objection is, speaking with respect to the
25 standards of care and the safety rules -- all right --

DR. KOFKE -- DIRECT

1 I want to ask you, have you reached any conclusion as
2 to whether or not the nurse anesthetist met the
3 standard of care in the way that she was providing the
4 anesthesia to Mr. Mikell?

5 A. Yes, I have.

6 Q. All right. And what is your --

7 A. I think that she fell below the standard of
8 care because she didn't -- she didn't focus on the
9 patient at the time that there were -- not -- more or
10 less irrelevant distractions going on in the room. And
11 it could have been something else, it could have been
12 someone making a -- making a joke somewhere else in the
13 room. And whenever this is going on, you focus.

14 Q. Okay. And if she hadn't breached that
15 standard of care, do you believe that Mr. Mikell would
16 have suffered a cardiac arrest?

17 A. I believe he would not -- he would not have.

18 Q. All right. And if she hadn't breached that
19 standard of care, do you believe Mr. Mikell would have
20 ended up spending all this time in the hospital that we
21 heard about this morning?

22 A. He would not have.

23 Q. And if she hadn't breached that standard of
24 care -- I'll save that question for later -- let's turn
25 our attention to Dr. Nelson for a moment. Have you

DR. KOFKE -- DIRECT

1 reached any conclusions as to whether Dr. Nelson's
2 conduct met or breached the standard of care?

3 A. Yes.

4 Q. All right. And what are those conclusions?

5 A. It's -- in a patient who he recognized was
6 going to be very tricky, and that's why they used an
7 unusual anesthesia technique -- he just popped in and
8 then left. And -- and -- and he had to have heard
9 about the sats in the 80s at the beginning of the case,
10 but whenever he popped in, purportedly they were --
11 they were okay, but it's not seen anywhere in the
12 record. And then -- then he left, you know, so that's
13 his breach.

14 Q. Okay. And if both of the anesthesia care
15 providers, Dr. Nelson and the nurse anesthetist had
16 been present in the room and attending to the patient,
17 do you have any conclusions as to whether or not they
18 would have been able to prevent the cardiac arrest?

19 A. Oh, yes. I think that the two of them could
20 have made sure that the airway was -- was patent. It's
21 a word we use. And then he -- he could have managed
22 the airway while she managed the electronic record.

23 Q. All right. Now, have you -- have you reached
24 both of those conclusions as to the standard of care to
25 a reasonable degree of medical certainty?

DR. KOFKE -- DIRECT

1 A. Yes.

2 Q. Okay. And beyond that, are you confident?
3 Are you sure?

4 A. Yeah, I'm sure.

5 Q. No question in your mind --

6 A. No.

7 Q. -- that they both breached the standard --

8 A. No.

9 Q. -- of care?

10 A. No.

11 Q. All right.

12 MR. RANSOM: Your Honor, it's at this point in
13 time that I would segway into the matter that relates
14 to the motion.

15 THE COURT: Okay. All right. Ladies and
16 gentlemen, I'm going to have to make a decision on a
17 motion concerning evidence. And as I've done in the
18 past, I'm going to ask you to leave the courtroom so
19 I'll be free to comment on the facts and discuss the
20 situation with the attorneys out of your presence
21 because I'm not allowed to talk about the facts in your
22 presence about the case. That's your job as fact
23 finders.

24 So please leave your note pads in the chair.
25 Let me see, we have been here about an hour. When we

DR. KOFKE -- DIRECT

1 finish this, we'll probably take our afternoon break,
2 so you can take yours now.

3 All right. See you in about 20 minutes.

4 (WHEREUPON, the jury leaves the courtroom at 3:25
5 p.m.)

6 THE COURT: All right. Mr. Ransom, I'm assuming
7 you're going to go in now to his death two months
8 later; is that correct?

9 MR. RANSOM: That's right, Your Honor.

10 THE COURT: Okay.

11 BY MR. RANSOM:

12 Q. So, Dr. Kofke, I want to talk now a little bit
13 with you about the things that took place with Mr.
14 Mikell after the cardiac arrest. All right. And you
15 were present this morning to hear Dr. Higgins --
16 Higgins testify?

17 A. Yes.

18 Q. All right. And in addition to hearing his
19 testimony, you also had access to the record that we
20 were going through with him this morning?

21 A. Yes.

22 Q. All right. You've also reviewed the
23 records -- I think the company is called Gentiva, the
24 home health care company that came and saw Mr. Mikell?

25 A. Yes.

DR. KOFKE -- DIRECT

1 Q. Okay. So you've -- you've had access to the
2 whole gamut from A to Z on his --

3 A. Yes.

4 Q. -- record?

5 A. Yes.

6 Q. And you've also reviewed all the depositions?

7 A. Well, the ones you sent me. I don't know if
8 it was all of them.

9 Q. Okay. All right. So you're aware, of course,
10 that after the cardiac arrest, he's in a coma and he's
11 placed into a hypothermic state, admitted to the ICU?

12 A. Yes.

13 Q. All right. He's breathing on a ventilator,
14 undergoes a tracheostomy?

15 A. Yes.

16 Q. All right. He's being fed through a tube?

17 A. Yes.

18 Q. Correct. He has suffered an injury to his
19 kidneys that requires hemodialysis?

20 A. Yes.

21 Q. And some of his heart medications have been
22 changed?

23 A. Yes.

24 Q. Okay. In your view, based on your review of
25 the entire record, did Mr. Mikell ever completely

DR. KOFKE -- DIRECT

1 recover from all of that?

2 A. He wasn't driving his bus -- he wasn't driving
3 his bus, so I don't think that, you know, just in terms
4 of his -- his activity, his ability to return to what
5 he was doing exactly before, he had not fully
6 recovered. I think he was on a trajectory, but he had
7 not fully recovered by that time.

8 Q. All right. Did he ever return to the level
9 that he was at before the colonoscopy?

10 A. I don't think so. I mean, this -- his energy
11 levels were significantly depressed. And as I say,
12 there's no way he was going to go back to work.

13 Q. Okay. Now, you've got a subspecialty
14 certification in critical care; correct?

15 A. Yes.

16 Q. All right. Is Mr. Mikell, with his critical
17 illness at the time that he spent in the ICU, the type
18 of patient that you see in your practice?

19 A. The -- multiple organ failure is something
20 that -- that, sure, we see. And we'll often have
21 patients in the unit for weeks, sometimes months. And
22 it's a very long road to recovery after that.

23 Q. Okay. So you're familiar with this type of an
24 illness?

25 A. Yes.

DR. KOFKE -- DIRECT

1 Q. And the effect that it has on a patient long

2 --

3 A. Yes.

4 Q. -- term?

5 A. Yes.

6 Q. Okay. So what effect, in your view, did all
7 these things have on Mr. Mikell?

8 A. Well, he -- he was -- he had this significant
9 loss of energy. He was still -- still had sleep apnea
10 and all the -- and all the problems that he had before.
11 But he -- his trach was -- was evidently doing some
12 oozing, so that produced a delay in getting his
13 anticoagulation going. And in my view, he was at
14 significant risk for developing clots in his veins or
15 in his heart, and having a lethal event from that.

16 And his arrhythmia medicines were stopped.
17 So -- so he was -- he wasn't back to normal. You know,
18 he was in an exquisite -- was an exquisite process
19 that his primary care doctors were doing beforehand, to
20 have him managed just right. And they were starting to
21 go about that, but they hadn't finished it. And, you
22 know, that's when he passed.

23 Q. Okay. I've got what we've marked as
24 Plaintiff's Exhibits 39 and 40, and these are parts of
25 his medical record, specifically cardiology visits that

DR. KOFKE -- DIRECT

1 he had with a Dr. Van Bakel, both before and after the
2 colonoscopy.

3 MR. COOKE: No objection.

4 THE COURT: That's 39 and 40?

5 MR. RANSOM: It's 39 and 40.

6 THE COURT: Okay. Admitted without objection.

7 (WHEREUPON, Plaintiff's Exhibits Nos. 39 & 40
8 admitted into evidence.)

9 BY MR. RANSOM:

10 Q. Now, Dr. Kofke, have you, as a part of your
11 review of this matter, previously seen Exhibits 39 and
12 40?

13 A. These are the cardiology follow-up notes in
14 December. And the one in July -- I believe that these
15 were reviewed -- the one in December, I remember. The
16 one in July, I'm not a hundred percent sure.

17 Q. Well, what I wanted to do was talk a little
18 bit about the changes in Mr. Mikell's medications that
19 took place between the July office visit, which was
20 before the colonoscopy, and the December office visit,
21 which was after. Okay?

22 A. Yes.

23 Q. And are you familiar generally with those
24 medication changes?

25 A. Yeah. I've gone through his record and -- and

DR. KOFKE -- DIRECT

1 tabulated them also.

2 Q. So, I've got a little bit of a summary here if
3 I can get this to work.

4 THE COURT: Mr. Ransom, I don't have any
5 objection if you want to lead him through this process,
6 just to sort of move it along.

7 MR. RANSOM: That's what I'm trying to do,
8 Judge.

9 THE COURT: Please.

10 BY MR. RANSOM:

11 Q. Okay. So, what we see here is, I've got a
12 little table of medication changes. We've got some
13 medications that were stopped, and some medications
14 that were started. If you would take us down through
15 the list of these medications, and give us your
16 understanding of what the significance of those drugs
17 are and the changes and so forth.

18 A. So the Fosinaphril is an ace inhibitor that
19 dilates the arteries in a body so that the heart
20 doesn't have some much resistance to beat against, and
21 it's a great drug for heart failure, but it had been
22 stopped.

23 Bidil is actually Hydralazine and Isosorbide
24 combined. And I'm not sure of the dosing of the two is
25 the same, but they were still Hydralazine and

DR. KOFKE -- DIRECT

1 Isosorbide were still -- were given before and after.

2 Potassium chloride was -- was not being given
3 after. Typically that's needed with -- with a
4 diuretic.

5 This is -- Tikosyn is a drug -- frankly, I'm not
6 that familiar with --

7 COURT REPORTER: Can he slow down.

8 THE COURT: Slow down just a little bit, doctor.
9 Slow down just a little bit.

10 A. Yeah. Tikosyn, it is a drug for arrhythmias
11 and that was -- that was stopped and the arrhythmias --
12 the arrhythmias can kill people.

13 The Warfarin is a blood thinner, which the chart
14 indicated he was to be on for life. And his incident
15 was October 1. He left at the end of October. And I'm
16 not sure when exactly his anticoagulation was stopped
17 peri-operatively. But he certainly was not on it at
18 the end of December into New Years. And that's an
19 anticoagulation for -- not really for the treatment of
20 heart arrhythmias, but to prevent clots in the heart and
21 to prevent clots in the veins with -- both of which he
22 was prone to.

23 Then the Zaroxolyn is a diuretic which is used
24 to keep fluid off the body for people who have heart
25 failure. Started was this Aranesp, which is like a

DR. KOFKE -- DIRECT

1 drug which simulates the bone marrow to make red cells,
2 but it also has side effects -- side effects reported
3 with it of -- that include cardiac arrest and -- and a
4 predisposition to clotting.

5 The Ativan was for anxiety, and as I stated --

6 THE COURT: Let me interrupt -- let me interrupt
7 for just a second. Okay.

8 MR. RANSOM: Yes, sir.

9 THE COURT: I understand you want to develop
10 this in front of the jury.

11 MR. RANSOM: Right.

12 THE COURT: All I want to hear is does he have
13 an opinion as to the cause of man's death on January 2,
14 2011. And if he does, what is that opinion and why.

15 MR. RANSOM: Thank you, Your Honor.

16 THE COURT: Okay.

17 MR. RANSOM: I'm sorry. He didn't understand
18 that.

19 THE COURT: I mean, that's where I'm coming
20 from. I understand where you are going and the jury
21 needs to hear that, but I don't.

22 MR. RANSOM: Got you.

23 A. Okay.

24 THE COURT: Okay.

25

DR. KOFKE -- DIRECT

1 BY MR. RANSOM:

2 Q. So, Dr. Kofke, you heard the judge's question,
3 he's interested to know -- do you have an opinion as to
4 whether or not the events of October 1, 2010 caused or
5 contributed to Mr. Mikell's death on January 2nd of
6 2011?

7 A. Yes.

8 Q. All right. And what is that opinion?

9 A. I think that if he hadn't had that cardiac
10 arrest, he would have gone home and continued his
11 exquisitely designed medication, Paradigm that he was
12 on. But instead he had a cardiac arrest and a
13 protracted period in intensive care and in the
14 hospital, and they were working on trying to get him
15 back to that stage. But during that period, he didn't
16 have his arrhythmia medicine. He didn't have his
17 anticlotting medicine.

18 And the way this presented with the sudden death
19 at home is entirely consistent with either a massive
20 clot to his head, or a massive clot going from his --
21 from his legs to his lungs, or an arrhythmia, all of
22 which he's at high risk for, and all of which he wasn't
23 being treated for. So I think that it's more likely
24 than not that it was one of those three things that
25 caused the sudden death at home.

DR. KOFKE -- DIRECT

1 Q. More likely than not --

2 A. Yeah --

3 Q. -- one of those things that's related to the
4 cardiac arrest?

5 A. Yes.

6 THE COURT: I'm looking for some different word
7 but -- okay.

8 BY MR. RANSOM:

9 Q. All right. So the phraseology that I'd like
10 to see if I can get you to confine yourself to, Dr.
11 Kofke, is do you have an opinion, to a reasonable
12 degree of medical certainty, as to whether or not the
13 events of October 1, 2010, most probably caused Mr.
14 Mikell's death?

15 A. Yes.

16 Q. All right. And what is your opinion?

17 A. My opinion is based on the things that I just
18 said, his medications were changed in a way that
19 predisposed him to -- to this process, and thus I
20 conclude that the -- that the events of -- that the
21 cardiac arrest, to a -- to a degree of medical
22 certainty was responsible for the death in early
23 January the following year.

24 THE COURT: All right, sir. I know you've got
25 depositions that say contrary to that, and -- but let

DR. KOFKE -- DIRECT

1 me hear you on your arguments, because that's what I
2 wanted to hear. And he's basically said that. And I'm
3 not going to get into the weight of that evidence, but
4 in my opinion, he's met the standard required to give
5 that opinion.

6 And I understand you've got some problems with
7 it, but let me hear you on your motion. Because as I
8 said, we were listening to this in camera. I've heard
9 it.

10 MR. COOKE: All right. My -- my objection is
11 twofold.

12 THE COURT: Okay.

13 MR. COOKE: The first is, as you know from his
14 prior deposition, he was asked on numerous occasions,
15 do you have an opinion or do you intend to give an
16 opinion -- do you have an opinion about the cause of
17 death. And each time he said, no, I don't. No, I
18 don't.

19 So just from a pure discovery standpoint, that
20 was over a year ago in answers to interrogatories,
21 he -- he -- he gave his affidavit with his opinion,
22 which had no opinion on causation. Under the rule,
23 they are required to supplement their answers to
24 interrogatories if there's a change in the opinion of
25 the expert. And this -- this is a giant change --

DR. KOFKE -- DIRECT

1 THE COURT: Well, legally -- legally that goes
2 to the weight and sufficiency. You're arguing they
3 haven't revealed it, therefore, I should bar it? Is
4 that your argument?

5 MR. COOKE: Yes. Yes.

6 THE COURT: That's your first argument?

7 MR. COOKE: That's my first argument.

8 THE COURT: What's your second argument?

9 MR. COOKE: My second argument is that the court
10 does have a role as the gatekeeper. And it must
11 exclude testimony that is prejudicial and does not have
12 probative value. In this case, he -- he has previously
13 testified, and is absolutely true, that nobody knows
14 the cause of death. There was no autopsy done. The
15 medical examiner didn't even examine the patient.

16 She excluded obvious things, like suicide and
17 homicide. And at that point, she just said probably
18 coronary insufficiency, which she says in her testimony
19 includes a host of possible causes. He could have --
20 he could have choked. He could have had a stroke. He
21 could have had sudden heart failure, which he was at
22 risk for. He was at risk for that for --

23 THE COURT: I don't want to interrupt you,
24 but -- and you know it better than I do, because you've
25 lived with it. If I remember correctly, in some of

DR. KOFKE -- DIRECT

1 those depositions that was in your motion, he -- he
2 sort of qualified it by saying that I have not looked
3 at the records for this purpose.

4 MR. COOKE: That's true.

5 THE COURT: And he kept saying that repeatedly.
6 And he said, I need to examine the records more closely
7 for that purpose if -- now, that may not be the exact
8 quote, but he kept repeatedly saying that.

9 MR. COOKE: He did say -- he did say that. But
10 there is not a record, and there never will be a record
11 of the cause of death, because there was no autopsy
12 done. And -- and he -- with all due respect to the
13 doctor, he would have to admit that there could be
14 other causes of death.

15 THE COURT: I understand that. But to me, that
16 goes to the weight and sufficiency of his testimony,
17 not the admissibility.

18 MR. COOKE: Well, with due respect, I think it
19 does because of the threshold that he has to -- he has
20 to say -- he has to be able to say -- and it has to
21 have some scientific basis to it, that more probably
22 than not this death was caused by something for which
23 the defendants were responsible, than for something for
24 which they were not responsible.

25 THE COURT: Well, I think in his opinion, he

DR. KOFKE -- DIRECT

1 said it was classic -- either arrhythmia or blood clot
2 causing the death?

3 MR. COOKE: He says that those would be classic
4 causes of that death, but there's no evidence in this
5 case that that was the cause of death. It could
6 have -- it could have been poisoning. It could have
7 been a stroke. It could have been choking --

8 THE COURT: I mean, isn't that true in every
9 case -- in every death case unless you've got an
10 autopsy, you run a bunch of drug tests, et cetera, on
11 every dead body? I mean, if that's going to be the
12 requirement in court --

13 MR. COOKE: But an autopsy does give -- it does
14 rule out other possible causes. But in this case
15 nothing has been done to rule out other possible
16 causes, nothing has been done. It's not the doctor's
17 fault. It's nobody's fault, but an autopsy was never
18 done. And there was no effort done to -- to ascertain
19 the cause of death. And one thing we do know is that
20 he was at risk of sudden cardiac death before October
21 of 2010.

22 So -- and, Your Honor, I mean -- I know he has
23 used the words, but I submit that the court still has a
24 -- a thresh -- a gatekeeper responsibility to exclude
25 prejudicial expert testimony that's not based upon the

DR. KOFKE -- DIRECT

1 evidence and not based upon reasonable science.

2 THE COURT: Anything else?

3 MR. COOKE: No.

4 THE COURT: Thank you so very much.

5 MR. RANSOM: Judge, I think the import of the
6 argument that Mr. Cooke is making is that you --

7 THE COURT: I'm sorry, what?

8 MR. RANSOM: The -- the import of the argument
9 he's making is that you could never prove causation in
10 any wrongful death case where there isn't an autopsy,
11 and I don't think that can be the case.

12 But, Your Honor, I think you've analyzed it
13 correctly, the issues that they are raising go to the
14 weight of his testimony --

15 THE COURT: I don't know if I have or not, I
16 would have already ruled. But go ahead. Okay.

17 MR. RANSOM: Okay. Right. So as to the issue
18 about his deposition testimony, it's fairly clear if
19 you start looking at that --

20 THE COURT: My problem is he said the man died
21 of arrhythmia heart problem, or blood clot. He hasn't
22 tied that back into what happened in -- when was it --
23 October the -- excuse me -- October the 1st. That's
24 where he has to go. That's my difficulty with what
25 I've heard so far, he hasn't said October 1st when he

DR. KOFKE -- DIRECT

1 arrested, would cause the blood clot or the arrhythmia
2 when he actually died -- factually, is what I'm saying,
3 I hadn't heard that.

4 MR. RANSOM: And, Judge, that's why -- what he's
5 saying is, when they changed all of his medications,
6 he's taking a drug to prevent blood clots --

7 THE COURT: Because I cut you off on all that
8 medication.

9 MR. RANSOM: Yeah, he's taking --

10 THE COURT: Summarize that for me please.

11 MR. RANSOM: Right. He's taking -- he's taking
12 a drug to prevent blood clots. He's taking a drug to
13 prevent heart arrhythmias. He's taken off of both of
14 those drugs as a result of this cardiac arrest. He's
15 not put on those drugs after he's discharged from the
16 hospital.

17 As we saw from Dr. Huggins, one of the things
18 that he had was an appointment to go see his
19 cardiologist so that they could start dilating his
20 medications back in the way that they had in the years
21 leading up to the colonoscopy. So what Dr. Kofke is
22 saying is, look, when they take him off of those
23 medications now, his risk of having an arrhythmia or a
24 blood clot goes through the roof.

25 And he says based on his experience with these

DR. KOFKE -- DIRECT

1 types of patients at his hospital that he treats, he's
2 saying, look, I can just tell you, this is what happens
3 to these people. And I think that, you know, that's me
4 trying to explain the basis for him coming to that
5 conclusion.

6 THE COURT: I understand. And I cut you off on
7 that, and I apologize. Anything else?

8 MR. RANSOM: Not unless you have any other
9 questions, Your Honor.

10 THE COURT: No. Anything very briefly in reply?

11 MR. COOKE: Just -- just briefly in reply. This
12 testimony comes directly out of the Ross case. If you
13 recall, the one where they said -- there was -- one of
14 them was Rocky Mountain Spotted Fever, the other case
15 involved a portion of the testicle. And what the
16 expert there said was delay in diagnosis makes it --
17 makes it more at risk of the bad outcome. And that's
18 exactly -- that's exactly Dr. Kofke's testimony.

19 He's saying that taking him off of these drugs
20 makes him more susceptible to a blood clot or an
21 arrhythmia, but that does not meet the test of -- but
22 for those, he more probably than not would not have had
23 those, if he had those. We don't even get to that
24 point.

25 Because at least in the Ross case and -- you

DR. KOFKE -- DIRECT

1 knew he had Rocky Mountain Spotted Fever. In the other
2 case, you knew he had necrotic testicle. But the court
3 said in that case, Doctor, all you could say was that
4 the delay in treatment made it more susceptible, you
5 couldn't say that he wouldn't of had it but for. And
6 so he doesn't even meet the threshold of showing what
7 the cause of death was, let alone more probable than
8 not it -- it wouldn't have occurred but for that. And
9 I don't think that's what Your Honor was saying.

10 THE COURT: All right. Thank y'all very much.
11 We're going to take a short break. Okay. Doctor,
12 during the break, don't discuss the case with anyone.
13 You may step down.

14 (WHEREUPON, a brief recess was taken.)

15 THE COURT: Is the plaintiff ready to proceed --
16 anything from the plaintiff -- for the record, the
17 motion is denied.

18 MR. COOKE: Thank you.

19 MR. RANSOM: Yes. I think we are ready to
20 proceed.

21 THE COURT: Is the defense ready to proceed?

22 MR. COOKE: Yes, Your Honor, we are.

23 THE COURT: Bring us the jury, please.

24 MR. COOKE: Your Honor, before they come in,
25 just --

DR. KOFKE -- DIRECT

1 THE COURT: Hold on just a second. I'm sorry.

2 MR. COOKE: Logistically, should I still make
3 the same objections in front of the jury?

4 THE COURT: Yeah, I would if you want to. I
5 mean whatever -- whatever you feel comfortable doing.

6 MR. COOKE: Okay.

7 THE COURT: Whatever you feel comfortable doing.

8 MR. COOKE: Well, I'd feel comfortable not doing
9 it, but I don't want to waive anything, so just to be
10 safe, I'll --

11 THE COURT: I would suggest that you make it and
12 I'll rule. Okay?

13 MR. COOKE: Thank you.

14 THE COURT: Okay. It won't take long.

15 MR. COOKE: What if I change your mind?

16 THE COURT: Pardon?

17 MR. COOKE: What if I change your mind?

18 THE COURT: Well, I think it goes to the weight
19 and sufficiency.

20 THE COURT: Please bring the jury.

21 (WHEREUPON, the jury enters the courtroom at
22 approximately 4:02 p.m.)

23 THE BAILIFF: The jury's all present, Your
24 Honor.

25 THE COURT: Thank you very much. You may

DR. KOFKE -- DIRECT

1 proceed please, sir.

2 MR. RANSOM: Thank you, Your Honor.

3 BY MR. RANSOM:

4 Q. Dr. Kofke, are you ready to continue?

5 A. Yes.

6 Q. Now, to sort of pick up where we left off, do
7 you have an opinion, to a reasonable degree of medical
8 certainty, as to whether or not the nurse anesthetist
9 most probably breached the standard of care?

10 A. Yes.

11 Q. All right. What is that opinion?

12 A. That the -- the standard of care was breached
13 because the nurse was distracted by events by the -- by
14 the medical record, and didn't focus on the patient
15 like she -- she should have.

16 Q. Okay. And do you have an opinion, to a
17 reasonable degree of medical certainty, as to whether
18 or not the anesthesiologist, Dr. Nelson, also breached
19 the standard of care?

20 A. Yes.

21 Q. All right. And what is that?

22 A. And that is that he had a patient who -- who
23 he knew was tenuous, and he didn't pay that much
24 attention to, making only a brief stop in the room --
25 as documented any way -- before the -- before the

DR. KOFKE -- DIRECT

1 arrest arose. So he wasn't around for the sats in the
2 80s or any of that stuff.

3 Q. Okay. Because he was going in and out?

4 A. Yes. I'm not sure how many -- once or twice,
5 but I don't see documentation for more than that.

6 Q. Okay. Now, do you also have -- been able to
7 reach any conclusion, to a reasonable degree of medical
8 certainty, as to whether or not Mr. Mikell would have
9 suffered the cardiac arrest and ended up in the
10 hospital if the nurse anesthetist and the
11 anesthesiologist had met the standard of care?

12 A. I think that this would not have happened if
13 either one of them had met the standard of care. It
14 didn't require both.

15 Q. Okay.

16 A. But both would have been clearly better.

17 Q. Now, what I want to do is turn from the events
18 of October 1, 2010, and your analysis of those events
19 --- which you have now testified about -- and move into
20 the hospitalization and the long term consequences for
21 Mr. Mikell and the things that took place. Okay.

22 A. Okay.

23 Q. Now, do you consider those to be areas of
24 medicine in which you're also an expert?

25 A. The critical care part, certainly.

DR. KOFKE -- DIRECT

1 Q. All right. So, now you've had an opportunity,
2 in preparing to testify today, to review all of
3 Mr. Mikell's medical records?

4 A. Yes.

5 Q. And you were present in the courtroom this
6 morning when Dr. Huggins testified and we went through
7 all of them?

8 A. Yes.

9 Q. So the various exhibits that were marked
10 through Dr. Huggins' testimony, and admitted into
11 evidence this morning, you are familiar with those?

12 A. Yes.

13 Q. All right. Have you also reviewed the records
14 from the home health care people that were coming to
15 Mr. Mikell's house after he got out of the hospital?

16 A. Yes.

17 Q. Okay. Now, what I want to ask you is were
18 there any changes to Mr. Mikell's medications after he
19 got out of the hospital that you think were important?

20 A. So before he went into the hospital, he was on
21 medicine to keep his heart beating regularly. And he
22 was on medicine to thin his blood, with notes saying
23 that he should be on lifelong anticoagulation because
24 some were -- are in his pre-hospitalization notes
25 afterwards. Those -- those drugs importantly were --

DR. KOFKE -- DIRECT

1 were dropped off, along with a couple of other drugs
2 that -- for his heart failure -- heart failure therapy.
3 So, yeah, there was a significant change in his
4 medication paradigm comparing after with before the
5 arrest.

6 Q. Okay. And we've had the -- Exhibits 39 and 40
7 have been admitted into evidence. Exhibit 39 is a July
8 27, 2010 office note from Mr. Mikell's visit with his
9 cardiologist. I think it's Dr. Van Bakel. And Exhibit
10 40 is a December 14, 2010 office note from a visit with
11 Dr. Van Bakel; have you reviewed those two?

12 A. Yes.

13 Q. Okay. So one is the last visit that he had
14 before the colonoscopy, and the other is the last visit
15 he had before his death; do you understand that?

16 A. Yes.

17 Q. Okay. So I want to put on the screen a
18 comparison of the medications that will show the
19 changes to the meds that he was taking, and ask you
20 if -- for the jury's benefit, you can -- well, that
21 wasn't the thing to do -- if you could go through this
22 and explain to the jury a little bit about what these
23 medication changes were, and the effect that they would
24 have had on Mr. Mikell's overall health.

25 A. So, the ones that are -- the ones that are

DR. KOFKE -- DIRECT

1 stopped are what I just crossed out -- I meant to
2 circle. The first is Fosinophril. So whenever you
3 have heart failure, if you have high blood pressure for
4 the heart to squeeze against, then the heart doesn't
5 beat so effectively. So Fosinophril is called an
6 unloading agent, and it unloads after blood reduces --
7 so whenever the weak heart squeezes, more blood goes
8 out. So that's a heart failure -- a heart failure
9 medicine that had been -- they hadn't -- hadn't been
10 resumed yet.

11 Bidil is a drug that was stopped, but it's
12 actually a combination of these two, so we won't
13 necessarily say that it was stopped, although I'm not
14 sure of the ratios of Hydralazine and Isosorbide.
15 Hydralazine is for high blood pressure, but it's also
16 similar to Fosinophril, good for heart failure. It
17 decreases the pressure that the heart has to squeeze
18 against.

19 Potassium Chloride is -- was stopped, but it was
20 probably being given as a -- as a -- to treat the side
21 effects of being on a water pill. So the water pill
22 had been stopped, and therefore the potassium stopped:

23 The Tikosyn is a drug that I'm not that familiar
24 with, but I looked it up. And it's an arrhythmia --
25 it's a pill for arrhythmia. Whenever the heart -- this

DR. KOFKE -- DIRECT

1 is the way the heart normally beats, you know, -- you
2 know, in a regular fashion. And if there's an
3 arrhythmia, it might go like this or it might go beat,
4 beat, beat, and stop, beat, beat, beat; or actually go
5 into ventricular fibrillation or something more
6 dangerous. So that's an anti-arrhythmic agent. I'm
7 not sure why it was held. Maybe it had something to do
8 with his kidney function, but it was held.

9 And then there's the Warfarin, which is the
10 blood thinner. Warfarin or Coumadin, you may have
11 heard of -- and that's for people who have heart
12 arrhythmias. Whenever the heart has arrhythmias, or if
13 there's heart failure, the heart beats weakly. Then
14 you'll have areas of spaces where the blood will -- the
15 blood, instead of going forward, might just kind of
16 hang around, and have these little eddies. And where
17 you have these little eddies, clots form.

18 And so if the heart isn't beating regularly or
19 if the heart is beating weakly, then blood thinners are
20 used as matter of -- a matter of course to prevent
21 major strokes.

22 And it's also -- it also has a secondary role in
23 people who are -- not -- not very active, or very
24 ambulatory, preventing clots from forming in the
25 legs -- in the legs which can -- can go to the lungs

DR. KOFKE -- DIRECT

1 and cause a pulmonary embolism. So those are the drugs
2 that were stopped.

3 The drugs that were started were Hydralazine and
4 Isosorbide -- are actually a continuation of the Bidil,
5 so we shouldn't count that a necessarily started.

6 Ativan was started for anxiety. And then this
7 Aranesp is a drug that is designed to stimulate the
8 bone marrow. I don't have that much experience with
9 it.

10 And one of the reasons with -- with that in that
11 category of drug is because they make patients prone to
12 clot, and clots are a bad thing in my field. You know,
13 and -- and -- and it can, you know -- if you look in
14 the side effects on the FDA -- that the FDA puts out
15 for drugs -- there are so many side effects, it's hard
16 to tell which ones are real and which ones aren't. But
17 it -- but what I looked up, it indicated a ten
18 percent -- a ten percent chance of death with it.

19 So -- so anyway, these were the changes in his
20 medications which occurred because he had had a cardiac
21 arrest on October 1st.

22 Q. Okay. Was he receiving any other
23 antiarrhythmic agent there on the list after they stop
24 the Tikosyn?

25 A. I -- I don't think so.

DR. KOFKE -- DIRECT

1 Q. All right. Was he receiving any other blood
2 thinner after they stopped the Warfarin?

3 A. Let me make sure about Aspirin. (Pause.)
4 They had him on Aspirin, a baby dose of aspirin which
5 would have had a little bit of an -- an little bit of
6 an anti-platelet effect, not an anti-clotting effect.

7 Q. And then does the Aranesp have any adverse
8 side effects on his heart?

9 A. Well, it is said -- I don't understand the
10 mechanism, so I'm -- I'm not eager to say that it does
11 or doesn't. It is written that it does. But if I
12 don't understand the mechanism, then I'm not sure what
13 to make of it.

14 But I -- I do understand about the coagulation
15 pre-disposition with it, and the sudden death business
16 with it. And it's probably from the direct heart
17 effect.

18 Q. Now, Ativan, is that a drug that might have an
19 effect on a patient's sleep apnea?

20 A. If it's -- well -- well, yeah. I mean it can
21 make them more sleepier, and more prone to -- you know,
22 to have -- to have these hypoxia episodes while in his
23 sleep and not -- not wake up like I said you do
24 normally.

25 Q. Okay. Now, Dr. Kofke, to your understanding,

DR. KOFKE -- DIRECT

1 did Mr. Mikell ever completely recover from the
2 critical illness that required him to be hospitalized?

3 A. He was impressively on the way to recovery,
4 but he wasn't there yet. And the notes that I read
5 indicate a lot of fatigue, you know, still sleeping up
6 -- sleeping with the head of the bed elevated, not
7 feeling right. And the week before he died, he had a
8 lot of coughing, which may indicate a worsening of the
9 heart failure. You know, so he -- he wasn't there yet.
10 And I didn't read anywhere that he was back to work and
11 driving buses.

12 Q. Did he ever return to the level of functioning
13 that he was at right before the colonoscopy?

14 A. I don't think so.

15 Q. So as a result of the hospitalization there at
16 MUSC and Kindred, can you say to a reasonable degree of
17 medical certainty whether or not the cardiac arrest and
18 the injuries, and the hospitalization, and the
19 treatment and the changes to his medications, most
20 probably caused his death?

21 A. I think that clearly --

22 MR. COOKE: Your Honor?

23 THE COURT: I'm sorry.

24 MR. COOKE: I just -- just have an objection to
25 the lack of foundation per our previous argument.

DR. KOFKE -- DIRECT

1 THE COURT: All right. The objection is
2 overruled. Thank you very much.

3 MR. COOKE: Thank you.

4 A. I think that the two events, his death in
5 early January and his cardiac arrest on October 1st,
6 are inextricably linked.

7 Q. Okay. All right. Inextricably linked, so let
8 me make sure that I ask though -- because, as lawyers
9 here in the courtroom, we have a certain formulation
10 that it is best for us to use --

11 MR. COOKE: Object to the leading question, Your
12 Honor.

13 THE COURT: Don't lead your witness, please,
14 sir.

15 BY MR. RANSOM:

16 Q. So, let me ask again, can you say to a
17 reasonable degree of medical certainty, that
18 Mr. Mikell's death was most probably caused by the
19 cardiac arrest on October 1st?

20 MR. COOKE: Objection. That's a leading
21 question.

22 THE COURT: No, sir. Overruled.

23 A. The two -- the phrase you used was "medical
24 certainty". I mean, to me, it's obvious. That's what
25 I want to say. It's obvious that they're linked. But

1 your language is to a medical certainty, it's -- that
2 it's --

3 Q. A reasonable degree --

4 A. To a reasonable degree of medical certainty
5 they are linked.

6 Q. Okay. So one caused the other?

7 A. Obviously --

8 MR. COOKE: Objection, Your Honor. That's a
9 leading question.

10 THE COURT: Don't lead the witness.

11 MR. RANSOM: Thank you, Dr. Kofke. Those are
12 the only questions I have for you right now.

13 THE COURT: Cross-examination.

14 MR. COOKE: Thank you, Your Honor.

15 **CROSS EXAMINATION BY MR. COOKE:**

16 Q. Good afternoon, Dr. Kofke. I have a few
17 questions to ask you about your opinions that you have
18 rendered here today. You work in an academic setting,
19 don't you?

20 A. Yes.

21 Q. In Pennsylvania?

22 A. Yes.

23 Q. And you are a neuro-anesthesiologist?

24 A. I call myself a neuro-anesthesiologist, but
25 all neuro-anesthesiologists are general -- general

1 anesthesiologists, too.

2 Q. Well, did you have special training -- we know
3 about having to go to college and go to medical school,
4 and then do -- maybe an internship or a residency to
5 become an anesthesiologist. Did you have additional
6 training that made you a neuro-radiologist (sic)?

7 A. During my -- I listed on my CV that I got the
8 exposure during my instructor year between residency
9 and fellowship. I focused on neuro-anesthesia. And
10 then, when I did my critical care fellowship when I was
11 in the OR -- I think it was two months -- I did
12 neuro-anesthesia. So that was the basis for it. There
13 is no formal fellowship program in neuro-anesthesiology
14 right now -- or back then.

15 Q. Is there a fellowship program for cardio
16 neurology?

17 A. That's --

18 Q. I'm sorry -- cardio anesthesiology?

19 A. Yes.

20 Q. And did you ever take that?

21 A. No.

22 Q. Have you had any special training in cardio
23 anesthesiology beyond your training as an
24 anesthesiologist?

25 A. No.

1 Q. Do you know Dr. Nelson?

2 A. No.

3 Q. Have you ever heard of him?

4 A. No, not -- not before this.

5 Q. Okay. Do you know that he did do a fellowship
6 in cardio anesthesiology?

7 A. Cardiac anesthesia, yes.

8 Q. And what would that entail?

9 A. Depending on when you -- if it was before or
10 after the rules -- you know, there's an accreditation
11 program, so I don't remember if he was. But it
12 typically is a year of working in the OR with patients
13 undergoing cardiac surgery.

14 Q. So your -- your work, as I understand from
15 going back to your deposition, that 80 percent of your
16 operating room work is neuro anesthesia, then the rest
17 of it is pretty much interventional radiology; is that
18 still true?

19 A. Yes. Yes. And -- and, you know, we don't
20 have a specialty call team. So if the day ends early,
21 I might get assigned to GI, or there might be a GI I
22 might help out.

23 Q. Are -- are there anesthesiologists in your
24 department that are called upon when there is a
25 particular cardiac issue with a patient, either because

1 it's heart surgery or because that patient is known to
2 have impaired cardiac function?

3 A. We only get a cardiac consult whenever there's
4 cardiac bypasses, or if there's general heart disease.
5 So every anesthesiologist is expected to be able to
6 take care of patients who have heart disease.

7 Q. Do you know anesthesiologists in your hospital
8 who did do fellowships in cardio anesthesiology?

9 A. Yes.

10 Q. So what do they do in your hospital?

11 A. They do anesthesia for cardiac surgery and
12 lung transplant.

13 Q. Well, why do they do it instead of you doing
14 it?

15 A. Because they did a fellowship in it and they
16 like doing it. I -- I could never do that.

17 Q. And because they have special training in it?

18 A. Yes.

19 Q. And what about in your -- in your endoscopy
20 section, have you heard the testimony about the type of
21 room that this procedure was done in for Mr. Mikell?

22 A. Well, I'm not sure that I've heard the
23 testimony, but it's clear it was not an OR anesthesia
24 room, a GI -- a GI endoscopy suite.

25 Q. So do you know that it differed from regular

1 GI suites in that it was staffed -- fully staffed with
2 anesthesia as an operating room would be?

3 A. I don't know what -- I don't know the
4 difference. I just know that there was an
5 anesthesiologist and a nurse, but I don't know if it's
6 different -- higher -- you know, I can't comment on
7 that.

8 Q. Okay. Did your hospital not have special
9 suites for people who need a full anesthesiology
10 attending in a -- in a colonoscopy procedure?

11 A. Yeah, sure. It's a very busy service.

12 Q. But are all your rooms the same? In other
13 words, if I went in -- if a healthy person went in for
14 a colonoscopy in your hospital, would he go to the same
15 room, the same type of room that somebody like
16 Mr. Mikell did?

17 A. Yeah, pretty much. You know, they're --
18 they're all equipped for anesthesia and -- and GI
19 procedures for above or below.

20 Q. Okay. And they all have the board certified
21 cardio anesthesiologist and the CRNA?

22 A. No.

23 Q. In fact, most of your work is done with
24 residents rather than CRNAs, isn't it?

25 A. Mostly, that's right.

1 Q. Would you agree with me that it might be an
2 advantage if you were going to render opinions about
3 cardiac complications and anesthesiology, if you had
4 had a fellowship in cardiac anesthesiology?

5 A. No. That teaches you how to take care of
6 patients who are undergoing heart surgery. Every
7 anesthesiologist can take care of patients with heart
8 disease.

9 Q. So that that fellowship really doesn't make
10 much difference then?

11 A. Not for this sort of thing.

12 Q. You -- this is not the first time you've
13 testified as an expert witness, is it?

14 A. That's correct. It's not.

15 Q. And it's not -- in fact, it's not the first
16 time you've testified as an expert witness for Mr.
17 Ransom?

18 A. Correct.

19 Q. You've testified for him on how many
20 occasions?

21 A. I think this is the first trial, but there's
22 been depositions -- depositions, you know, a handful of
23 depositions over the years.

24 Q. And about how many cases a year do you review
25 for attorneys in general?

1 A. You know, there's -- there's various types of
2 review. They send me a record, and I say, you don't --
3 you don't have a case. Forget it. That's two hours of
4 time. Or another -- I'll get another kind of review,
5 which then grows into something like this one has,
6 where it gets more involved. So taking all kinds,
7 maybe 20 a year.

8 Q. Maybe 20 a year?

9 A. Yeah, taking all kinds.

10 Q. And you charge, according to your deposition,
11 \$500 an hour?

12 A. Yes.

13 Q. From when you leave to when you get home?

14 A. Yes.

15 Q. How many hours have you spent working on this
16 case?

17 A. I -- I haven't added it up, maybe 40, 50 maybe
18 over -- since 2010.

19 Q. All right. So going back to the practice that
20 you're familiar with, is it true that less than 10
21 percent of your time you're working with a CRNA?

22 A. Yes. Yes.

23 Q. And CRNAs have more experience than residents;
24 correct?

25 A. Yes. Yes.

1 Q. But you, being in a teaching hospital, you're
2 normally working with residents, and you're trying to
3 teach them sort of on the job training for them, is
4 that right?

5 A. Yes.

6 Q. Do you agree that you can trust a CRNA more in
7 terms of being able to be a little bit further away or
8 to do other things while they are managing the case?

9 A. Yes. Yes, I do.

10 Q. In your practice, if you had CRNAs under you,
11 you would be able to supervise up to four at one time;
12 correct?

13 A. Yes, that's a lot in my hospital.

14 Q. Do you know how many Dr. Nelson was
15 supervising the day that he was taking care of
16 Mr. Mikell?

17 A. I seem to recall one other, but I'm not sure.

18 Q. So that would be a pretty good attending to
19 CRNA ratio, wouldn't it?

20 A. Yes, yes.

21 Q. It would be about twice as good as four to
22 one, wouldn't it?

23 A. It would be better than four to one. Now, if
24 you want to say -- yeah, yes.

25 Q. So almost by definition, if you're supervising

1 four CRNAs, you are going to be in each room an average
2 of a quarter of the time; right?

3 A. I would -- I would think so, yeah.

4 Q. Because you would be circulating among those
5 rooms?

6 A. Yes.

7 Q. So if you had only two CRNAs going at a time,
8 you would be splitting the time between those two;
9 correct?

10 A. Right.

11 Q. And that's better; right?

12 A. Right. You should be more available.

13 Q. I believe you testified that you -- in general
14 terms, you think that the attending should be two
15 minutes away from the -- the operating room?

16 A. Those are the general standards for
17 availability that -- that people have promulgated, and
18 it's entirely empiric, the numbers. And I don't think
19 they're based on science.

20 Q. Right. And as I recall, you couldn't cite any
21 particular standard or regulation about that, that's
22 just the way you've always done it; right?

23 A. That's the way I've always been told to do it
24 by my chairs and administrators who are worried about
25 liability.

1 Q. So being directly across the hall from -- from
2 the room would be acceptable generally?

3 A. Oh, oh, yes.

4 Q. For the doctor. We've heard -- you showed
5 some diagrams of what sleep apnea looks like, and what
6 a patient looks like when he's laying down. And
7 that -- that patient would have been in a supine
8 position, correct? The laying on your back?

9 A. In those diagrams, yes.

10 Q. Okay. So that doesn't actually represent what
11 a patient having a colonoscopy would be doing, does it?

12 A. Correct. It's -- a patient in for a
13 colonoscopy is typically on his side, and curled up a
14 little bit.

15 Q. And is it generally believed that that
16 position is less likely to obstruct from something like
17 sleep apnea?

18 A. Yes.

19 Q. But your drawing doesn't show that affect,
20 does it?

21 A. No.

22 Q. And you don't contend that Mr. Mikell should
23 have been intubated for this procedure, do you?

24 A. No.

25 Q. And why is that?

1 A. You know, I think a little sedation was all he
2 needed. And the plan that they laid out is probably
3 something similar to what I would have done, what they
4 laid out.

5 Q. And there are -- are actually risks associated
6 with intubating a patient; right?

7 A. Right. There's risks to intubating, and risks
8 to not intubating, and it's a balancing act. It's a
9 judgment on the part of anesthesiologist.

10 Q. Are you aware of any testimony that -- that
11 Mr. Mikell was actually given a choice, possibly to be
12 intubated if he preferred?

13 A. I think he was told that it might happen, but
14 I don't remember if he was -- if he was given a
15 specific choice in his preop discussion.

16 Q. And it would be true, wouldn't it, that there
17 is a risk if you -- if you intubate a patient, that you
18 might wind up having to take him to the ICU to get them
19 extubated?

20 A. Right. That was, I think, in Dr. Nelson's
21 deposition, that one of the reasons he didn't want to
22 intubate him, was he worried about taking it out at the
23 end of the case, which underscores his concern about
24 the patient's fragility.

25 Q. Now, who designed the anesthesia plan for

1 Mr. Mikell?

2 A. I think it was Dr. Nelson, but I'm sure that
3 he did it -- at least I do it with consultation with
4 the CRNA. You know, what do think -- you know, have
5 a -- a little discussion.

6 Q. Let's walk through that plan, because I
7 believe you've covered it in your direct testimony.
8 But you kind of went through it fast and used some big
9 words. What did they do to try to mitigate or lessen
10 the risks of complications for Mr. Mikell?

11 A. So -- so what they know is that he's got heart
12 failure and that he's got sleep apnea, both of which
13 may be sensitive to high doses of anesthesia. So they
14 decided, well, then let's -- instead of giving him just
15 a syringe full of Propofol, let's just start him on an
16 infusion and watch him and -- and watch him.

17 And with an infusion, you get a gradual -- a
18 gradual increase in the blood level. Eventually,
19 you're going to get to the fully anesthesia level that
20 you would get with that -- with that big slug. But
21 before you get to that full anesthesia level, you'll
22 have had time to see him stop breathing, or obstruct
23 his airway, or a drop in his blood pressure. And then
24 you can adjust the Propofol dose to react to the
25 patient in front of you, rather than giving -- just

1 giving some dose. So it was a good plan.

2 Q. It was a good plan?

3 A. Yes.

4 Q. That's what I was getting around to, you agree
5 with me that it was a good plan?

6 A. Yes.

7 Q. Even considering all of the -- or especially
8 considering all of the complications, potential
9 complications -- complicating factors that Mr. Mikell
10 had?

11 A. Yes.

12 Q. And you have no criticism of the preanesthesia
13 evaluation that he was given?

14 A. No.

15 Q. And you don't contend that he was not a
16 candidate for a colonoscopy?

17 A. No, I -- I wouldn't, no.

18 Q. He was -- he was what they call an ASA 3 risk;
19 is that right?

20 A. Yes.

21 Q. What does that mean?

22 A. So there's four categories of ASA risk. One
23 is you're totally healthy. Two is you have a systemic
24 illness, but it hasn't disabled you. Three, you have a
25 systemic -- that is an illness over your whole body,

1 and it has disabled you. And four is you have a
2 systemic illness and you're bedridden from it. That's
3 my poor man's way of explaining it.

4 Q. And he qualified as an ASA 3?

5 A. Yes.

6 Q. And -- but -- but your -- but your sort of
7 litmus test is if he's able to conduct normal
8 activities, walk around and so forth, then it's okay to
9 do a colonoscopy?

10 A. I don't know about a litmus test, but it's a
11 factor, yes.

12 Q. Just to review the risk factors that
13 Mr. Mikell had in this particular case were congestive
14 heart failure; is that one?

15 A. Yes.

16 Q. What is that?

17 A. It's where the heart beats weakly. It beats
18 weakly, and you're prone to getting fluid built --
19 built up in the lungs and you have poor exercise
20 tolerance.

21 Q. Okay. And is that reflected in his reduced
22 ejection fraction?

23 A. Yeah.

24 Q. Is that the test that you referred to?

25 A. Yes. It was mildly reduced.

1 Q. Mildly reduced before this colonoscopy?

2 A. Yes.

3 Q. And he had obstructed sleep apnea, you talked
4 about that. He had hypertension?

5 A. Yeah, he was treated with fluid reducing
6 agents. It was -- it was controlled.

7 Q. Arrhythmia?

8 A. Yes.

9 Q. Insulin dependent diabetes?

10 A. Yes.

11 Q. Why is that a problem?

12 A. Well, it's -- it's a risk factor. You know,
13 it's associated with problems like neuropathy, coronary
14 disease, strokes, predeposition to having clots; clots
15 here and there, and the narrowing of the arteries and a
16 hardening of the arteries. And also it's a risk factor
17 for managing the blood sugar. So you're on a daily
18 diet and everything's fine, and then suddenly you stop
19 it, and you undergo anesthesia. It's -- the blood
20 sugar needs to be monitored carefully to not get too
21 high or not get too low.

22 Q. He had an enlarged heart?

23 A. Yes. That's part of the heart failure.

24 Q. Why is that bad? To have an enlarged heart,
25 why is that bad?

1 A. So the -- the problem with that as it is
2 related to the heart failure is that the -- as I say,
3 whenever the heart isn't -- isn't beating normally, and
4 it's enlarged like that, it will have areas within the
5 heart which aren't moving -- moving with the flow
6 so-to-speak, and sort of have stagnant areas. And you
7 can be prone to develop a clot, which then can cause a
8 stroke. So that's one of the main reasons that that's
9 an issue. And, also, if it's really bad, you can be
10 prone to an -- prone to an arrhythmia related to an
11 enlarged heart and the heart failure.

12 Q. And he was obese?

13 A. Yes.

14 Q. How much did he weigh?

15 A. Three hundred pounds is what I seem to recall,
16 but I'm sure that that varied.

17 Q. Do you know how tall he was?

18 A. I don't remember, five -- 5'6" or eight -- or
19 something. I'm not sure. Not real tall.

20 Q. Do you -- is there a way in medicine that you
21 characterize the level of obesity in a patient?

22 A. It's a body mass index, but I don't -- I don't
23 remember seeing it on the chart.

24 Q. Had he had an ablation procedure done on his
25 heart?

1 A. Right. That would be for the atrial -- I
2 think it was atrial arrhythmia beforehand.

3 Q. What do we mean when we say risk in medicine?
4 Have you ever seen a medical procedure where you could
5 reduce the risk to zero?

6 A. That's a great question. A great issue
7 actually is defining -- risk is -- is a very subjective
8 thing. You may want to look up papers or people who
9 have looked at the risk of this problem after --
10 associated with such and such procedure or condition,
11 but still fundamentally it comes down to the patient in
12 front of you, who may not -- may not be exactly the
13 same at the population that was in that paper.

14 So risk is a very subjective -- all I can tell
15 you is that it's subjective entity. And it's -- you
16 know, kind of like what Justice Potter said, you kind
17 of know it when you see it if it's high risk. It's a
18 joke between me and you.

19 Q. Right. But that had to do with pornography;
20 right?

21 A. Yes. You know it when you see it.

22 Q. You would agree with me that when the patient
23 has risk factors, those are risk factors even when the
24 doctors and the nurses are being as careful as they
25 could possibly be; right?

1 A. I absolutely agree with that. Sometimes bad
2 things happen even though everything is done right.

3 Q. Not to be -- not to be trite, but you turn on
4 the news at night and the weather report comes on, and
5 he says 30 percent chance of rain. Then it's rain the
6 next day and you get mad at the weather man, right,
7 because he said 30 percent chance, but it rained. So
8 for you, it's a 100 percent chance.

9 Well, it's even worse in the medical field,
10 isn't it, Doctor, because if you -- if you sit down --
11 your patient down and you say, you know, I want you to
12 have the procedure, but you have a three to four
13 percent chance of having a cardiac arrest or dying even
14 during this procedure. Now, to most of us, that seems
15 like a pretty small chance. But to the one that's in
16 that three or four percent, that's a pretty bad
17 outcome, isn't it?

18 A. Yes. That's also a framing error. You can
19 say have a 96 percent chance of getting -- of not
20 having a problem, or four percent chance of having one.
21 And people react to that differently.

22 Q. Right.

23 A. But, yeah, that's a -- that's what we have to
24 deal with. I'm always reluctant to assign discrete
25 numbers like that. I prefer the fuzzy low, medium,

1 high, you know, whenever I talk to families.

2 Q. Well, that's fair enough. So -- so that's --
3 that's a little consolation to the family or the doctor
4 whose patient happened to be in that three or four
5 percent that was going to have a bad outcome no matter
6 how careful he or she was?

7 A. Right. It's very -- it's very difficult to
8 deal with.

9 Q. It's happened to you?

10 A. Yeah.

11 Q. I'm going to talk about the records that we've
12 looked at. I'm going to show you a couple on the board
13 here. But you agree with me, don't you, that it would
14 be unfair to -- to assume that all the times that are
15 written on any chart are exactly right?

16 A. I think, in general, there is -- you know,
17 there's some truth to that except for times which
18 are -- in the past, that's certainly been true whenever
19 we did paper. Now that we have electronics, one would
20 think that we wouldn't have an issue. But then you get
21 into clocks being synced, you know which clock is on,
22 which there can sometimes be issues even with
23 electronics. But it's going to get better. We are
24 just getting better and better with that, so it's
25 getting less and less.

1 Q. And, I mean, let's just start with the basics.
2 And if a human being is entering something on a time
3 sheet, my watch might be five minutes off that watch,
4 which it happens to be, by the way.

5 A. Right. That was the point I was making,
6 right.

7 Q. And, also, if you're busy taking care of a
8 patient, you don't always have time to write things
9 down right then, do you?

10 A. Correct. Correct.

11 Q. And so a lot of times you have to go back
12 after the case is over, after the emergency has
13 subsided and you have a break, and you go back and fill
14 in parts of the record that you weren't able to fill in
15 before; right?

16 A. Yes, I've done that.

17 Q. And oftentimes you have to remember what time
18 something happened, or what specifically happened at a
19 particular time?

20 A. Right, and you -- you do your best.

21 Q. And do you know -- do you know doctors and
22 nurses that sometimes even carry little scraps of paper
23 around with them, or write things on their hands so
24 that they'll remember it?

25 A. Right. Yes, yes.

1 Q. So that's not -- that's not subversive, is it,
2 when a nurse at the end of the day goes back and looks
3 at the chart and fills in things that were missing or
4 fixes times that were wrong? That's what she's
5 supposed to do; isn't it?

6 A. I agree with that, yes.

7 Q. I want to -- I'm going -- can we fire this
8 thing up here -- I'm going to start with -- that's
9 good. I'm going to leave that right there. This chart
10 that's above you, is that -- is that a smaller version
11 of what I'm holding right here?

12 A. Yeah, yeah.

13 Q. It should be on your screen.

14 A. Yeah, yeah.

15 Q. Now --

16 A. Yeah, that's the same -- that's the same
17 record.

18 Q. I'm going to pick a little bone with you if I
19 can.

20 A. Uh-huh.

21 Q. The whole time that you were responding to Mr.
22 Ransom's questions, you were looking down here at the
23 part of the chart; right?

24 A. Yes.

25 Q. And I notice that you weren't really paying

DR. KOFKE -- CROSS

1 attention to what's up here at the top of the chart.

2 A. Uh-huh.

3 Q. And what do you call this part down here?

4 A. It says "real time data graph". It's what
5 they -- is what that record calls it.

6 Q. All right. How many depositions did you read
7 of the health care providers at the Medical University?

8 A. Two from the CNRA, one from -- I don't know,
9 eight maybe.

10 Q. Okay. Did you read the deposition of Dr.
11 Reeves, who's the chairman of the Anesthesiology
12 Department?

13 A. No, I think that was recent.

14 Q. Okay. Did you read the deposition Dr. Nelson?

15 A. Yes.

16 Q. Did you read the deposition of Mr. Fisher, who
17 is the IT specialist from the hospital?

18 A. I don't remember that.

19 Q. Were you told anything about what he said?

20 A. No.

21 Q. What about Ms. Thompson, who is the one who is
22 trying to help get the machine on line?

23 A. She had an affidavit, I think. That's all I
24 read.

25 Q. Are you telling me that -- are you telling me

1 that you were unaware that every single person who
2 testified about this record, said that the times are
3 not right on this real time graph down here?

4 A. It was -- I didn't need people to tell me that
5 because the testimonies were discrepant that I read,
6 and some of the records are even different from each
7 other. There's a cue one minute record and a cue 15
8 minute record. And there's a record that -- like this
9 that goes all the way out, and there's little
10 discrepancies in them. So that's why -- earlier I said
11 I focused on three times that I think are true, and one
12 is the time that the scope was put in, and those two
13 times that those texts went out.

14 Q. And --

15 A. And the other stuff is just -- is just in
16 relation to those times.

17 Q. Okay. Now, you used a lot of terminology, you
18 said -- you know, when you say cue, I know what you
19 mean --

20 A. Oh, sorry.

21 Q. -- but I think a lot of people may not.

22 A. Sorry. Yeah, cue means every -- so there's a
23 record which is every one minute; and there's records
24 that are 15 minutes just for the anesthesia part. And
25 then there's this record, which goes from the

DR. KOFKE -- CROSS

1 anesthesia part to the PACU, and they don't all agree
2 with each other. Could you move that so we can see the
3 left -- the left.

4 Q. There we go. So this one would be the cue 15
5 minute one; right?

6 A. Yes.

7 Q. And the reason we know that is because across
8 the top there are time intervals that are 15 minutes.
9 Okay. Now, have you heard any testimony or read any
10 testimony or been told of testimony by every single
11 person at the Medical University, from the IT
12 Department all the way down to the chairman of the
13 department, to the people who are at --

14 A. I'd say up to the chairman of the department.

15 Q. Up to the chairman -- they may not agree that
16 these -- that these are the entries that you have to
17 look at if you're trying to correlate with time, and
18 not this chart down here?

19 A. That may be.

20 Q. Have you heard that?

21 A. I don't recall that. I mean, I already
22 concluded that myself, that none of the times are --
23 are anything I'd hang a lawsuit on.

24 Q. Well, you've hung a lawsuit on this chart
25 right here because that's exactly what you were showing

1 Mr. Ransom when you were describing when this cardiac
2 arrest took place, and when people were in the room and
3 when people were not in the room; correct?

4 A. I think what I said was that related to the
5 times that are true. I had a sense that that drop --
6 that there was a significant drop in sats, and that
7 that was usually following or associated with the
8 cardiac arrest. I have trouble telling you the exact
9 times, I agree despite -- notwithstanding all the
10 high-tech electronics.

11 Q. You said something very quickly that I want to
12 focus on for a few minutes. You said there was a cue
13 15 minute chart and a cue one minute chart?

14 A. Yes.

15 Q. And you were given both of those, weren't you,
16 Doctor?

17 A. Recently, yes.

18 Q. All right. Mr. Ransom did not give you the
19 one minute chart last year when you gave your
20 testimony?

21 A. No.

22 Q. You have not seen that until recently?

23 A. Correct.

24 Q. Okay. I'm going to show it to you. Were
25 you -- were you told that this was provided to Mr.

1 Ransom in 2013?

2 A. No.

3 Q. Let me ask you to look at this chart and tell
4 me if that appears to be the one minute chart?

5 A. This whole thing -- yep -- yes.

6 Q. All right.

7 MR. COOKE: I'd like to mark that for
8 identification at this time.

9 (WHEREUPON, Defendant's Exhibit No. 6 was marked
10 for identification.)

11 BY MR. COOKE:

12 Q. I'm going to give that to you so you can refer
13 to it. I'm going to put some pages up to look at. Do
14 you have a page there that shows the administration of
15 Propofol?

16 A. You don't have the page number, do you?
17 Propofol, there's a 75 indicated at 7:41.

18 Q. Okay. I'm looking at a page at the bottom, it
19 says "MUSC 2118"; do you have that?

20 A. Yes. That's what I'm looking at.

21 Q. Okay. So -- so you see the Propofol line
22 right down there. It's at the bottom section, right
23 into the -- is that the --

24 A. Right there.

25 Q. And that indicates what?

1 A. That's mites per kilogram per minute. So 75
2 is -- is sort of an ordinary anesthesia inducing dose,
3 but it's an infusion. So it's given by a drip and it
4 says 7:41.

5 Q. All right. And that was administered at 7:41?

6 A. No, I don't think so.

7 Q. When do you think it was administered?

8 A. Sometime before then because the scope went in
9 at 7:42. And I just know from years of experience that
10 30 seconds or 60 seconds of 75 mites per kilo per
11 minute, it hasn't even gotten up the arm yet. You
12 know, so that -- this record is wrong.

13 Q. All right. Do you know when the Propofol was
14 stopped?

15 A. I think it continued right on through the
16 PACU, but that's just based on my memory. So you can
17 see they decreased it just like I said would be the
18 appropriate thing to do.

19 Q. Okay. And what do you base your belief that
20 they continued it through?

21 A. I'm pretty sure that it's written somewhere
22 that it continued into the PACU. It looks like they
23 stopped it during the code, but I think -- maybe I'm
24 just remembering it wrong. See -- I see little marks
25 for Propofol.

DR. KOFKE -- CROSS

1 Q. Well, let me put --

2 A. Oh, yeah, I see it again at nine fifteen.

3 It's back on.

4 Q. How about at 7:53?

5 A. Well, on 7:53 here, it looks -- I assume that
6 that little mark means off.

7 Q. You do?

8 A. I don't know that, but I assume that little --
9 that little asterisk, followed by a carat, c-a-r-a-t.

10 Q. The one that I've got your circle around?

11 A. Yeah. Yeah.

12 Q. Okay. So the proper answer to my question
13 then would have been that it was turned off at 7:53?

14 A. Well, no. I think the times are wrong in this
15 record. They have to be. Because the start time at
16 7:41 can't be right. This -- this record is probably
17 offset. But, then again, none of their records agree
18 with each other, even though they're electronic.

19 Q. So you think all the -- all the times on all
20 the records are wrong?

21 A. Well, I -- I just don't know. I don't know
22 which one -- one of them is right. Maybe it's this
23 one.

24 Q. Yeah --

25 A. Except -- except that I discount this one.

1 because a minute -- a 30 second to 60 seconds of
2 Propofol infusion is not going to be enough to start a
3 colonoscopy at 7:42.

4 Q. All right. Is there any basis to believe that
5 the Propofol was not turned off at 7:53?

6 A. No. I just -- I just don't believe the times
7 on this record.

8 Q. And if you go on to the -- to the next page,
9 you see that little carat mark?

10 A. Yes. That one?

11 Q. Yeah, that one.

12 A. Yeah, and it continues.

13 Q. And that one, and that one, and that one, and
14 that one, and that one -- all the way through on this
15 page, to at least to 8:13?

16 A. Right. So I -- so I conclude from this that
17 at some point during this whole event, Propofol was
18 turned off. I'm just not going to agree with you on
19 the exact times.

20 Q. Because it might or might not have been 7:53,
21 which is what the chart shows?

22 A. Right. It might have been 8:00, or it might
23 have been -- it might have been sooner. I'm not sure.

24 Q. Do you know when Dr. Nelson was in the room?

25 A. I don't remember the exact times, but there

DR. KOFKE -- CROSS

1 was a notation that he was in, then out, then he.
2 wrote -- he wrote something on her log in about the --
3 the need for Mayday or the help or something. And
4 he -- he -- he's the one who had to have indicated the
5 station -- he was present for induction, so that's two
6 or three times that he was -- that I expect he was
7 in --

8 Q. Okay.

9 A. -- oh, you've got the answer. Oh, that's 10
10 --

11 Q. That's October 1st.

12 A. Oh, okay. Yes.

13 Q. At 7:48, do you have any reason to -- to doubt
14 the accuracy of that record?

15 A. I don't trust -- I just don't know what to
16 make of the -- any of the times. And I think that
17 this 7:48 may have been edited. I'm not sure after the
18 fact. Because as we agreed, we try to make things
19 accurate. So it -- it may have been -- none of this is
20 evidence that he was in -- he was in at some time
21 during the -- during the event.

22 Q. Well, doctor, what do you rely on if you don't
23 rely on the medical records?

24 A. Good question.

25 Q. It's--

1 A. It's a sad state that I can't be confident in
2 times on this record.

3 Q. Well, you could say that about a handwritten
4 record, couldn't you?

5 A. Yeah. Yeah.

6 Q. And 15 years ago --

7 A. And this is supposed to have fixed that.

8 Q. Fifteen years ago, we would be looking at a
9 handwritten record, and you could be saying the exact
10 same thing. Well, a human being put that number in,
11 and I don't know if that number is true or not.

12 A. And, typically, those numbers were illegible.

13 Q. Right. All right. So this one, at least
14 we've got something that has been entered into the
15 computer, and you know that there's an audit trail,
16 right? So we can go find out exactly who put that
17 number in and when that number was put in; right?

18 A. Yes. Yes.

19 Q. And you just testified a few minutes ago that
20 there's nothing wrong whatsoever with somebody sitting
21 down at the end of the case, and going back and putting
22 in times and entries?

23 A. Right. Right. That's not my -- my point is
24 that that specific time may or may not be true. But
25 sometime during this event, I'm confident that it went

1 in.

2 Q. Okay.

3 A. But maybe not 7:48, maybe 7:55, or 7:43, or 7
4 -- I don't know.

5 Q. So this one, it says "Nelson memo, Nelson MDA
6 in, nasal airway in, O2 stat, up to 94 percent, patient
7 remains lateral". And at the same time, it says
8 "anesthesiologist assessed patient, reviewed chart, and
9 formulated anesthesia plan". And then it said at 7:48,
10 "anesthesiologist present induction". Then at 7:51
11 memo, "Nelson out".

12 A. Yes.

13 Q. Now, didn't you say a little while ago that --
14 that exactly what you would expect for the attending
15 anesthesiologist to do would be to be in the room, and
16 that when the sats are up to an acceptable level in the
17 90s, that it's okay for him to leave the room and rely
18 on the CRNA to monitor the patient and to call him if
19 he's needed?

20 A. As a general concept, yes. But in this case,
21 the sats have been running in the 80s for most of the
22 record. And, you know, that sat of 94 isn't -- isn't
23 reflected in any of the -- any of the electronic
24 records. That's a memo. And I don't -- I don't
25 disbelieve that it happened, but it must have been very

1 brief.

2 Q. Well, here is a record -- do you remember
3 seeing this one? Do you know what that top row is?

4 A. So that's the vital signs -- oh, it says
5 anesthesia PACU record, but right now we're on the
6 anesthesia part, yes.

7 Q. Okay. And what does that one, that SPO2
8 percentage, what does that mean?

9 A. That's the -- the level of oxygenation in the
10 blood based on the pulse.

11 Q. Okay. So that's what we're referring to as
12 the oxygenation?

13 A. Yes.

14 Q. Saturation. And then you get over here -- and
15 notice that there are no numbers until you get to what
16 time?

17 A. 7:48.

18 Q. Okay. And what's the first number that's
19 there?

20 A. Ninety six point seven.

21 Q. Okay. So does that, in any way, compare with
22 the note that says that the sats were up to 94 percent?

23 A. Right. That -- that agrees with that. I just
24 don't understand why it isn't on the lower -- on the
25 lower chart, which has the graphical second to second

1 outlook.

2 Q. All right. Well, do you know -- do you know
3 who puts those numbers in? The numbers that we're
4 looking at right there, do you know -- do you know who
5 puts those numbers on the chart?

6 A. I think that they -- they -- they go from the
7 physiological monitor straight over to the -- to the
8 PICIS, to the anesthesia record.

9 Q. Right. You know that, don't you, Doctor, that
10 there's no human that's sitting down, going by memory
11 on those numbers, that those numbers are automatically
12 populated to that chart by the machine itself?

13 A. Right. Right.

14 Q. Okay. And timestamped to the minute?

15 A. Yes.

16 Q. And you know -- you see also that the reason
17 that those numbers weren't in there before 7:48 was
18 why?

19 A. There was issues with the PICIS -- the
20 PICIS -- PICIS -- PICIS -- not PACIS -- PICIS --

21 Q. We're all going to say PICIS.

22 A. The PICIS anesthesia record communicating with
23 the physiological monitors.

24 Q. Right. And your testimony was that it was a
25 great distraction to the nurse anesthetist to be

1 texting while all this chaos is going on; right?

2 A. Yes.

3 Q. Okay. But what you testified to is that the
4 one thing that you know for sure is that she texted at
5 7:39 and at 7:46?

6 A. Yes.

7 Q. Correct. And that the machine was fixed by
8 7:48?

9 A. That -- if you're going by that, I'm not sure.
10 But the machine did get fixed.

11 Q. Well --

12 A. I'm telling you, these numbers are goofy.

13 Q. Well, tell me what you want to go by and tell
14 me what other numbers you want to go by. You are
15 accusing these people of medical malpractice, Doctor,
16 based on this record. And I want you to tell me what
17 other evidence you have that says that those are goofy
18 numbers?

19 A. Well, let's start out by comparing the cue --
20 the real time data graph for the cue 15 minute and the
21 cue one record, and you'll see that the 47 percent sat
22 with the cue one record has it at 7:34 -- 7:34 or so.
23 And the cue 15 record has it occurring at 7:48. So
24 what accounts for difference? You know, how am I
25 supposed to trust this stuff?

DR. KOFKE -- CROSS

1 Q. Are you talking about that graph?

2 A. That one says 7:35. And the other record
3 right there has 7:48.

4 Q. All right.

5 A. Why is that?

6 Q. Let me ask you --

7 A. I guess you're supposed to ask the questions,
8 but I can't answer that.

9 Q. Well, if you read any of those depositions you
10 would know the answer to that. You would know the
11 answer to that if you had read those depositions.

12 A. I don't think so. I think that the records
13 are -- are not agreeing with each other, and that this
14 is an electronic record, and it's -- I just don't
15 understand why they don't agree.

16 Q. All right. Are you aware of any evidence
17 whatsoever from any witness, from any document, from
18 anywhere else that these numbers aren't correct and
19 that the times aren't; correct?

20 A. I don't dispute the numbers themselves. They
21 probably did occur. But maybe that 96.7 was at 7:32
22 when he rolled in the room, and that was at normal --
23 he was still awake.

24 Q. All right. But what -- but what we have --
25 what we have is by your own testimony, the one thing

1 that you're pretty sure about is that -- back here
2 at -- what was it -- 7:39, there was a text to IT. And
3 you said that this is a problem because the nurse
4 anesthetist was -- was -- Donna Embrey in there by
5 herself, and she couldn't be taking her emergency
6 measures to take care of this patient when he was
7 desaturating. But we don't have any evidence that he
8 was desaturating here unless you go back and look at
9 your graphic chart down here that -- that everybody in
10 the world acknowledges is not correct?

11 A. But it's an electronic record, which -- I
12 don't understand why.

13 Q. Well, because you didn't read the depositions,
14 so that's why.

15 A. Oh.

16 Q. All right. And then we know that at 7:46,
17 there was the last text to the IT Person saying please
18 call me; right?

19 A. Yes.

20 Q. And then we know that, oh, look, at 7:48,
21 everybody start populating, and it's completely
22 populated from then on. And we know, based on this,
23 that at 7:48, Dr. Nelson was in the room; the nasal
24 airway was placed, and an O2 sat up to 94 percent;
25 patient remains lateral -- that's on his side; right?

DR. KOFKE -- CROSS

1 A. Yes.

2 Q. Anesthesiologist assessed the patient,
3 reviewed the chart, and formulated an anesthesia plan.
4 Anesthesiologist present for induction. And then at
5 7:51, Dr. Nelson out. So if that number is right, if
6 that sat was up to 94 percent or 90 percent or 92
7 percent or 98 percent, then it was okay, wasn't it, for
8 Dr. Nelson to leave and to rely on the CRNA to monitor
9 that patient and call him where he could be there
10 within minutes?

11 A. It -- it -- it depends on his understanding of
12 the previous sats being in the 80s, and how distracted
13 she was by the record issues. But, yeah.

14 Q. Right.

15 A. Yeah.

16 Q. All right.. Let me just ask you this: Other
17 than -- other than this graphic chart down here, do
18 have you -- have you seen any record that showed that
19 he had sats in the 80s back before 7:48?

20 A. This one here, the cue 15 minute chart.

21 Q. Which one?

22 A. That one I'm pointing at. That has the sats
23 dropping at 7:48.

24 Q. You're looking at that again; right?

25 A. Yeah.

1 Q. I said, other than this graph down here --

2 A. But this one is on a different time scale now.
3 Don't you see how they're offset?

4 Q. I said, other than the graph, this shows --

5 A. Oh, well, then if you -- you go up above, the
6 very first sat that's on this record is 47.

7 Q. This -- this one -- this one shows this
8 data -- this data was being populated by the computer;
9 right? Right?

10 A. Yeah. Yeah, but it was -- I actually don't
11 know how this real time data graph is showing, and yet
12 the -- the real time variables are off time. But
13 nonetheless, they -- there is some congruence on this
14 one in that it shows the sats of 47 on the bottom, and
15 the sats of 47 on the top at the same time. And the
16 time on that I can't read, but where it says 47 up top.

17 Q. Do you have any basis for disputing the
18 accuracy of this information here?

19 A. No, not really. I mean, I have to -- I have
20 to trust the caregivers who put it in.

21 Q. And let me ask you to look now at the one
22 minute chart. This is the one that shows one minute
23 intervals. And I'm going to ask you, is there any
24 desaturation data available at 7:40, 7:41, 7:42, 7:43,
25 7:44, 7:45, 7:46, 7:46?

DR. KOFKE -- CROSS

1 A. Right. No, the only evidence we have is that
2 note says sats up to 94, meaning they were lower before
3 then --

4 Q. Now --

5 A. -- some unknown number.

6 Q. One little trick about this one here, is that
7 this 15 minute chart, that's an average number, isn't
8 it? That's --

9 A. It's unclear to me. I can't imagine a 47.5
10 average, so it must have charted the lowest.

11 Q. The lowest over an entire 15 minute period?

12 A. Yes.

13 Q. All right. And where did that number come
14 from, Doctor, if we know that this machine was not
15 recording the data. It was showing the people in the
16 room the data. It was not recording the data until
17 7:48. Where do those numbers come from?

18 A. I don't know. I can't reconcile that.

19 Q. Can you tell me, is there any evidence in this
20 record about when the resuscitative efforts began?

21 A. No. No. She has a memo -- a memo in there,
22 if you put it up -- or he does, that CPR started and
23 Mayday -- Mayday called. So at 7:57 is when the
24 cardiac arrest is first recorded by the caregiver.

25 Q. Okay. Now, Mr. Ransom has talked about this

1 entry here. At 7:56, it says, "memo, came into room.
2 Patient hypoxic, with a junctional rhythm and no
3 papable pulse. ACLS Protocol initiated. Mayday team
4 called". And he's critical because that -- that note
5 was originally put in as saying "8:00". And donna
6 Embrey corrected it to 7:55. So my question to you is,
7 do you know of any evidence to show that her correction
8 was right or wrong?

9 A. No.

10 Q. I'm going to show you something and see if we
11 can do some detective work together. What does -- what
12 does PIP mean?

13 A. Peak Inspiratory Pressure.

14 Q. And what does FI02 mean?

15 A. Fractional -- fraction of inspired oxygen.

16 Q. And what do those tell you?

17 A. The PIP tells me if the anesthesia circuit is
18 being used. And in this case, it was off of the nasal
19 cannula, it won't be recording. So if the PIP is
20 recording a number above zero, then it is -- an effort
21 is being made to ventilate the patient either by mask
22 or after intubation by ventilator.

23 Q. So, we put a yellow highlight on this line,
24 and you see the one that says FI02 percentage?

25 A. Yes.

DR. KOFKE -- CROSS

1 Q. Then the one that says PIP?

2 A. Yes.

3 Q. All right. And who records that information?

4 A. I think it's taken off of the machine into
5 the -- into the computer.

6 Q. Okay. So once again, just like everything
7 else that we've seen, there's no data at 7:34, 7:35,
8 7:36 on until, what time -- 7:48?

9 A. Yes.

10 Q. And you see these numbers, the PIP number is
11 zero, zero, zero, zero --

12 A. Which one is -- it's the bottom row?

13 Q. Yes. The bottom number is the PIP.

14 A. Uh-huh.

15 Q. And so what do all those zeros mean? Once
16 it's -- once the machine starts recording?

17 A. They mean that no tidal is being given --
18 either through -- the PICIS, the pressure -- there's no
19 pressure in the circuit being recorded.

20 Q. Okay. And would that indicate that they are
21 not -- that nobody is bagging the patient at that
22 point?

23 A. If they're using an anesthesia circuit, that's
24 what that would indicate.

25 Q. Okay. And then what about these numbers up

1 here, there's one that says 99. It's right at 7:48 and
2 it starts recording, then it's 35, 26, 29, 24, 26, 29?

3 A. What is that? What is that you're reading?

4 Q. That's FI02. So what does that indicate?

5 A. That initially the patient was getting nearly
6 100 percent O2, but then he quickly decreased -- you
7 know, I don't think it's correct.

8 Q. All right. And that -- well, could the rest
9 of these be correct the 35, 26, 29, 24, 26, 29?

10 A. I mean, they could be. But why would you be
11 giving someone in this situation 25 percent oxygen?

12 Q. What situation are you talking about?

13 A. One who is unstable like this, and with sleep
14 apnea, and with the desats that are just up to 94
15 percent.

16 Q. Well, that's what we're about -- that's what
17 we're about to get to, Doctor. If I look at the next
18 entry, at 7:55, what happens there?

19 A. Move it over a little. So at 7:55, now the
20 sat -- now the FI02 is reading 99 percent, and tidal
21 CO2 is still quite low, so the ventilation is
22 inadequate and the -- you know, the patient -- perhaps
23 the patient still needs a cannula -- no --

24 Q. You don't bag somebody with nasal cannula, do
25 you?

1 A. No, so -- but nonetheless, the end tidal CO2
2 is quite low, and I don't know where it's coming from,
3 either the nasal cannula or the anesthesia circuit.
4 And then untitled CO2 is low, and the tidal volume are
5 low, and the Peak Inspiratory Pressure is low, but the
6 FIO2 is 95 percent. And the thing is only reading four
7 breaths per minute, so it's a little confusing what
8 exactly that -- that indicates.

9 Q. Well, let me ask you a more focused question.
10 Does that indicate to you that somebody started bagging
11 this patient right around 7:56 or 7:55?

12 A. That's -- on the 7:56 column, where the Peak
13 Inspiratory Pressure is 27, it looks like someone is
14 indeed bagging the patient, and starting to get some
15 CO2 out. And then 7:57, the CO2 is zero. That might
16 be because of -- that might be because the cardi count
17 (ph) has gone done.

18 Q. Okay. So --

19 A. So there was some bagging going on through the
20 anesthesia machine.

21 Q. All right. And then if we go back to the note
22 from that time, 7:55 was a note saying?

23 A. "Patient turned supine from lateral to
24 establish better assisted bag mask ventilation. Nasal
25 airway out, pharyl (ph) airway in.

DR. KOFKE -- CROSS

1 Q. And then it came into room, what do you think
2 she is referring to there?

3 A. I think that's the MDA, Dr. Nelson.

4 Q. Okay.

5 A. He probably typed that in himself, but under
6 her log in.

7 Q. All right. "Patient hypoxic with a junctional
8 rhythm, no palpable pulse. ACLS protocol initiated.
9 Mayday team called". And do you see evidence in the
10 record that there was a junctional rhythm at that time?

11 A. Yeah, that's up above because I think that
12 there is on this record. The other records -- that
13 record doesn't show. It -- go ahead and go to the --
14 what's the -- the upper part has the rhythm.

15 Q. This upper part of this?

16 A. Oh, no. That one has the rhythm, see where it
17 says "a junctional -- a junctional PEA".

18 Q. Right. So that would be correct, right, 7:46
19 there's a junctional rhythm; correct?

20 A. Well, again, it's probably correct. I'm just
21 not sure of the times on it, because they are so
22 discrepant across the records. But nonetheless, he
23 developed -- this documents that it occurred.

24 Q. So what I'm trying to do is I'm trying -- I'm
25 trying to tie some objective data to things that human

1 beings entered into the record. And this -- this page
2 is all stuff that human beings entered; right?

3 A. Yes.

4 Q. In the old days, it would be handwritten on a
5 flow sheet of some kind, but here it's typed into the
6 machine?

7 A. Off of the Mayday record.

8 Q. Well, maybe so.

9 A. Yeah.

10 Q. And here -- but here is what we've got. We've
11 got the computer putting numbers in that show, you say,
12 that this patient was being bagged beginning about 7:55
13 or 7:56; right?

14 A. I think that's what -- I think that's what
15 this record gets you to conclude.

16 Q. That's what I'm saying.

17 A. Yes.

18 Q. Okay. So you agree -- you agree that the
19 objective data that the computer put into this chart
20 corroborates the statement of these health care
21 providers, that says that they began in -- at 7:55,
22 turned him supine, established better assisted bag mask
23 ventilation, took the nasal airway out, that was
24 appropriate, wasn't it?

25 A. Yes.

1 Q. Put the oral airway in -- that was
2 appropriate?

3 A. Yes, I think so.

4 Q. Okay. And that the patient was hypoxic with
5 junctional rhythm, with palpable pulse, both of the --
6 both the anesthesiologist and the CRNA are there
7 assisting in resuscitating this patient, and the Mayday
8 was called?

9 A. Yes.

10 Q. The ACLS protocol -- and that's all right,
11 isn't it? Isn't that exactly what they should have
12 done?

13 A. The general sequence is, I trust -- I trust
14 the exact times, you know, they were put in after the
15 fact.

16 Q. And the resuscitation was done in an
17 outstanding manner?

18 A. I would -- I would -- I would rate it as such,
19 yeah.

20 Q. And the -- the -- the process of lowering
21 the -- the temperature of the body, I mean, that was
22 really cutting edge stuff back then; wasn't it?

23 A. Yes, yes, absolutely.

24 Q. And you have no criticism whatsoever -- in
25 fact, would it be fair to say that you have admiration

DR. KOFKE -- CROSS

1 and respect for that, and that it probably had a lot to
2 do with avoiding organ damage to -- to Mr. Mikell?

3 A. Well, they did a great job, you know. They
4 had organ damage and they worked with it.

5 Q. I want to talk -- let me just ask you one
6 other thing to correlate this. Do you have any
7 evidence whatsoever, have you ever seen it anywhere in
8 this chart that it says that Donna Embrey was texting,
9 or e-mailing, or surfing the web, or doing anything
10 that was distracting her after 7:48?

11 A. No. No. I think that's -- the last text was
12 7:46. And there would be some period of time to react
13 to that. But, yeah, 7:48 sounds right.

14 Q. All right. And the status quo at 7:48 was
15 Nelson -- "memo, Nelson MDA in" -- that means a room,
16 "nasal airway in, O2 sat up to 94 percent"?

17 A. From the lower level that must have been while
18 she was distracted arguably.

19 Q. All right.

20 A. I don't have evidence of that. You're right.

21 Q. But the patient remains lateral?

22 A. Right.

23 Q. Okay. He's not having a cardiac arrest now,
24 is he?

25 A. Correct.

1 Q. In fact, everything is just like you would
2 want it to be?

3 A. Well, he's in a pre-arrest state, but -- but
4 according to the numbers, that's correct.

5 Q. Okay. Well, we know now that he's in
6 pre-arrest state, but there's nothing in those numbers
7 that shows that?

8 A. Correct.

9 Q. And the condition that he was placed in there
10 was exactly where you would want him to be at that time
11 of this procedure? He's got nasal airway in; he's got
12 his sats up to 94 percent; he's on his lateral --

13 A. Yes.

14 Q. Remains lateral?

15 A. Yes.

16 Q. I want to talk to you a little bit about your
17 last opinions that you gave. I don't mean for this to
18 sound demeaning in any way, because you're obviously
19 very well qualified in what you do, but you're not a
20 cardiologist?

21 A. Right.

22 Q. Okay.

23 A. Correct.

24 Q. You're not an internist?

25 A. Correct.

1 Q. You're not a nephrologist?

2 A. Correct.

3 Q. And there are people who are those things and
4 who are pretty good at taking care of their patients?

5 A. Right.

6 Q. And do you know anything about the
7 cardiologists and the nephrologists that were taking
8 care of Mr. Mikell?

9 A. Of the doctors individually, no.

10 Q. What about the qualifications?

11 A. I don't know except that they put themselves
12 out as that. I assume that if they had those -- if
13 they were practicing like that, the hospital must have
14 screened their qualifications.

15 Q. Do you know -- do you know why those changes
16 in the medications that you referred to were made?

17 A. They were concerns about his kidney
18 functioning, metabolizing him appropriately. And there
19 -- for the anti-arrhythmic, I believe, and for
20 anti-coagulant, there was concern that he was still
21 oozing from his trach. He just had that taken out.
22 And they didn't want him to have a major bleeding
23 issue. So, again, as I said earlier, it's -- it's a
24 balancing act this medicine -- this medicine thing is.
25 And that's what they were trying to balance, the risks

1 of putting him back on his previous therapy vs. not
2 doing it, and having him succumb to his disease.

3 Q. Are you aware of any evidence, testimony or
4 medical records, or anything that says that Dr. Van
5 Bakel, or any of Mr. Mikell's physicians, didn't have
6 him on exactly the medications that they wanted him to
7 be on when he was discharged, and then later seen in
8 December of 2010?

9 A. I -- no, no, not really.

10 Q. I'm going to ask you some questions about your
11 the testimony you've previously given in this case.

12 MR. COOKE: Your Honor, do I hand this to you or
13 to the clerk or the court reporter?

14 THE COURT: You can just go ahead and open it.
15 Ladies and gentlemen, this is a deposition that was
16 taken previously by the parties. A deposition is a
17 sworn statement that the parties take routinely during
18 the course of a case that's being litigated. And it
19 was a court stenographer that took everything down,
20 such as the court stenographer here is taking
21 everything down. And it is a sworn testimony. And
22 it's been under seal and it's being opened at this
23 time. Please proceed.

24 MR. COOKE: Thank you, Your Honor.
25

DR. KOFKE -- CROSS

1 BY MR. COOKE:

2 Q. I'm going to hand you the original transcript
3 of your deposition that was taken in Media,
4 Pennsylvania on March 4, 2014, about a year ago.
5 Doctor, is it or is it not true that you have no
6 opinion and are not going to comment on the cause of --
7 of Mr. Mikell's death?

8 A. Are you asking me to -- you mean right now?

9 Q. Yeah. The way this works is I have to ask you
10 a question, and then let you answer it. And then I get
11 to refer to your deposition.

12 A. Okay. So, yes, I do -- I do intend to -- to
13 discuss a cause of death and a link to the cardiac
14 arrest.

15 Q. All right. So let me ask you to look at page
16 115 of your deposition. Do you see that?

17 A. At 115?

18 Q. Line 22. The question was asked of you when
19 you were under oath that day, "And do you intend to
20 testify about the cause of Mr. Mikell's injuries or
21 death -- alleged injuries or death?"

22 Answer: "All I'm going to comment on is the
23 cause is cardiac arrest."

24 So is it fair to say that you've changed that
25 testimony in that you now are willing to give testimony

1 as to the most likely cause of Mr. Mikell's death?

2 A. Well, that sentence -- that's what I said.
3 And then I forget who -- was -- was it you who was
4 asking me -- kept asking me the same question over and
5 over again. And, finally, I volunteered a cause, so --
6 so you -- you -- you badgered me into giving you a
7 cause.

8 Q. All right. Let's keep going then. I'm going
9 to badger you some more; right?

10 A. Yeah. Yeah.

11 Q. Go to page 117, line 3, "Do you have any
12 opinions about the cause of Mr. Mikell's death?" And
13 can you read your answer please?

14 A. "No, I didn't review his chart carefully for
15 damages or, you know, things like that."

16 Q. "And are you going to be rendering any
17 opinions about whether the cardiac arrest caused any
18 injuries and/or worsening of his cardiac function?"
19 Your answer?

20 A. "I didn't review his chart carefully for these
21 elements, so I don't think I should comment. I was
22 asked to review the anesthesia management."

23 Q. All right. And the question, "And so just to
24 clarify, you're not going to give any opinions about
25 whether the cardiac arrest that occurred on October 1,

1 2010, caused or contributed to any alleged damage to
2 his heart or worsening to his heart function?" And
3 your answer?

4 A. "If his heart got worse after this, I think I
5 have to say that the cardiac arrest contributed to it
6 because it wouldn't have happened without the cardiac
7 arrest. But after the cardiac arrest and the
8 hypothermia" -- there's a typo there -- "I didn't focus
9 on any of that stuff.

10 Q. Okay. "And if the medical records indicate
11 that his heart function, meaning his ejection fraction,
12 was the same if not slightly better following this
13 incident, are you going to disagree with that
14 information?"

15 A. "No, no, because -- well, as I said, I didn't
16 carefully review it. But if you tell me or someone
17 tells me that the heart improves afterwards, well, then
18 I don't think the cardiac arrest made his heart get
19 better. It was probably was other therapies" --

20 COURT REPORTER: I'm sorry --

21 A. "No, no, because -- well, as I said, I didn't
22 carefully review it. But if you tell me or someone
23 tells me that the heart improved afterwards, well, then
24 I don't think the cardiac arrest made his heart get
25 better. It probably was other therapies that he was

1 getting, you know, in the ICU."

2 Q. "And if his heart function was about the same
3 afterwards, does that -- do you intend to say that the
4 cardiac arrest worsened his cardiac functioning?"

5 A. "Only if it was worse, so -- so no."

6 Q. And we now know that by all of the testing
7 that was done, and any objective standard, that there
8 was no damage done to Mr. Mikell's heart?

9 A. "I hate to be so -- so -- one hundred percent,
10 but his ejection fraction was okay, but he was still --
11 still systematic in terms of his fatigue and so on."

12 Q. Right. I said -- I said there is no evidence
13 of damage to his heart?

14 A. No.

15 Q. His heart is a muscle; correct?

16 A. No. No, I don't think so.

17 Q. His EKG, his ejection fraction, all the tests
18 that the cardiologist can do show that there was no
19 damage done to Mr. Mikell's heart?

20 A. Right. Because the cause of the arrest was
21 hypoxia, not MMI.

22 Q. Well, that's another good point, he did not
23 have a heart attack; correct?

24 A. Correct.

25 Q. At page 123. Question was asked on line 18,

DR. KOFKE -- CROSS

1 "And so is it your opinion that because Mr. Mikell
2 suffered an arrest, that it must have in some way
3 contributed to his death?" This is I think what you're
4 referring to.

5 A. Yes.

6 Q. Your answer is "Yes, that's why I used the
7 word contributed. I'm not sure about cause." Do you
8 see that?

9 A. Yes.

10 Q. And the question was then asked, "And then
11 you're not able to provide any information regarding
12 what factors about his condition or what sequela the
13 arrest may have caused that contributed to his death;
14 is that correct?" And your answer?

15 A. That's correct.

16 Q. And you have changed in the past year since
17 your deposition -- and I assume it's because you have
18 gone back and looked at the records now, where you say
19 you were not going -- it would not be appropriate for
20 you to comment before?

21 A. That's right.

22 Q. All right. And so I assume that you have
23 found an autopsy somewhere?

24 A. No.

25 Q. Because there was no autopsy done?

1 A. Correct.

2 Q. And, in fact, the medical examiner did not
3 even see Mr. Mikell, did she?

4 A. That's my understanding.

5 Q. Have you read her deposition?

6 A. She -- yes, I think -- yeah, I read her
7 deposition. She just read the chart and then assumed
8 the cause.

9 Q. She read the chart and assumed the cause?

10 A. Yes.

11 Q. So we don't know what he died from, do we?

12 A. Not -- not -- not with one hundred percent
13 certainty, that's correct.

14 Q. Well, what was done to rule out choking?

15 A. There was no test done to rule that out.

16 Q. Okay. What was done to rule out sudden
17 cardiac death?

18 A. Well, we all die of cardiac death, you know.
19 You know, there -- you know, there was nothing -- that
20 could be neither proven or disproven, the cardiac
21 cause, the cardiac arrhythmia cause.

22 Q. Was -- was Mr. Mikell at risk of dying from
23 his heart disease before October 1st of 2010?

24 A. Yes. But the cardiologist chose not to put a
25 defibrillator in. So, you know -- so, again, we're

DR. KOFKE -- CROSS

1 talking about risks. He wasn't a super high risk, but
2 clearly he was a risk because he had all these other --
3 he had kidney -- kidney issues, diabetes and -- and
4 heart failure.

5 Q. So if I gather the thrust of what you're
6 testifying to this jury today, contrary to what you
7 said a year ago, you now believe that because he was
8 taken off of blood thinners and his antiarrhythmia
9 medicine, he was more at risk than he was before of
10 having a stroke from a blood clot; right?

11 A. Yes.

12 Q. Or a death from an arrhythmia?

13 A. Yes, or a pulmonary embolism.

14 Q. Or pulmonary embolism. That would go back to
15 the blood --

16 A. I haven't reviewed his -- his medications with
17 the kind of -- with that -- with very much scrutiny at
18 that time.

19 Q. And we have no idea if he died from anything
20 related to a blood clot, do we?

21 A. Well, we have an idea. I think it's obvious
22 that that's what happened. But I can't say with --
23 like a certainty of a pathologist doing an autopsy.
24 But to say that I have no idea, isn't -- isn't exactly
25 correct either. I've got to tell the whole truth.

DR. KOFKE -- CROSS

1 Q. Yeah. Well, I want you to tell me what --
2 what -- what facts do you know about this case. The
3 examination was done by deputy sheriffs, wasn't it?

4 A. By nurses -- by nurses who are deputies -- I
5 don't know what their legal title is, but by a nurse
6 who was -- who was a medical examiner.

7 Q. She never saw him, did she?

8 A. Correct.

9 Q. So, I said the examination -- the only
10 examination that was done of Mr. Mikell was done by the
11 deputy sheriffs who responded?

12 A. Oh, yes. And I think that they -- I think
13 that they told the medical examiner what they saw,
14 which was rigor mortis.

15 Q. Do -- do you know whether he was -- he was
16 found laying on his couch; correct?

17 A. Correct.

18 Q. And do you know whether he was wearing his
19 CPAP machine?

20 A. I don't know. I don't think so, because it
21 wasn't a matter that I recall mentioned.

22 Q. Well, he was supposed to have that, wasn't he,
23 if he slept?

24 A. If he was sleeping, yes. But the family said
25 that he -- used -- seldom sleeps on his couch, so it

1 probably wasn't sleeping.

2 Q. Oh, that -- so -- so do you think there's some
3 evidence in the record that says whether he was or
4 wasn't sleeping?

5 A. No. The -- the depositions from the family, I
6 think, indicate that he usually sleeps in bed, not in
7 the couch. That's all. And the TV was on, suggesting
8 that he was watching something, you know, and had an
9 event.

10 Q. And there's nothing in the record whatsoever
11 that says he had a pulmonary embolism or that he had a
12 -- a stroke?

13 A. Correct.

14 Q. That -- in fact, no doctor even signed his
15 death certificate, did he?

16 A. Correct.

17 Q. And the death certificate doesn't say stroke
18 or pulmonary embolism, does it?

19 A. Correct.

20 Q. So what you're saying -- when we're going back
21 to the -- where we began this conversation, the nature
22 of risk, what you're saying, isn't it, Doctor, that he
23 was susceptible -- he was susceptible to having a
24 stroke, having a heart attack, having an arrhythmia, he
25 was -- he was susceptible to all those things before

1 October 1, 2010, wasn't he?

2 A. Well, yeah. They were being treated.

3 Q. Right. But he -- but despite the treatment,
4 he was at risk for all of those things? That's why he
5 was being treated?

6 A. But -- so our argument is that I think that
7 his risk was attenuated by being on meds before the
8 cardiac -- before the October 1st cardiac arrests, and
9 then those meds weren't reimplemented -- weren't
10 reinstituted yet by the end of December.

11 Q. Do you agree with me that even with all the
12 treatment, that all the best doctors were able to give
13 him, he was still at risk prior to October 1, 2010, of
14 dying from any one of the things that you have said he
15 could have died from?

16 A. Right. Right. Right. And -- and to be along
17 the same frame work of what we're talking about, he was
18 at risk before, but I think he was at more risk after.
19 It's relative. And -- and twice the risk, three times
20 the risk, I don't know. It was just more. And it was
21 more than enough that I'm confident that the -- the way
22 he presented is entirely consistent with the effects of
23 it -- either an arrhythmia or a clot.

24 Q. So I'm going to review -- I'm going to go back
25 and -- and I'm almost done. But I want to go back to

1 the -- the room where this procedure was being done.
2 You showed diagrams up there of how to properly help a
3 patient breathe who is obstructing. And I believe your
4 testimony was that the nurse was negligent because she
5 was ineffective in clearing his airway -- his airway --
6 clearing the obstruction?

7 A. Yes.

8 Q. And the reason was that because she was
9 distracted sending text messages; right?

10 A. Yes.

11 Q. And was not able to do it with one hand, I
12 guess?

13 A. Correct.

14 Q. Okay. But if that were not true, if she was
15 not texting at the time that he was desaturating; and,
16 in fact, the doctor was present almost immediately in
17 assisting her in replacing the nasal airway with an
18 oral airway and bagging, then it would not be true,
19 would it, Doctor, that she was guilty of being
20 distracted and unable to properly ventilate this
21 patient?

22 A. Well, what you have is a situation where we
23 know that at 7:39 or 38, there was a text that went
24 out. And we know that the colonoscopy started at 7:42,
25 and -- and that means that for the Propofol to have had

1 an effect enough for -- for them to be able to do the
2 colonoscopy, there must have been some five to ten
3 minutes before that -- of Propofol going -- during
4 which time she is distracted by the -- by the texting.
5 And it's after the procedure started, and then there's
6 another text even while the things in her -- in her
7 colon, during the procedure under Propofol, Propofol
8 going -- and that's the kind of stuff that makes me
9 believe that there was desaturation beforehand. And
10 I'm -- I'm with you that, you know, that you can show
11 me a chart that she says, no, that's not the right
12 time.

13 Q. Well --

14 A. I'm just telling you that -- you know, that's
15 how I put it together. The 7:42, I -- is a time that I
16 am sure of because that's -- that's documented
17 independently on the procedure form by another person,
18 who is not in anesthesia or surgery -- that 7:42, the
19 colonoscopy was started. That means the Propofol
20 started before then. And during that time that the
21 Propofol was running, she was distracted.

22 Q. But I did show you records, did I not, and not
23 one of them have you been able to say is inaccurate
24 that shows that after the last text, and once they got
25 that machine so that it was recording properly, that

DR. KOFKE -- CROSS

1 there was a saturation in the 90s that Dr. Nelson was
2 present, and that he -- the patient was stable;
3 correct?

4 A. Well, I don't know about stable, but you --
5 you had -- you had one high sat.

6 Q. One with last thing. How -- how was the text
7 message sent?

8 A. It wasn't sent on the phone. It was sent from
9 a -- from a device which had an URL. Are you guys
10 familiar with that thing that says that there's a
11 computer on a network, so it was sent from a computer
12 on a network. So -- so I -- I inferred that it was
13 sent from the computer behind her.

14 Q. Okay. Might it have been sent from the very
15 computer that she was supposed to be entering
16 information on to create this record that we looked at?

17 A. Yeah, that's my -- that's my supposition.

18 Q. Okay.

19 A. Which is behind her.

20 Q. So -- so she's supposed to be typing on that
21 terminal, isn't she?

22 A. Yeah.

23 Q. Okay. She's supposed to be making all of
24 these entries by typing those into the --

25 A. Yeah, yeah. What a system.

1 Q. And your testimony is that the difference
2 between Mr. Mikell having an arrest, and not having an
3 arrest that day, was that in addition to these things
4 that were put in the record, she took time to write
5 those two one line texts to the IT Department?

6 A. Well, it was two -- two texts, a phone call
7 and a fix in response to the phone calls, so six
8 things. But -- but you're right, you know, I think
9 many of those may have gone in after the fact. I'm not
10 sure. I know that there is -- there is some question
11 about the actual entry time for some of these. But I
12 think a lot of them did go in during the procedure.
13 And that seems to be their -- a routine, and why they
14 have it set up so they have to put their back to the
15 patient while they're entering this stuff is a good
16 question.

17 Q. Okay. But it's within the standard of care in
18 every single hospital in the United States for a nurse
19 to be doing exactly this? Everyone that's got a
20 computer --

21 A. Yeah.

22 Q. Computerized record --

23 A. As long as the patient is stable, you can do
24 that.

25 Q. And--

DR. KOFKE -- REDIRECT

1 A. And that's been in deposition testimony, if
2 the patient is sick, you don't do that stuff.

3 MR. COOKE: That's all I have. Thank you.

4 THE COURT: Redirect?

5 MR. RANSOM: All right. A moment's indulgence,
6 please, Your Honor.

7 THE WITNESS: What did he say?

8 THE COURT: He wants -- he wants to talk to his
9 friend for a second. Okay. Just hang on.

10 (PAUSE.)

11 MR. RANSOM: Your Honor, I do have a few
12 questions that I want to ask him.

13 **REDIRECT EXAMINATION BY MR. RANSOM:**

14 Q. Now, Dr. Kofke, Mr. Cooke was asking you a
15 number of questions about particular pages from the
16 medical record, asking you whether or not the entries
17 and the times and so forth were correct; do you recall
18 that?

19 A. Yes.

20 Q. All right. And you're aware that the Medical
21 University, in the context of my office's request for
22 Mr. Mikell's medical records, provided three or four
23 different printouts of his anesthesia record?

24 A. That's -- that's -- that's what -- kind of
25 what I've been talking about. There's at least three

1 that I've seen.

2 Q. Okay. And what I want to do then, in order to
3 try to highlight the difficulty that you had in placing
4 specific times is, to go through some of those records
5 with you real quick. So the first record that I'd like
6 to show you, this is what's already been marked as
7 Plaintiff's Exhibit 2. And if you'll look down here,
8 the first thing I'd like to point out to you on
9 Plaintiff's Exhibit 2, is that it's a document that's
10 been printed on October 1, 2010, and the time is 1347;
11 do you see that?

12 A. Yes.

13 Q. Okay. And I'm going to turn to one of the
14 back pages of this one, and it's actually a document
15 that's got a document control number of 611; do you see
16 that?

17 A. Yes.

18 Q. Okay. So the thing that I want to point out
19 on this record, is this entry right here that Mr. Cooke
20 was asking you about. You'll see it's timed at 8:00
21 a.m., and it's under the initials EWN, that's Eric W.
22 Nelson; okay?

23 A. Yes.

24 Q. And you see that it says that, "memo, came
25 into the room, patient hypoxic, a junctional rhythm and

DR. KOFKE -- REDIRECT

1 no palpable pulse" -- you can read that?

2 A. Yes.

3 Q. Okay. And that's timed at 8:00. And we don't
4 see any entries in this record about things happening
5 except at 7:50, 7:55, at any of those times; correct?

6 A. Correct.

7 Q. So that's the record that's printed at 1347.
8 This is about 1:47 in the afternoon on the day after
9 this has happened. The next record, this is marked as
10 Plaintiff's Exhibit 3. It's got one of those
11 narratives too. And you'll see this record has been
12 printed the next day, October 2nd, 2010, at 1850. All
13 right?

14 A. Yes.

15 Q. All right. That's about 6:15 in the
16 afternoon?

17 A. Yes.

18 Q. And if we look at that same entry, from the
19 first exhibit, that was under Dr. Nelson's initials at
20 8:00, now we see that it's under -- the nurse
21 anesthetist, Donna Embry's initials, and it's timed at
22 7:55; all right?

23 A. Uh-huh, yes.

24 BY MR. RANSOM:

25 Q. Now, Mr. Cooke's not really being fair with

1 you, because you don't have any independent way of
2 knowing which time is correct?

3 MR. COOKE: That's a leading question, Your
4 Honor.

5 BY MR. RANSOM:

6 Q. Do you have any independent way of knowing
7 which time is correct?

8 A. No.

9 Q. Now, if you'll notice here on this record --
10 and again this is Plaintiff's Exhibit 3 -- there are
11 three entries made by Dr. Nelson, and they all are
12 right in a row; do you see that?

13 A. Yes.

14 Q. And those are all things that he presumably
15 did at 7:48?

16 A. Or he entered at 7:48.

17 Q. That's right. And that's four entries under
18 his initials, all one right after another?

19 A. Correct. Those are just filling out the
20 stations that we all have to enter in one manner or
21 another on these.

22 Q. Well, now I want to look at another record,
23 and this is Plaintiff's Exhibit No. 5. And this one
24 has been printed out on April 2, 2013, at 1314; do you
25 see that?

DR. KOFKE -- REDIRECT

1 A. Yes.

2 Q. And I'd like to take judicial notice, Judge
3 that that's about six months after the lawsuit was
4 filed in 2012. So let's look at those same entries,
5 and we see -- we got two entries by Dr. Nelson. And
6 now there's an entry by Donna Embrey that's been
7 interposed in between those two; do you see that?

8 A. Which one? Memo to Nelson out -- or -- oh,
9 DBE -- Nelson MDA in, nasal airway in, that would be --

10 Q. That's right.

11 A. Yep.

12 Q. So -- so yeah, what we see on that Exhibit 5
13 is that the entry, memo, Nelson MDA in, comes right
14 before the entry anesthesiologist assessed patient.
15 All right. And that is not the same order that we see
16 in Exhibit 3, that was printed on October 2nd -- do you
17 see that? It's a different order of entries?

18 A. Uh-huh.

19 Q. So, clearly, it's obvious to anybody who looks
20 at these records, isn't it, that sometime between
21 October 2nd and April -- October 2nd, 2010, and April
22 2, 2013, somebody has gone back and changed these
23 entries; right?

24 A. It looks like it.

25 Q. I mean, have you ever seen an electronic

1 medical record system, Dr. Kofke, where the computer
2 rearranges the times and the order of the entries all
3 by itself?

4 A. No. No, it wouldn't do that. But it has --
5 many of them have ways for humans to interact and --
6 and -- and correct errors of the electronic record.

7 Q. Okay. And one of the other things that we
8 know from some of the records in this case, is that
9 this real time graph that's showing this desaturation
10 right here, it's somehow or another been corrupted so
11 that that desaturation is shown occurring at several
12 different times; right?

13 A. To at least two different times.

14 Q. Right. So on this board over here, that's
15 page 504, you've said that it shows that desaturation
16 beginning -- what, 7:46, 7:47-ish?

17 A. Right. Right after the colonoscope was put
18 in.

19 Q. Right. All right. And that would be
20 commensurate with about the same time as the last text
21 message?

22 A. Yes.

23 Q. Okay. And when we look here on Plaintiff's
24 Exhibit 7, what we see is -- it shows that that
25 desaturation begins at 7:34?

DR. KOFKE -- REDIRECT

1 A. Yes.

2 Q. Okay. This is -- you'll see down here, this
3 is page 120 of 342, that's the printout of the one
4 second record, but --

5 A. One minute or one --

6 Q. Well, it might be the ten second. Then when I
7 turn to the third -- the second page of Exhibit 7, we
8 see that the desaturation is now occurring at yet
9 another time, at 7:35. And when we turn to the third
10 page, we see that now the desaturation is taking place
11 at another time all together now, right?

12 A. Yes.

13 Q. So this is what you're referring to when you
14 say there are discrepancies in the record?

15 A. Yes. Yes. And eventually -- yes, that's
16 right.

17 MR. RANSOM: Your Honor, I would offer Exhibits,
18 3, 4, 5, 6, and 7 into evidence at this time.

19 THE COURT: Any objection?

20 MR. COOKE: No objection.

21 THE COURT: All right, 3, 4, 5, 6 and 7 admitted
22 without objection.

23 (WHEREUPON, Plaintiff's Exhibits Nos. 3 - 7
24 admitted into evidence.)

25

- DR. KOFKE -- REDIRECT

1 BY MR. RANSOM:

2 Q. So because of the discrepancies in the record,
3 you've had to make certain assumptions; fair enough?

4 A. I made inferences, yes.

5 Q. Inferences, I like that. An inference means
6 you've taken certain facts that are known, and you've
7 drawn certain conclusions by the application of a
8 reasoned principle?

9 A. Yes.

10 Q. Okay. And the facts, as I think you've
11 understood them to be -- or what you've testified is,
12 you have relied upon the time that's set forth in the
13 document that Ms. Fleming put into evidence,
14 Defendant's Exhibit 1 that shows --

15 MR. COOKE: Your Honor, I object to the leading
16 questions.

17 THE COURT: I think he's sort of summarizing
18 right now. He hasn't even gotten to the question yet.
19 Okay. Let me hear his question and then I'll rule on
20 your objection.

21 BY MR. RANSOM:

22 Q. Exhibit 1 shows the scope goes in at 7:42?

23 A. Yes.

24 Q. Is that --

25 THE COURT: Rephrase the question. It's

1 leading. Just ask him what this is showing.

2 BY MR. RANSOM:

3 Q. Is that the time that you're relying upon?

4 A. 7:42, yes, for the colonoscope going into the
5 rectum.

6 Q. Okay. Is that an electronic record?

7 A. No.

8 Q. Do you find that record to be reliable?

9 A. Yes.

10 Q. And then the other thing is this Plaintiff's
11 Exhibit 12, these text messages, do you consider that
12 to be reliable?

13 A. Yes.

14 Q. Okay. Mr. Cooke had asked you whether
15 sometimes bad things happen to patients even when
16 everything is done right. Do you have the opinion that
17 everything was done right in Mr. Mikell's case?

18 A. No.

19 Q. You testified in your deposition in March of
20 2015, that the only way that I think that it didn't --
21 that the cardiac arrest didn't contribute to it, is if
22 he went on to totally recover, and get hit by a car or
23 something. I mean, you know, die of some other cause
24 unrelated to this; do you remember telling Ms. Fleming
25 that?

1 A. Yes.

2 Q. In March of 2015?

3 A. Yes.

4 Q. Okay. And since that time, you've spent
5 additional effort reviewing records?

6 A. Right. So at that time, I was relying on my
7 knowledge that he hadn't survived, and that -- that the
8 people who have this problem typically don't do well in
9 the long term. And he didn't do well in the long term.
10 And then I went and looked at the records more
11 carefully and confirmed that.

12 Q. Okay. And I think you said it was obvious to
13 you that the two were linked together?

14 A. Yes.

15 Q. Okay. Thank you. I don't have any other
16 questions.

17 THE COURT: Recross?

18 MR. COOKE: No questions.

19 THE COURT: Pardon?

20 MR. COOKE: No questions. Thank you.

21 THE COURT: Okay. You may step down, Doctor.
22 Thank you very much.

23 All right, Madam Forelady, ladies and gentlemen
24 of the jury, if you'll leave your note pads in your
25 chair. Be back in the jury room at 9:30 in the

1 morning, we'll get started at that time. Please don't
2 discuss the case or do any electronic research on the
3 case. So see you in the morning at 9:30.

4 (WHEREUPON, the jury leaves the courtroom at 5:45
5 p.m.)

6 THE COURT: I'm going to make the doctor's
7 deposition Court's Exhibit No. 1.

8 (Court's Exhibit No. 1 marked:)

9 THE COURT: Anything from the plaintiff before
10 we adjourn?

11 MR. RANSOM: Nothing, Your Honor.

12 THE COURT: Anything from the defendant?

13 MR. COOKE: Nothing, Your Honor. Thank you.

14 THE COURT: See you at 9:30 in the morning.

15 (WHEREUPON, the hearing was concluded.)
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1 * * * Wednesday, April 20, 2016 * * *

2
3 THE COURT: Anything from the plaintiff before we
4 bring the jury?

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

6 THE COURT: Anything from the defendant?

7 MR. COOKE: We do, Your Honor. For the record, we
8 would actually have -- I would appreciate the court's
9 indulgence. I have a motion to strike parts of Dr.
10 Kofke's testimony. May I proceed with that?

11 THE COURT: Yes, sir.

12 MR. COOKE: So --

13 THE COURT: I mean, I think you objected yesterday
14 to his testimony, and I overruled you. But as far as
15 striking part of it, you had a motion to that effect.
16 I really haven't ruled on that.

17 MR. COOKE: And this is -- this is a continuation
18 of that. But it also has to do with -- it includes the
19 cross-examination yesterday. So the first -- the first
20 is I would move to strike his testimony concerning the
21 relationship between the cardiac arrest and death
22 and -- and his -- his testimony.

23 And my -- the basis for that is that, first of
24 all, it lacks foundation. And second that it's not
25 relevant because it doesn't meet the medical causation

1 requirement.

2 His testimony was that there was inextricable
3 linkage between the two. And it was only -- it was
4 only Mr. Ransom who was able to say "so it caused it".
5 And, of course, I objected. And, of course, you
6 sustained that objection, but his -- his
7 characterization of the relationship. And you remember
8 in his deposition, he said, I think that it -- I think
9 it contributed, but I can't say caused.

10 THE COURT: Right.

11 MR. COOKE: And then yesterday he said I think
12 there's an inextricable link between the two. Your
13 Honor --

14 THE COURT: But if I remember correctly -- and you
15 correct me -- he added the medication issue?

16 MR. COOKE: He did add the medication.

17 THE COURT: Once he said one -- he was on blood
18 thinners before. Once he took him off of the blood
19 thinner, that other medication -- I don't know what --

20 MR. COOKE: The arrhythmia medication.

21 THE COURT: -- or blood thinner, that made him
22 more susceptible. Therefore, it was conducive to
23 either clot or arrhythmia.

24 MR. COOKE: Correct.

25 THE COURT: Okay. Which is different from what

1 was in the deposition, if I remember correctly.

2 MR. COOKE: That's right. Because he had not
3 reviewed those records --

4 THE COURT: Right.

5 MR. COOKE: -- at the time of his deposition. So
6 -- but even with that, Your Honor, I go back and I was
7 -- I kept calling the twisted -- tor -- testicle case,
8 and the rocky mountain spotted fever case.

9 And what I was referring to is Sherer vs. James,
10 of course, which is where the Supreme Court reversed
11 the Court of Appeals, which there was a previous case
12 in the Court of Appeals called Clark vs. Ross. That
13 was -- that was the first case in which the court said
14 that it's enough -- it's relevant and it's enough to
15 get to the jury if you show that you increased the
16 chances of the bad result happening.

17 And the Supreme Court in Sherer vs. James said
18 that's not the standard. He said that's -- it said
19 that's okay for standard of care that is a -- you know,
20 a physician does have a duty to not increase the risk
21 of harm to a patient, but that does not -- that's not
22 relevant on the standard of the -- on the causation,
23 showing that you made the patient more susceptible to
24 the ultimate outcome is not sufficient. You must --
25 you must show to a reasonable degree of medical

1 certainty that but for that increased risk, it would
2 not have occurred.

3 And in this case, by definition, because we
4 don't know the cause of death. We -- there's no way to
5 know that but for taking him off the Coumadin, or the
6 anti -- or the arrhythmia medication, that it wouldn't
7 have occurred.

8 And I would add to that that this -- this expert
9 was not qualified to make that -- that conclusion and
10 did not have proper -- enough facts to do that, thus
11 lack of a foundation. That's -- that's point one.

12 Point two is, I really am serious about this
13 failure to -- to supplement the answers to
14 interrogatories. It really -- it really berated me as
15 I went home last week to think that the whole time that
16 the plaintiff was moving to sanction the Medical
17 University for not being forthcoming in producing this
18 -- the information about the Mayday record, and the
19 court heard yesterday that there was an honest -- an
20 honest disagreement, even among the people at the
21 Medical University about whether that record ever
22 existed. And to this day, there's an honest
23 disagreement about it.

24 But the whole time that we were being grilled
25 about that, I had -- we had moved for summary judgment

1 based on -- on their expert saying, I am not forming
2 any opinion about the cause of death. He was told to
3 go back and look at more records, records which he had
4 from -- from the beginning of this. And they defied
5 the Rule 26 that says you must reasonably supplement
6 your interrogatory responses on the substance of your
7 expert's opinion.

8 And what they -- what they have done is they
9 came. He did more work. They did not disclose it
10 until last week -- a week before trial. And it's a
11 huge difference. Now, all of a sudden where we were
12 moving for summary judgment because he couldn't have
13 any opinions -- didn't have any opinions about
14 causation of the wrongful death, now he's willing to do
15 it based on his secret review of these additional
16 records. That's an important point.

17 The second -- the second that we would strike
18 would be his testimony as to the negligence of -- of
19 the doctor. Now, he had no -- up to this day in his
20 original affidavit that he submitted with the
21 complaint, and in his deposition and in his answers to
22 interrogatories, he never said that he felt that Dr.
23 Nelson had deviated from the standard of care.
24 Yesterday was the first day that we ever heard that.

25 But even with that, even with that, his

1 testimony failed under Fletcher vs. The Medical
2 University of South Carolina. That was -- that was my
3 case, but it was almost identical to this situation
4 where you had a bad result, and you had the expert
5 acknowledge that you can have a bad result in the
6 absence of negligence. But nevertheless, I think that
7 the doctor did something wrong.

8 He says -- and I'm quoting testimony from the
9 Fletcher case -- the expert said right there on the
10 witness stand, "Do you have an opinion, Doctor, as to
11 whether or not Dr. Brothers and Dr. Ross, the agents of
12 MUSC in performing this surgery, deviated from the
13 standard of care? I think so. I think they did."

14 And the court says, "However, Dr. Wood testified
15 on cross-examination that complications such as trauma
16 to the phrenic nerve and damage to the thoracic duct
17 could have occurred during this procedure, even in the
18 absence of any surgical negligence."

19 He also testified, "Do you see anything in
20 there, in the operative note and records, that
21 indicates that Dr. Brothers used any improper technique
22 to do the operation? No."

23 "Essentially Fletcher asks us to conclude that
24 this occurrence of a complication is itself evidence of
25 negligence. However, South Carolina does not recognize

1 the doctrine of res ipsa loquitur."

2 "Simply no evidence establishes how Dr. Brothers
3 or Dr. Rios deviated from the standard of care". And
4 then it said, "Unfortunately, two of the risks
5 associated with this procedure did befall Fletcher.
6 Nevertheless, we are not permitted to speculate that --
7 that that misfortune was the result of negligence in
8 the absence of any evidence as to how the physicians
9 deviated from the standard of care."

10 And you recall Dr. Kofke's testimony was that,
11 well, I think Dr. Nelson was negligent because he was
12 not in the room enough. But then when you asked him,
13 well, how much was he in the room. He said, I can't
14 tell because the records are goofy. I don't trust any
15 of the records.

16 So it's exactly the same situation. He's
17 inferring from a bad result negligence on the part of
18 the physician. And I think that the same applies to
19 the nurse, but I'll address that at summary judgment --
20 I mean, at the directed verdict stage rather than a
21 motion to strike.

22 THE COURT: Okay.

23 MR. COOKE: Thank you.

24 THE COURT: Thank you. Yes.

25 MR. RANSOM: Thank you, Your Honor. As to the

1 allegation that he lacked the proper foundation for his
2 opinions, I think his testimony was fairly clear that
3 he had considered the totality of the medical record.
4 He had been present in the courtroom during Dr.
5 Huggins's testimony. He had reviewed all of the
6 various exhibits about the injuries and the
7 hospitalization, and the treatment and the rehab, and
8 the changes in the medication. He's board certified in
9 the subspecialty of critical care.

10 He said that these are the very same patients
11 that he sees --

12 THE COURT: Talk to me about when -- I understand
13 that argument. I -- what I'm concerned about is when
14 you notified the defense of this change in the
15 deposition to what was going to occur at trial. Okay.

16 MR. RANSOM: Well --

17 THE COURT: I think that's very significant and
18 important. I agree with you -- I'm not going to say I
19 agree with them in ruling in their favor, but I do
20 think that's important.

21 MR. RANSOM: The first thing --

22 THE COURT: In a deposition, he very clearly said
23 that he didn't have an opinion. Okay.

24 MR. RANSOM: Right.

25 THE COURT: And now he comes in and says he does.

1 Now, when did you notify the defense of that?

2 MR. RANSOM: Judge, back on this issue that at his
3 deposition he very clearly said that he didn't have --

4 THE COURT: He said he had not reviewed the
5 records properly. He didn't say he wouldn't have an
6 opinion. He said -- I understand that. But my
7 question is, when did you notify the defense or have
8 you?

9 MR. RANSOM: Right. So this is what I'd like --

10 THE COURT: See, I have no way of knowing that.

11 MR. RANSOM: This is what I'd like you to
12 understand, Judge, on that very issue -- is you know
13 that the discovery process in this case was filled with
14 fits and starts, information was coming in. We were
15 struggling to get information, much of what we now know
16 about what actually happened in this case, came through
17 the deposition testimony of Donna Embrey on February
18 22nd of this year.

19 As I pointed out through some of the exhibits, I
20 think it was Exhibit 41 yesterday, once her testimony
21 is transcribed by the court reporter, both Mr. Cooke's
22 office and my office are sending additional materials
23 to our respective experts for their review. And he's
24 got a February letter to his expert and a March --
25 early March letter to his expert. And I'm doing the

1 exact same thing.

2 And as you will recall, I mean I had a trip
3 where I was out of the country for two weeks. And as
4 soon as I got back, and had an opportunity to begin to
5 refocus on this case, I sent Mr. Cooke an email. And I
6 told him, I said, you know what Mr. Cooke, I'm pretty
7 sure that Dr. Kofke is going to have some additional
8 opinions once he's had an opportunity to complete his
9 review of all this new material.

10 And it was at that time that we were in the
11 process of scheduling additional depositions in this
12 case -- and, in fact, we took four additional
13 depositions on April 7th and April 8th.

14 Now, I had already told Mr. Cooke -- perhaps as
15 many as -- as much as two weeks before that, that Dr.
16 Kofke was going to have some additional opinions in the
17 case.

18 Now, two of the depositions that we took on
19 April 7th and April 8th were Dr. Reeves, the chairman
20 of the Department of Anesthesia, and Dr. Berry, the
21 defense expert. That was on a Thursday and on a
22 Friday.

23 I contacted Dr. Kofke over the weekend to try to
24 impart to him some of the important information that we
25 had received through that testimony, because the

1 transcripts weren't even yet available. All right.

2 Dr. Kofke and I talked. I then got to my office
3 the following Monday morning. I can't remember the
4 date. It may have been April 10th, and sent Mr. Cooke
5 the letter that he's included in his motion, saying
6 okay, Dr. Kofke has now had an opportunity to review
7 everything. He knows that you have challenged his
8 opinions on the causation issue at his deposition, so
9 he's strengthened that. And here is what he is
10 prepared to testify to at trial of this case.

11 I don't know that there was any other way,
12 Judge, that I could go through the process of educating
13 Dr. Kofke about all of the new information that became
14 available in this case, other than what I did. And,
15 again, it's the timing of it.

16 THE COURT: Well, how did this new -- how did --
17 how did this new information you achieved, when you
18 took these additional depositions, influence his
19 decision?

20 MR. RANSOM: Influence his opinions?

21 THE COURT: Yeah. His -- excuse me -- I said
22 decision -- I mean his opinion.

23 MR. RANSOM: Most importantly, it influenced his
24 opinions about the conduct of Dr. Nelson. Because what
25 we discovered through these text messages and these

1 phone calls --

2 THE COURT: Because I haven't even gotten to Dr.
3 Nelson yet. That's my next question to you, but go
4 ahead.

5 MR. RANSOM: Well, so, you know, once we get the
6 document that reveals those conversations, those
7 communications, and then we have an opportunity to
8 depose -- redepose --

9 THE COURT: Are you talking about you didn't have
10 access to the text messages at the time -- until these
11 depositions?

12 MR. RANSOM: Well, it's all --

13 THE COURT: Because that's when he said the text
14 occurred -- I think at 42 -- 7:42?

15 MR. RANSOM: That's right.

16 THE COURT: And they didn't have time, the -- and
17 the colonoscopy started out, but when -- anyhow, the
18 medication would not have been effective. They
19 couldn't have started a colonoscopy if they just
20 started the medication at 7:42.

21 MR. RANSOM: Right. And that's a record that was
22 first -- the existence of those communications was
23 first revealed to the plaintiff, I -- I believe -- I
24 stand to be corrected, but I think it was Dr. Reeves
25 who had testified in late September, that there had

1 been some sort of a computer system glitch. That was
2 the first notice that we had.

3 And then subsequent to that, we sent some
4 additional written discovery, and the Medical
5 University answered. As I recall, it was the first
6 week of December. It may have been the second -- the
7 8th, but it was shortly before the second hearing that
8 you conducted on the motion for sanctions.

9 Included in that material was the messages --
10 the text messages themselves that we've got marked here
11 as Plaintiff's Exhibit 12. All right.

12 So, it's at that point in time that we realized,
13 well, we're going to have to take Donna Embrey's
14 deposition again, and we can begin the process of
15 thinking through that, and we ultimately get that
16 scheduled for February 22nd. All right.

17 Now, again, I apologize -- and Mr. Cooke is no
18 less busy than I am. But as you know, Judge, I mean to
19 try to get medical care provider's depositions
20 scheduled with everybody's calender, I mean, that's
21 when we got it done.

22 Now, I'm recognizing during this process that
23 I'm going to have to involve Dr. Kofke in updating him
24 on what's all going on. And I've got to make a
25 judgment decision. Okay. I mean, I take

1 responsibility for it.

2 Am I going to start peppering him with a little
3 piece of information here, a little piece of
4 information here, another little piece of information.
5 So I make the decision once we get Nurse Embrey's
6 testimony, and I have the chance to circle the wagons
7 with her around all of this new information, then when
8 we get the transcript and it's all, you know,
9 compartmentalized in one package, if you will, off it
10 goes to Dr. Kofke.

11 Again, I keep highlighting that's the exact same
12 process that they went through with Dr. Berry. All
13 right. So, as quickly as I'm able to get this new
14 information together, get to it Dr. Kofke, consult with
15 him to find out exactly what his view is, I'm sending a
16 letter to Mr. Cooke.

17 Now, importantly, I would note that even though
18 they're sending additional information to their expert,
19 Dr. Berry, they are not supplementing their discovery.
20 They're not telling me what his new opinions are. I'm
21 not crying about that, because I was able to get
22 another deposition from him on April 8th. All right.

23 But I find it very interesting that I'm now
24 being criticized for not supplementing discovery when,
25 in truth, I didn't do anything less --

1 THE COURT: Well, I don't think he's criticizing
2 you. He's saying it didn't happen. Okay.

3 MR. RANSOM: Yeah.

4 THE COURT: Properly. That's all he's saying. I
5 don't think it's any criticism. I didn't take it he's
6 criticizing you personally.

7 MR. RANSOM: No, and him -- and I'm not meaning to
8 criticize him personally.

9 THE COURT: He's just representing his client.
10 Okay.

11 MR. RANSOM: That's right.

12 THE COURT: Okay. Go ahead. Tell me about Dr.
13 Nelson.

14 MR. RANSOM: All right. So, Dr. Nelson, I think
15 it's probably true that when he was deposed in March of
16 2015, Dr. Kofke was focused on the conduct of the CRNA.
17 And I think it's probably accurate that he didn't have
18 a whole lot of criticism about what Dr. Nelson had
19 done.

20 But what we find with these text messages, and
21 what we discovered through additional depositions,
22 especially in Donna Embrey's deposition in late
23 February of this year, is this business about, wait a
24 minute now, whose -- what's going on? When are people
25 coming in and out of the room.

1 And the text messages -- all right -- are very
2 important in that regard. And one of the things that
3 you'll recall that Mr. Cooke did yesterday with Dr.
4 Kofke was he barbecued him pretty good about, well, the
5 Propofol starts at 7:41. All right. Well, when you
6 looked at those text messages, the first text message
7 comes in at -- the first text message comes in 7:39,
8 and the last text message is at 7:46.

9 Now, with Nurse Embrey, she established in her
10 testimony the timeline then, that she was aware of this
11 problem with the machine before she rendered the
12 Propofol to the patient, and she was engaged in the
13 process of trying to correct this malfunction after the
14 patient had already been knocked out. Now, obviously,
15 Dr. Kofke doesn't understand how that is consistent
16 with some of the other information.

17 But my point is, it's at this -- it's at this
18 stage in his analysis where he begins to realize, hey,
19 wait a minute. This record isn't entirely clear as to
20 when people are coming and going, and what they're
21 doing; and at what point in time it is that Dr. Nelson
22 is in the room and not in the room. And I went through
23 all of that in great detail with Donna Embrey in her
24 second deposition, which Dr. Kofke then had the
25 opportunity to review.

1 And so I think it wasn't until he saw that
2 business going on, if you will, that he began to
3 realize, hey, wait a minute. He's in charge of this.

4 THE COURT: Well, did he -- I think -- Donna
5 Embrey apparently changed one of the records three
6 times about when Dr. Nelson was coming and going.

7 MR. RANSOM: Right.

8 THE COURT: Did Dr. Kofke see that or have access
9 to that?

10 MR. RANSOM: Well, he -- he certainly had access
11 to Donna Embrey's testimony at her second deposition.
12 And those issues were a large part of the focus of that
13 questioning, so I think the short answer is, yes, he
14 did --

15 THE COURT: Okay.

16 MR. RANSOM: All right. And I think that this is
17 what influenced him to begin to think, wait a minute,
18 Dr. Nelson has got some culpability here, too.

19 THE COURT: All right. Anything else you want to
20 tell me?

21 MR. RANSOM: Is there any other question you have
22 --

23 THE COURT: I have no more questions. But
24 anything else you want to tell me, because I've been
25 interrupting you? And I apologize. The only way I can

1 focus on something sometimes is to ask questions.

2 MR. RANSOM: As Mr. Apostolou is pointing out, the
3 only other thing I would tell you, Judge, is that if
4 Nurse Embrey had answered some questions at her first
5 deposition truthfully, we would have had all this
6 information long prior to Dr. Kofke's deposition in
7 March of 2015, and none of this would even be an issue.

8 THE COURT: Okay. Mr. Cooke.

9 MR. COOKE: As an aside, you're going to find out
10 in the next couple of hours, that Donna Embrey told the
11 truth there, and everything -- you'll understand --

12 THE COURT: Well, I'm not trying to pass judgment
13 whether she did or didn't. Okay. It's not my job.

14 MR. COOKE: Let me just get down to the -- to the
15 nut. All this stuff about the records or what records
16 we had and the audit trails were produced and their
17 understanding -- I get that -- I get that as far as
18 fine tuning his opinions about Donna Embrey. I mean,
19 if he wants to say now that I think she was texting,
20 you know, I guess I can't really complain about that.

21 But that has nothing whatsoever to do with his
22 having gone back after we moved for summary judgment,
23 based on his testimony in his deposition, and looking
24 at records that he had all along. These are the
25 subsequent treatment records that shows the medications