

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

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SC Court of Appeals

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 IV OF IV

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MEDICAL UNIVERSITY OF
SOUTH CAROLINA

1 it in a rainbow.

2 MS. FLEMING: Yeah, we can live that in.

3 THE COURT: Huh?

4 MS. FLEMING: We can leave that in.

5 THE COURT: You leave that in. Okay. All right,
6 page 56 lines 12 through 21, who wants that in?

7 MR. RANSOM: That's my objection. Yeah, so she --
8 she's asking who else in the family had heart problems.
9 What's that got to do with anything?

10 THE COURT: All right. I'm going to take that
11 out. Okay; 12 through 21. Page 57, 2 through 25; and
12 page 58, 1 through 17; who wants that in or out?

13 MS. FLEMING: May I just review the designation
14 real quick, please.

15 THE COURT: You want it in?

16 MS. FLEMING: I want to review it quickly.

17 THE COURT: Okay. It's just about when she found
18 him at his house, and she was going over there and the
19 TV was on.

20 MS. FLEMING: Yeah, we'll keep it in please, yes.

21 THE COURT: Okay. You want it in or out?

22 MR. RANSOM: I have no objection.

23 THE COURT: All right. That's all I have that's
24 marked in pink; is there anything else?

25 MR. RANSOM: Yes, there are. Ms. Fleming had

1 objections to a couple of other pages, Judge, if I
2 could just --

3 THE COURT: Tell me what pages.

4 MR. RANSOM: All right. Page 50, lines 20 through
5 25..

6 THE COURT: Page 50, lines what?

7 MR. RANSOM: Twenty through 25. That is where Ms.
8 Mikell is asked whether her son is seeing a doctor for
9 his kidneys, before his admission, and she says no.

10 MS. FLEMING: She doesn't -- she has a lack of
11 foundation. She has no idea. She doesn't say how she
12 knows that or how she doesn't know that.

13 THE COURT: You want it in?

14 MS. FLEMING: No, I want it out.

15 MR. RANSOM: That's her question.

16 THE COURT: You want it out?

17 MR. RANSOM: I want it in.

18 MS. FLEMING: All of these are my questions, Rob.

19 MR. RANSOM: Right.

20 MS. FLEMING: I took her deposition. I'm asking
21 her for discovery purposes.

22 MR. RANSOM: Well, I want it in.

23 MS. FLEMING: No. I think -- I think she lacks a
24 foundation to say whether or not he was seeing any
25 kidney --

1 THE COURT: Well, the question was, "Do you know
2 whether Mr. Mikell had been seeing a doctor for his
3 kidneys before his admission to MUSC". And he says,
4 "No. You don't know? No, he did not, not before". I
5 mean, first you say she doesn't know, and then she
6 says -- answers the question.

7 MS. FLEMING: Well, she doesn't -- she doesn't say
8 why she knows that, or why she doesn't know it.

9 THE COURT: All right. I'll take it out. What
10 else?

11 MR. RANSOM: The next objection is page 52, line
12 18, through page 53, line 13.

13 THE COURT: Okay. Who wants that out?

14 MS. FLEMING: We had moved to exclude that.

15 THE COURT: You want it out?

16 MS. FLEMING: Yes, please. It's just talking
17 about how he felt; right?

18 MR. RANSOM: Right.

19 THE COURT: Tired -- I mean, why can't she testify
20 to that? How -- how her son was doing?

21 MS. FLEMING: I mean, I think it -- at this point
22 it's hearsay.

23 THE COURT: Why do you want it out, other than you
24 don't like it?

25 MS. FLEMING: I think it's hearsay.

1 THE COURT: Pardon?

2 MS. FLEMING: I think it's hearsay.

3 THE COURT: It's hearsay. I guess, it is hearsay.
4 I'll take it out. All right. What's -- what's the
5 next objection.

6 MR. RANSOM: The next one is page 55, line 22;
7 through page 56, line 4 --

8 THE COURT: Twenty -- through line 4.

9 MS. FLEMING: Uh-huh. The same objection as the
10 previous objection. And then also relevance at this
11 point.

12 THE COURT: All right. I'm going to take that out
13 on hearsay. What's next?

14 MR. RANSOM: I'm sorry, Your Honor -- okay.
15 Only -- I think the last one is page 79, line 14,
16 through page 80, line 1.

17 THE COURT: Seventy-nine, line 14 you said?

18 MS. FLEMING: Yes.

19 MR. RANSOM: Yes.

20 THE COURT: Through 80, line what?

21 MR. RANSOM: Line one.

22 THE COURT: I'm going to let that in. She's just
23 saying what she told the kids. Anything else?

24 MS. FLEMING: No.

25 MR. RANSOM: I think that's it, Judge.

1 THE COURT: All right.

2 MR. RANSOM: For the court's information, I've got
3 to communicate these rulings to a fellow court
4 reporter's office. And assuming he's able, then he's
5 got about an hour, I understand, of editing technical
6 work before he can send me the final --

7 THE COURT: Why don't we just plan on doing that
8 after we finish the doctor's testimony?

9 MR. RANSOM: Oh absolutely.

10 THE COURT: Will we have time to do that?

11 MR. RANSOM: I'm hoping we will.

12 THE COURT: Well, let me know. If not, we can do
13 it Monday morning, whatever. All right. Anything else
14 we need to deal with or can deal with before we go to
15 lunch?

16 MR. COOKE: No, we are good. Thank you.

17 THE COURT: See you at 1:30. Thank you.

18 MR. RANSOM: Thank you, Your Honor.

19 (WHEREUPON, a lunch break was taken.)

20 THE COURT: All right. Our next witness is Dr.
21 Berry; is that correct?

22 MS. FLEMING: That's correct.

23 THE COURT: Y'all ready to call him?

24 MS. FLEMING: We are.

25 THE COURT: Anything before we bring the jury?

1 MS. FLEMING: Nothing.

2 MR. RANSOM: Judge, I will say that in terms of my
3 technical guy to edit that audio, it's not going to be
4 able to be done this afternoon, so.

5 THE COURT: Okay.

6 MR. RANSOM: It would be Monday.

7 THE COURT: Can he get it done by Monday?

8 MR. RANSOM: Yes. It will be ready by Monday, no
9 question about that.

10 THE COURT: All right. Bring us the jury, please,
11 sir.

12 (WHEREUPON, the jury enters the courtroom at
13 approximately 1:39 p.m.)

14 THE COURT: Call your next witness, please.

15 MS. FLEMING: The defense calls Dr. James Berry.

16 DR. JAMES BERRY, having
17 been duly sworn, testified as follows:

18 THE CLERK: Please state your first and last name,
19 and spell your last name and clearly into the
20 microphone.

21 THE WITNESS: James Berry, B-e-r-r-y.

22 **DIRECT EXAMINATION BY MS. FLEMING:**

23 Q. Good afternoon, Dr. Berry.

24 A. Good afternoon.

25 Q. Could you please tell the jury a little bit

DR. BERRY -- DIRECT

1 about who you are and -- do you live here in
2 Charleston?

3 A. No. I'm currently living in Nashville,
4 Tennessee. I'm a professor at Vanderbilt University
5 Medical School. I was born and raised in Texas and got
6 to Tennessee only after 42 years in Texas.

7 Q. So tell the jury a little bit about where you
8 went to undergrad and where you obtained your medical
9 degree?

10 A. So, I grew up in West Texas. I went to Rush
11 University in Houston. And I liked Houston -- I'm not
12 sure why -- it's hot and humid, which I understand it's
13 like that here, too.

14 I stayed at the University of Texas Medical
15 School there. I got my MD degree. Stayed on to do --
16 well, did an internship -- the one year internship that
17 was called talked about earlier at a hospital up the
18 street called St. Josephs. And then came back to the
19 University at Texas at Houston for the three years of
20 anesthesia training. And stayed in Houston on faculty
21 as an Assistant Professor for about ten years. So that
22 gets us up to 2000.

23 I moved to Jackson, Mississippi, the University
24 of Mississippi in 2000. It didn't work out as well as
25 I thought, and moved to Nashville in 2003, and have

DR. BERRY -- DIRECT

1 been there ever since.

2 Q. And what position do you hold at Vanderbilt
3 University?

4 A. I'm a Professor of Anesthesiology, I have been
5 for 13 years now. And, actually, just stepping down as
6 the longest running division chief in the department.
7 The division is called Multispecialty. It's really
8 adult anesthesia and it's everything that's not
9 subspecialized. It's not pediatrics. It's not
10 obstetrics. It's not cardiac. But mostly sicker
11 adults having nonheart -- noncardiac procedures. And
12 so I ran -- I ran that group for 12 years, about 30
13 faculty under my supervision. And we took care of
14 everything from liver transplants, to trauma, to -- to
15 colonoscopies.

16 Q. And are you board certified?

17 A. Yes.

18 Q. In what area of medicine are you board
19 certified in?

20 A. So my initial board was in anesthesiology.
21 And after that, I also had an interest in underwater
22 diving medicine, so I had a second board certification
23 in undersea medicine or dive medicine.

24 Q. And are you a member of any professional
25 organizations?

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1 A. Sort of the usual, the State Anesthesia
2 Society, the American Society of Anesthesiologist,
3 which is the National Society. I also served as an
4 examiner for the American Board of Anesthesiology,
5 which I think also was discussed earlier.

6 Q.. Okay. Now, you mentioned that you provide
7 care to -- to cardiac patients, who undergo noncardiac
8 procedures. Could you explain your experience in
9 treating -- providing anesthesia care to cardiac
10 patients who undergo noncardiac procedures?

11 A. Well, sadly, nowadays, most patients over 50
12 have some sort of heart disease, and even some younger
13 than that. The -- obesity is common. Sleep apnea is
14 is common. Hypertension is very common. Opiate
15 addiction or opiate dependence is very common. So our
16 patients are sicker and sicker, so they may have
17 coronary artery disease, where the arteries of the
18 heart are narrowed, so they are at risk of heart
19 attack.

20 They could have congestive heart failure, where
21 the heart doesn't pump as well as it should. They
22 could have valve disease, where the heart valves are
23 tight or narrow. And so primarily that's our patient
24 population. And these people need surgery and
25 anesthesia like anyone else. And so we have to deal

DR. BERRY -- DIRECT

1 with those chronic conditions, whether they need their
2 gallbladder out, or their stomach stapled, or their
3 appendix out -- or, you know, any of the other
4 procedures.

5 Q. Now, in your practice, do you routinely
6 provide anesthesia care for patients undergoing
7 colonoscopy?

8 A. Yes, I do. In fact, the last time was early
9 last week.

10 Q. And approximately how many colonoscopy
11 procedures do you do in any given year?

12 A. In a year, so it's once a week, 20 -- it could
13 be -- it could be in the many hundreds.

14 Q. Now, at Vanderbilt, do you work with CRNAs, do
15 you supervisor CRNAs?

16 A. Yes, we're a training program, so we train
17 medical students and residents, but we also supervise
18 CRNAs because there aren't enough trainees to go
19 around, and they kind of get the most educational
20 cases, some of the more routine anesthetics and
21 surgeries would be covered by CRNAs.

22 Q. Now, I know the supervision model that we've
23 talked a lot about this week -- is the attending
24 anesthesiologist required to be physically present in
25 the room throughout a procedure with a CRNA?

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1 A. No. CRNAs are very experienced. Some of them
2 have 30 years doing anesthesia all day, every day. So
3 these are registered nurses, with critical care
4 experience, with two to three more years of school. So
5 they are highly trained at giving anesthesia.

6 The times that we support them and work as a
7 team, is in the preoperative area for assessment when
8 the case gets going, when the procedure gets going,
9 should anything unusual happen in the middle, and then
10 towards the end.

11 So since we supervise as I heard earlier,
12 between two and four CRNAs in two to four different
13 rooms at the same time, we are constantly moving around
14 around, cycling around. And -- but we are required to
15 be immediately available if there's ever a problem.

16 Q. What have you reviewed in order to give
17 more -- or prepare to give testimony in this case?

18 A. Oh, dear. I don't think I could remember all
19 of it. So, there's like four binders of medical
20 records. There were two binders full of depositions,
21 like 27 different depositions. There was another
22 separate CD full of supplemental medical records. It's
23 probably more material than I could easily enumerate.

24 Q. Sure. Have you found the records to be
25 adequate in order to -- to come -- to reach opinions in

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1 this case?

2 A. Well, there's a lot of material in the
3 records, and a lot of it is relevant, and a lot of it
4 not. Some of it is, as you probably have noticed
5 already, is a little difficult to interpret. Computer
6 records are great when they are turned into paper and
7 printed out. Sometimes they don't look quite right,
8 but I -- I think I got the concept.

9 Q. And that was -- that was sort of leading into
10 my next question, you heard a lot about anomalies in
11 the record, including the missing Mayday form, and the
12 data in the anesthesia chart not being available before
13 7:48 a.m. Do you -- do you feel as though you need to
14 have the Mayday form in order to render opinions in
15 this case regarding the standard of care?

16 A. No. Because that was really after the fact.
17 That's a -- that's a record that's made, almost as a
18 redundant piece of charting. When that team is
19 mobilized, they record what they do. They didn't
20 really contribute a lot to the resuscitation; that
21 resuscitation was done by the anesthesia team. And so
22 I'm not terribly -- terribly upset about it, it not
23 being present.

24 Q. And likewise, do you -- in order to render
25 opinions about the standard of care in this case, do

DR. BERRY -- DIRECT

1 you need the vital sign data prior to 7:48 a.m. in
2 order to do that?

3 A. Well, as always, it would be nice -- more is
4 always better. It does record the part of the
5 anesthetic and the part of the resuscitation that --
6 that seems the most relevant. It's the same issue with
7 computer charts; when they work, they're great. When
8 they don't, which is frequently, it's -- you -- you're
9 missing something. But in this case, I don't think it
10 was a -- was a huge impact.

11 Q. Do any of the anomalies that we just discussed
12 impede your ability to evaluate the care that was given
13 to Mr. Mikell?

14 A. Well, I looked at lot of information. And I
15 think I have, at least in my mind, a pretty good
16 concept of what happened, and the sequence of events,
17 so -- so I'm good.

18 Q. Do they affect your ability to render opinions
19 and the quality of the care that was provided to
20 Mr. Mikell during his colonoscopy on 2010?

21 A. No, they don't affect my ability.

22 MS. FLEMING: The defense would tender Dr. Berry
23 as an expert in anesthesiology at this time.

24 MR. RANSOM: No objection, Your Honor.

25 THE COURT: What's your legal objection?

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1 MR. RANSOM: There is none.

2 THE COURT: Okay. No objection?

3 MR. RANSOM: Yeah. Dr. Berry is qualified.

4 THE COURT: Okay. Thank you very much.

5 BY MS. FLEMING:

6 Q. Dr. Berry, have you formed an opinion about
7 whether Dr. Nelson or Donna Embrey deviated from the
8 standard of care in managing Mr. Mikell's airway on
9 October 1, 2010, during his colonoscopy?

10 A. I do have an opinion.

11 Q. And what is your opinion?

12 A. That their attention to the airway was prompt
13 and reasonable and appropriate.

14 Q. Have you formed an opinion about whether any
15 deviations from the standard of care by Dr. Nelson or
16 Donna Embrey proximately caused Mr. Mikell's arrest on
17 October 1, 2010, during his colonoscopy?

18 A. I also have an opinion on that. And it is
19 that I don't see any deviations from the standard of
20 care. What caused the arrest is still probably going
21 to remain a mystery. I have some opinions on that, but
22 I don't think that Ms. Embrey or Dr. Nelson really did
23 anything that I wouldn't have done.

24 Q. We can talk some a while about why that may
25 have happened --

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1 A. Sure.

2 Q. But is it your understanding that there was a
3 pre-anesthesia evaluation of risk done by -- not just
4 Eric Nelson, but another doctor named Dr. Inabinet?

5 A. Yes.

6 Q. Have you formed an opinion about whether the
7 potential risks of anesthesia were adequately discussed
8 with Mr. Mikell?

9 A. Yes. And only based on Dr. Nelson's statement
10 that -- that he did. I -- it sounds as if he had a
11 fairly detailed discussion, more detailed than I
12 probably would have had, especially in terms of the
13 option of intubation versus an unsecured airway.

14 Q. And in your opinion did Mr. Mikell have risks
15 of undergoing anesthesia?

16 A. Oh, absolutely. He had COPD. He had
17 hypertension. He had -- he was overweight. He had
18 sleep apnea. He had heart failure. He was not an
19 atypical patient, but he had serious and significant
20 risk factors.

21 Q. And does a patient's medical history impact
22 the anesthesia plan that is developed for a particular
23 patient?

24 A. Oh, absolutely. The patient with sleep apnea,
25 for example, as we've talked about, is at risk for --

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1 everyone says airway obstruction, but it's really
2 snoring. That word wasn't used, but that's how you
3 understand it. So many people have a loved one who
4 snores at night, it's not uncommon. It's not anything
5 disastrous or catastrophic. It's not airway collapse,
6 it's snoring. And sometimes, in patients with sleep
7 apnea, that obstruction gets worse and may obstruct
8 their breathing completely, and then they wake
9 themselves up. And then you hear that little snort,
10 and they start to breathe again.

11 So that's an issue. But half of our patients
12 have sleep apnea. There's so much obesity -- so
13 it's -- it's nothing special.

14 COPD is a little bit more of a problem. It is a
15 lung disease that, if serious enough, can lead to heart
16 problems. And I actually believe that Mr. Mikell had
17 those sorts of heart problems that you can get from
18 COPD, where the heart is weaker.

19 High blood pressure is obviously a problem. It
20 strains the heart. It makes the heart work harder. It
21 leads to heart failure, which we also know he had. So
22 there's -- all that factors into anesthetic selection
23 and technique.

24 We are not people who work by formulas, and we
25 may talk about that a little bit later. There's no

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1 formula you plug in, that pops out that you need to
2 give an X amount of a drug. It is as much an art as a
3 science.

4 Q. Now, is -- is Propofol a drug that's commonly
5 given for sedation in the anesthesia setting?

6 A. Oh, yes. It is something we could almost not
7 live without. There were Propofol shortages a few
8 years ago, and we were going half crazy. Because it's
9 a drug we use for general anesthesia, for neurosurgical
10 anesthesia, so for brain surgery a lot, for sedation a
11 lot. It's used in the emergency rooms, so it's -- it's
12 very, very common.

13 It's use in colonoscopies and other GI
14 procedures is pretty new. That's only gone on about
15 five or ten years. And it's done because it wears off
16 so quickly and the patients perk right up, and they go
17 home within 20 minutes.

18 Q. Now, did Eric Nelson and Donna Embrey make any
19 modifications to Mr. Mikell's anesthesia plan based on
20 his medical history?

21 A. Absolutely. So if any of you came in to have
22 a colonoscopy, and you're relatively healthy, we would
23 start you at about 200 micrograms per kilo per minute
24 because that's what it takes to kind of have somebody
25 lie still.

DR. BERRY -- DIRECT

1 To get your --- up to that level, that blood
2 level, we have to first give you an -- an injection --
3 and all this is through an IV. Give you an injection
4 with a syringe, and then hook you up to an infusion
5 pump that slowly drips more Propofol in because this
6 stuff wears off really, really quick.

7 Q. Would it be helpful to --

8 A. Yes. If you have -- there's a picture
9 that's -- that's really good.

10 MS. FLEMING: Permission for the witness to step
11 down?

12 THE COURT: Yes, ma'am.

13 (The witness stepped down from the witness
14 stand.)

15 A. So, if I'm giving you Propofol, I want you to
16 be sedated so that you will tolerate the colonoscopy.
17 If we say that this is the level that you need in your
18 blood to -- to lie still and let this GI doctor abuse
19 you, then I have to get you up to that level.

20 So one way that we do it is just with a syringe
21 full of Propofol. And I squirt it in, and it
22 immediately enters your bloodstream, and it hits your
23 brain. And like this shows, we get way up there, way
24 high real quick.

25 Now, when this Propofol wears off fast, it

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1 starts going away almost immediately. So you're good
2 for like 30 seconds, and then you start waking up. And
3 that's how we do it.

4 What I really need to do is keep your blood
5 levels up. And so I give you an injection with a
6 syringe, and then start a slow drip, slow infusion with
7 a -- just a little dropper, and it keeps your blood
8 levels up. So as far as it goes away, we're replacing
9 it. So that blood level stays high and stays at the
10 right level.

11 Now, if I didn't use the syringe, and just
12 hooked you up to the little drip, your blood levels
13 would go up very, very slowly. And after about 10 to
14 20 minutes, you might could get -- might get to where
15 you would tolerate a colonoscope. So that's the slow
16 approach. So, the normal injection, plus infusion,
17 gets you up to the right level and you're great.

18 In Mr. Mikell's case, they were a little worried
19 about him. They weren't so sure how bad his heart
20 failure was, how bad his sleep apnea was, so they --
21 they were going to go really easy. They were going to
22 go really slow.

23 Plus a guy with this many medical conditions
24 probably doesn't need this level -- this blood level.
25 He probably need less, because Propofol affects the

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1 brain and it affects the heart. They were going to
2 take it easy.

3 And so they took the conservative strategy and
4 used just the infusion, not the big dose up front with
5 the syringe, they just started him on -- on the drip,
6 his blood level slowly came up. And because the
7 infusion is 75, not 200 -- so that's like a third of
8 what you or I would need. It went up really, really
9 slowly. And they watched him. Because they can't
10 actually tell, just looking at anybody, how much
11 Propofol you need. All I can tell you is, if I give
12 you a little, see how you do; a little more, see how
13 you do. I can fine tune and adjust the dose so that I
14 get you just in that right spot.

15 So their approach was significantly modified
16 from what I would do with a regular, healthy person.
17 No big injection. Slowly get his levels up with
18 infusion. See how he did. In fact, I think -- so 75
19 for a little while. He had the little dip that we all
20 have. Okay.

21 Suddenly, I have anesthesia on board and nothing
22 to counter balance it, so I'm relaxed. My breathing
23 slows down. My heart/blood pressure goes down a little,
24 bit. And then here comes the scope, and I kind of perk
25 up a little -- I'm not awake, but it's like we kind of

DR. BERRY -- DIRECT

1 balance out the scales of justice. Now, I've got.
2 Propofol on one side, I've got the GI doctor with the
3 scope on the other side, so we're doing this little
4 balancing act.

5 Q. Now, we know from the record that
6 Mr. Mikell -- and feel free to sit or stand -- whatever
7 is most comfortable. We know that Mr. Mikell received
8 two milligrams of Midazolam or Versed before the
9 Propofol was started; how does -- how does the Versed
10 or Midazolam factor into his response to Propofol, if
11 at all?

12 A. It would tend to make him sleepy. Versed is
13 not a drug that depresses the heart or the breathing
14 very much. What it really does is kind of wipes your
15 memory. So that once you've had it, even if you woke
16 up a little bit from your procedure, you wouldn't
17 remember it. So it's kind of like a tree falling in
18 the forest. If no one know remembers it, did it really
19 happen sort of thing. So it really is an amnesic drug.
20 It produces amnesia, but it doesn't really have a lot
21 of respiratory effects or a lot of cardiac effects.

22 Now, we are using it less and less, because
23 after the 20 minute colonoscopy, it's still in your
24 system. It doesn't go away as quickly as Propofol.
25 But -- so the patients tend to be a little sleepier,

DR. BERRY -- DIRECT

1 and then to go home a little less quickly, but that's
2 the only -- probably the only difference to that.

3 Q. Now, despite giving a patient a reduced --

4 A. I'm going to sit back down.

5 Q. Sure.

6 (The witness returned to the witness stand.)

7 BY MS. FLEMING:

8 Q. Now, despite giving a patient a reduced dose
9 of Propofol, in intermitting the bolus -- will the
10 Propofol still have an affect on his respirations and
11 heart function?

12 A. It will. In any dose, it has some effect. In
13 healthy people, it's minimal. And, as I said, we'll
14 see that as a little dip in -- in breathing and maybe
15 blood pressure. But in his case, he had that little
16 dip and kind of came back, and everybody felt pretty
17 good about it. But I think what wasn't appreciated
18 until that moment is -- is how sensitive his heart was
19 to the drug.

20 Q. And when you say he had "a little dip
21 initially", are you referring to right around the time
22 that they put the nasal airway in?

23 A. Yes. So -- well, again, if I give you a drug
24 to put you to sleep, suddenly you've got a lot of drug
25 on board, and nothing to kind of counter balance that.

DR. BERRY] -- DIRECT

1 There's no one cutting on you, there's no surgeon or
2 procedure that's messing with you -- so you have
3 anesthesia without the -- without the pain part. And
4 so because of that imbalance, your body kind of goes
5 down in a general sense, your blood pressure, your
6 heart rate, your breathing, everything goes down.

7 And then as something happens, a little bit --
8 and we're funny, we call it stimulus. It's really
9 pain. A little stimulus happens, and you kind of perk
10 back up. And then we have to just weigh that balance
11 back and forth.

12 Some parts of the procedures hurt a lot, some
13 parts hurt just a tiny bit. And so as that -- that
14 stimulus ebbs and flows, we kind of dial up and down
15 the anesthesia, trying to -- to make it happen.

16 But in any patient I put to sleep, the first
17 couple of minutes they're down, they come back up.
18 Sometimes we have to help them, give them a little
19 nudge, because they're still getting ready for the
20 procedure. They're doing the prep or they're doing the
21 positioning or whatever, and so the little dip is
22 absolutely routine.

23 Q. Now, what is -- what is your understanding of
24 how Mr. Mikell responded once the nasal airway was
25 inserted by Donna Embrey and Dr. Nelson?

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1 A. So from -- from what I've heard, the drug
2 really kind of started to hit him about 7:48. He went
3 down a little bit, his breathing slowed down. His --
4 I'm sure, if we could see it, we'd see maybe a little
5 drop in blood pressure. That's expected. He
6 pre-snored a little bit; obstructed a little bit. They
7 put the nasal airway in. And -- and, basically, he
8 kind of came back up. Someone with obstructive sleep
9 apnea sometimes -- the little tube they put in is
10 green, and so it's a very bright colored. Sometimes
11 the patients want to take them home, but they really
12 are very uncomfortable. That's the wife who wants to
13 take them home, so they won't snore at night.

14 But that goes in. He perks back up. And then
15 the part, I think, that surprised everyone happened in
16 the next couple of minutes.

17 Q. And just to back up a moment --

18 A. Sure.

19 Q. Does the initial desaturation that you've
20 described as expected, is that -- does that, in any
21 way, indicate whether a patient is -- is that an
22 indication of whether Mr. Mikell was unstable at that
23 point?

24 A. Well, it's all relative. Some patients will
25 drop their sat down to 85; some will drop down to, you

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1 know -- if they started out at 97, they will drop down
2 to 90 and come back. It's all very individual. So in
3 someone with less reserve, who doesn't, you know,
4 breathe deeply as much as -- a younger or a smaller
5 patient might, they don't have as much oxygen reserve,
6 and so they'll have a little bigger dip.

7 And we don't see really well recorded, because
8 monitors are terrible at this, is actually how many
9 times he was breathing a minute. There's not a good
10 way to measure that automatically, so that would have
11 provided more information. But this -- this wasn't --
12 this wasn't unstable or unusual.

13 Q. And so do you have any opinion about whether
14 Mr. Mikell was unstable at any point prior to the time
15 that the nasal airway was inserted?

16 A. Oh, no, that part was fine. I think you can
17 call him unstable starting about -- I don't know --
18 7:54, where he had his little dip, recovered; and then
19 something else happened.

20 Q. And we'll come to that, but are there certain
21 values that you've referred to that help you, as the
22 anesthesiologist, monitor a patient's respirations and
23 oxygenation during a procedure?

24 A. Well, it's harder in a case of sedation like
25 this because the end tidal CO₂, which is a great

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1 monitor, tends to be inaccurate. We're basically
2 sampling air from right outside the nostril. And if
3 the patient breathes through their mouth, then you get
4 abnormal low numbers. The respiratory rate is actually
5 the best monitor of sedation and respiratory
6 depression, but it's actually hard to turn into an
7 electronic number because sensing someone's chest
8 moving is harder than it looks.

9 There are monitors that purport to do it, and
10 this one I think tries at some point. But unless the
11 patient is taking really deep, kind of regular breaths,
12 it's harder.

13 Oxygen saturation is important, but it's a
14 little bit of a lagging indicator. The best monitor is
15 an experienced anesthesia provider with eyes on the
16 patient.

17 Q. Now, after the nasal air was inserted, did Mr.
18 Mikell's sats come back up to a reasonable appropriate
19 level?

20 A. Yes. And that was the one I pointed out at
21 7:51 that -- that really looks like the classic dip in
22 recovery. And so at that point, everybody was happy.

23 Q. Was it appropriate for Dr. Nelson to leave the
24 room once the sats had come back up to an appropriate
25 level?

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1 A. Yes.

2 Q. Now, are there occasions -- at Vanderbilt, do
3 you use an electronic medical record?

4 A. We do. It's not the same one that was used
5 here, but it has a lot in common with it.

6 Q. And have you ever had occasions in your
7 practice where you had to page IT for support for help
8 with an electronic record?

9 A. Yes. In short -- the information that comes
10 from the anesthesia machine and monitors goes through
11 an internet cable, basically, and comes back to the
12 computer that does the anesthesia record. The machines
13 get moved, connections get knocked lose. And so it's
14 not an uncommon event.

15 Q. Was it -- do you have an opinion about whether
16 it was appropriate for Donna Embrey to page the IT
17 support team to help her with the PICIS record at 7:39
18 and again at 7:46?

19 A. Yes. I -- if it's as easy for them to page as
20 it is for us, it's a couple of clicks on the keyboard.
21 And so it doesn't -- it's not a distraction or some
22 sort of -- you know, it's not interfering with her
23 patient care.

24 Q. And how -- how long, generally, in your
25 experience does it take to page IT?

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1 A. Ten seconds.

2 Q. Do you have an opinion about whether Donna
3 Embrey's pages to IT prevented her from adequately
4 monitoring Mr. Mikell's status?

5 A. I do have an opinion. And since monitoring is
6 not just about looking -- certainly you can look away
7 and do something for a minute, you're listening.
8 You're watching. It's a -- it's a multisensory
9 function. So I don't see how 10 seconds, clicking a
10 couple of keys, is a -- is a significant distraction.
11 We multitask a lot in our business. We're looking at
12 this, looking at that, looking around; checking
13 everything. It's kind of like a pilot flying an
14 airplane. So, you know, it's just not realistic that
15 that was a significant problem.

16 Q. Now, we've heard testimony this week from Ms.
17 Embrey that once she got Mr. Mikell into the room and
18 hooked up to the monitors, she went to look at the
19 computer and realized that his chart wasn't pulled up;
20 do you have an opinion about whether she should have
21 waited to start the anesthetic before -- or until she
22 had the computer system up and working?

23 A. Well, I think there is so much advantage to
24 have the computer working, that you would like to do it
25 because you're alternative is to have to write it down,

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1 all down, all on paper. So I think that -- there was
2 nothing unsafe about what she did.

3 All the monitors -- the numbers were up. She
4 was ready to go. The computer wasn't charting. And I
5 can just hear her now going, oh, gosh, I'm going to
6 have to write this all down. Let me call these guys
7 real quick. The patient is fine. And -- and so,
8 fortunately, within what, eight minutes, it all came
9 back. And she's, oh, okay, good. I don't have to, you
10 know, copy all these numbers down on a paper chart.

11 So it is not unsafe to care for a patient
12 without a computer. We did it for a long time without
13 computers. The computers produce a beautiful record
14 when they work. It's really nice. It's really
15 detailed. In fact, you know, there's numbers on here
16 0.754 on to infinity, there's too much detail.

17 But the computerized record is supposed to be a
18 help and not a hindrance. It's supposed to save us
19 work, so we don't have to write down every blood
20 pressure. And so if it doesn't work, you go to your
21 back-up system. I'm sure she was grabbing a piece of
22 paper and getting ready to write all this down, and
23 suddenly it's back. So it's not a safety issue.

24 Q. And does the inability to have a computer
25 record up and available to chart in, in any way impact

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1 your ability to take care of and monitor the patient
2 adequately?

3 A. No. I mean that's what we do anyway. The
4 record just shows, in retrospect, that we have done it.
5 It documents, it records; but a computer doesn't take
6 care of a patient.

7 Q. Now, you started to mention that you think
8 that Mr. Mikell sort of started to take a turn around
9 7:54?

10 A. Yes.

11 Q. And what -- what do you rely on in support of
12 that opinion?

13 A. Well, so the pulse oximeter is a wonderful
14 tool. If I had to have one monitor, and I could only
15 have one, I would take that. Because it tells you not
16 only about breathing, it tells you about -- we call it
17 perfusion. It's blood flowing through the body; blood
18 pulsating through the body.

19 And if something goes wrong with either
20 breathing or blood circulation, the pulse oximeter will
21 pretty much tell you. The way it's designed, though,
22 there's a little bit of a time delay because it's a
23 very sensitive device, and any little touch or
24 vibration will upset it. So it sees every time the
25 heart beats, and it averages 10 or 20 heartbeats

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1 together to give you a number.

2 But once it's down, sort of below 70, into the
3 60s, 50s, 40s, and it's still picking up a signal, then
4 something has gone badly wrong with either breathing or
5 circulation, or probably both.

6 Q. Now, in the time period between 7:51, when Dr.
7 Nelson left the room and 7:54, 7:55, do you have an
8 opinion about whether Mr. Mikell was adequately
9 ventilated during that time?

10 A. I do. And I think he was. He had an airway
11 in place. At some point, they actually did around
12 that -- the end of that time, start to ventilate him
13 because -- because he clearly wasn't breathing well.
14 But his saturation, you know, in the 70s, 80s level,
15 especially the high 80s, that's -- that's okay. It's
16 not normal, but it's adequate.

17 Q. Now, we know from looking at the record that
18 at about 7:55, 7:56, Mr. Mikell is recorded to be in a
19 junctional rhythm. Do you have any opinion about why
20 Mr. Mikell arrested during his colonoscopy?

21 A. I do. I think it was a combination of things.
22 It was -- it was a bunch of little things, and not one
23 big thing. As discussed before, when you're CO2 level
24 goes up, which means you're not breathing as deeply as
25 you should, and your oxygen level goes down, usually

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1 again from not breathing as deeply as you should, that
2 produces a stress on the heart.

3 Those two factors make blood vessels constrict,
4 the blood vessels in the lung -- the pulmonary vessels.
5 And that adds an extra load on the right side of the
6 heart. That's the side that pumps blood through the
7 lungs. So that was two factors. So increase CO2,
8 decreased oxygen. And it's not from stopping
9 breathing, it's just from not breathing as deeply as
10 normal.

11 Then the propofol, even at low doses, has an
12 effect on the heart as well. It depresses its ability
13 to squeeze and it -- maybe it reduces it by 10 or 20
14 percent, but now you have three factors all piled up
15 together.

16 If you ever talk to people about analyzing risk,
17 it's never one thing. They talk about swiss cheese
18 with holes that line up, and somehow, you know, three
19 or four slices of cheese line up and suddenly there's a
20 hole all the way through.

21 I think this was a confluence of factors:
22 pre-existing disease; a little bit of respiratory
23 depression that most people would tolerate fine. Heart
24 failure that was -- heart failure, it's a funny word,
25 because it doesn't fail. It just sort of fails. It's

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1 not as good as it usually is, heart failure that was
2 made slightly worse by a drug that normally wouldn't
3 have a noticeable effect.

4 Q. Now, would it have made any difference had Dr.
5 Nelson remained in the room from 7:51 to 7:54, 7:55 in
6 the morning?

7 A. I can't see that he would have done anything
8 differently or that his very presence would have made a
9 difference.

10 Q. Now, do you have an opinion about whether
11 Mr. Mikell suffered a cardiac arrest during this
12 colonoscopy as a result of the deviation from the
13 standard of care by either Donna Embrey or Dr. Nelson?

14 A. Well, as I said earlier, I -- I looked through
15 this record for a long time. And I looked for things
16 that, you know, should have, might have been
17 different -- would have -- I would have done
18 differently. And so clearly, he suffered a cardiac
19 arrest, but I don't see anything that I would have done
20 differently that might have prevented that.

21 Q. Now, are there -- there's been some discussion
22 about certain values in the record. And when Dr.
23 Nelson was in the room -- or when he came back into the
24 room, are there any values that you can -- can look at
25 -- and specifically the positive inspiratory pressure

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1 and the FI02, does that provide you any information
2 about when this patient -- when Mr. Mikell started to
3 receive oxygen from the bag mask device?

4 A. Well, there are probably at 7 --

5 Q. I can enlarge this if it would be helpful.

6 A. No. It's just -- it's further down. So 7:56
7 to -- to start getting good, sort of believable CO2
8 readings, the one that said 24.8 peak pressure above
9 negligible, I mean that -- that's someone holding a
10 mask tightly on the face, squeezing a bag, those -- all
11 those ventilation perimeters get automatically
12 recorded, CO2, you know, for someone who's having
13 cardiac troubles of 25, is certainly more believable.
14 All the 0.7 and 10.5, and all those are garbage
15 numbers. They don't mean anything. Once you start
16 getting numbers in the range of 25 to 40, those are
17 actually believable CO2 numbers.

18 Now, there's one earlier, 52, 45, those are
19 somewhat believable. We've talked about the mouth
20 breathing issue.

21 Q. And when -- just for the jury's benefit, when
22 you're talking about the CO2 value --

23 A. Sure. So it's -- that row -- and I will sort
24 of point out the numbers that actually look like
25 they're not artifact or crazy. So we can see that --

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1 that during that initial little dip that I have
2 described, there are CO2 numbers that look like my own
3 respiratory depression -- normal is 40, 52s, you know,
4 breathing has slowed down and then kind of came back.

15 Q. And what does that CO2 value tell you, it says
6 ETCO2, what does that mean?

7 A. It is the concentration of carbon dioxide that
8 the patient exhaled. So there's not much in the air.
9 I breathe in, my CO2 is zero. I breathe out, almost
10 everybody has a CO2 right around 40. If you have a
11 COPD, sometimes it's a little higher. It could be as
12 high as 50. But you can actually capture that exhaled
13 gas, analyze it really fast, and produce a number -- or
14 even produce a curve that looks like a square wave. So
15 the bottom is breathing in, the top is breathing out.
16 That -- that kind of goes back and forth. It's a great
17 way to monitor respiration.

18 Q. And, Doctor, any other -- is there any other
19 information that's important to you in terms of
20 determining when Mr. Mikell had started to be bag
21 masked ventilated?

22 A. So as I think it had been pointed out earlier,
23 there's tidal volumes that are somewhere -- you know,
24 closer to a hundred -- positive pressure, so the bottom
25 two. So the bottom two numbers here. So those are

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1 the -- the numbers that actually make some sense, that
2 tell me that at 7:56, he was getting positive pressure.

3 Q. And what about the FI02 value, does that
4 indicate a change in oxygen source from a nasal cannula
5 to a bag?

6 A. It depends on how it's sensed. Normally FI02
7 isn't measured with the oxygen cannula. What it's more
8 likely to have been is the anesthesia machine is -- is
9 actually not being used, so it has a hose, a mask, a
10 bag, oxygen flow meters. If there's enough -- if the
11 machine is turned off, basically, if there's no -- if
12 you're not getting general anesthesia through a mask or
13 a tube, the numbers approach room air, 21 percent.

14 And so what it says to me is that about 7:56,
15 they said we need to mask this guy; turned on the
16 oxygen to the machine; put the mask over his face and
17 started squeezing the bag.

18 So, yeah, my interpretation is a little
19 different than what you may have heard earlier. But,
20 basically, that -- that number means somebody fired at
21 the machine, and got ready to ventilate him.

22 Q. Now, do you have an opinion about the -- the
23 resuscitation that was undertaken by Dr. Nelson and
24 Donna Embrey on Mr. Mikell?

25 A. Well, other than it was prompt. They

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1 recognized the breathing problem. They recognized the
2 circulatory problem. They intubated him. They started
3 chest compressions promptly. He got Epinephrine, which
4 is the first line drug, in an appropriate dose. And
5 although it took him a little while to come back, they
6 got him back. They saved this man's life.

7 Q. And do you have an opinion about whether
8 Mr. Mikell was appropriately and continuously monitored
9 throughout his procedure?

10 A. Well, there's not evidence, other than the
11 depositions, to say exactly when the monitors went on.
12 But we are such creatures of habit, to me, more likely
13 than not, they did what they do every day. They rolled
14 him in. They put all the monitors on. They get
15 everything ready. The numbers looked good. They start
16 their procedure. So, it would be difficult to imagine
17 and difficult to understand in -- in my experience,
18 just vanishing rare, to do something different. These
19 people have done this hundreds and hundreds and
20 hundreds of time. They do it the same way every time.

21 Q. Now, I think you mentioned that you thought
22 about this case a lot, and is there anything that -- do
23 you have an opinion, to a reasonable degree of medical
24 certainty, most probably whether there was anything
25 that Dr. Nelson or Donna Embrey could have done

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1 differently that would have prevented Mr. Mikell from
2 having a cardiac arrest?

3 A. Well, I thought about it a lot, but I've also
4 just kind of poured over the records. I don't know how
5 they might have known that his heart failure was
6 actually, in my opinion, more severe than had been
7 recognized. And whether that's -- you know, it would
8 have been manifest by his ability to walk around or
9 climb stairs.

10 They talked to him, took a history, and were,
11 you know, concerned that he had colonic illnesses. And
12 -- but the behavior of someone like this with almost
13 homeopathic doses of anesthesia, is the behavior of
14 someone with really bad heart failure. And so I don't
15 know, you know, what data they may have found, but it
16 wasn't in the record. Reality and his medical record,
17 his history, didn't seem to correlate.

18 Because someone who goes down like they've been
19 hit with a two-by-four, with this small dose of
20 Propofol, something else is going on. His heart is
21 worse than we thought. His breathing is worse than we
22 thought. Something that was not reflected in his
23 record.

24 So, yeah, I'm -- I am at a loss to say what
25 might have been done differently, or what I might have

1 done differently.

2 Q. I don't have any further questions. Thank
3 you.

4 THE COURT: Cross-examination.

5 MR. RANSOM: Thank you, Your Honor.

6 **CROSS EXAMINATION BY MR. RANSOM:**

7 Q. Good afternoon, Dr. Berry.

8 A. Good afternoon, sir.

9 Q. Just to get this out of the way at the very
10 beginning, because Mr. Cooke had asked Dr. Kofke who
11 was here earlier in the week -- just like Dr. Kofke,
12 you've been hired to provide testimony in this case and
13 you're charging, I think, \$500 an hour?

14 A. I've been paid for my time, not for my
15 testimony.

16 Q. Paid for your time. Okay. And you were hired
17 by MUSC in this case to defend the anesthesia
18 providers; right?

19 A. I was hired to evaluate the case and render my
20 opinion.

21 Q. And in order to provide an honest defense and
22 an honest evaluation, you would need to know what
23 actually happened?

24 A. I would need to know any information that's
25 available.

1 Q. Now, you gave the deposition in this case -- I
2 came to Nashville and had a chance to take testimony
3 from you; that was in June of last year; remember?

4 A. Probably. I don't remember.

5 Q. Last summer, it was a nice time to be in
6 Nashville. And the purpose of that deposition was to
7 allow me to learn what all of your opinions in this
8 case were; do you remember?

9 A. Yes.

10 Q. And, you know, the deposition was scheduled
11 for June of 2015, because it was at that point in time
12 that the Medical University, employers, and everybody
13 felt as though all of the information that you needed
14 in order to have -- final objective opinions in this
15 case had been provided, and you had plenty of time to
16 review it; right?

17 A. Yes.

18 Q. And you were relying on MUSC to provide you
19 with a picture of what had happened to Mr. Mikell that
20 was truthful and accurate and complete; right?

21 A. I was relying on them to provide records, yes.

22 Q. Because you wouldn't want to be caught in a
23 spot where you were providing an objective opinion that
24 was based on false information or half information;
25 right?

1 A. That's correct.

2 Q. All right. One of the things that you were
3 provided for review by MUSC was the deposition of Dr.
4 Guldan, and he was the one that they had designated to
5 speak on their behalf about the Mayday record and the
6 Emergency Medical Response Policy?

7 A. I believe I recognize the name. I don't -- I
8 don't remember any details of the deposition.

9 Q. And you remember they gave you his deposition
10 where he testified that the Emergency Medical Response
11 Policy -- we've got it marked as Exhibit 9 here -- he
12 testified the policy didn't apply to Mr. Mikell's case,
13 and that's why there wasn't a Mayday record; do you
14 remember that?

15 A. I actually do not.

16 Q. And so when I came to take your deposition in
17 June of last year, that was your understanding of what
18 the situation was, right, based on Dr. Guldan's
19 testimony?

20 A. You'll have to show me the specific testimony.
21 I don't actually remember seeing Dr. Guldan's
22 testimony.

23 Q. All right. Well, I asked you at your
24 deposition what information you had, and we went
25 through a list. And I think one of the things that you

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1 said was that you had Dr. Guldan's testimony; right?

2 A. I may have, I don't recall.

3 Q. All right. And when MUSC made you available
4 for your deposition last summer, one of the things that
5 they hadn't provided you with was the log of the text
6 messages, and the phone calls that Donna Embrey had
7 been engaged in, isn't that right?

8 A. That's correct.

9 Q. And that's been marked as Exhibit 12. Now, in
10 fact, the Medical University -- when I took your
11 deposition last summer, not only had they not provided
12 you with the text message and phone call log, they
13 hadn't even told you that those things had been gone
14 on, had they? You didn't even know that there had been
15 text messages and phone calls --

16 A. That's correct, yes.

17 Q. -- when they made you available for me to
18 learn what your opinions were. And they also had
19 informed you, when I took your deposition in June of
20 last year, they hadn't told you that there had been
21 this computer software glitch that had caused a problem
22 with the anesthesia record? They hadn't told you that
23 either, had they?

24 A. That's correct.

25 Q. You learned about that, for the first time, in

1 February of this year when you reviewed the September
2 2015 deposition testimony of Dr. Reeves; right?

3 A. Yes.

4 Q. So you didn't find out -- they didn't even
5 tell you about that until six, eight months after they
6 presented you for your deposition; right?

7 A. Yes.

8 Q. They also hadn't informed you at that point in
9 time, in June of 2015, that the Mayday policy did in
10 fact apply, and that there was indeed a Mayday record,
11 but that they had lost it? They didn't tell you that,
12 did they?

13 A. I don't actually recall what the discussion
14 was around that. If -- if I could have a moment, we
15 don't normally call Maydays in an operating room.
16 Procedural sedation suites are kind of a different -- a
17 little different situation, because there's not help
18 nearby. And so there may have been discussion about
19 the appropriateness or inappropriateness of the Mayday.
20 And I don't recall what their particular policy is.

21 Q. Right. You don't really know what their
22 policy is, so you don't really know whether or not
23 their Mayday record would have had information that
24 would be useful in reconstructing the events in this
25 case. But what you do know was that they didn't tell

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1 you, when they presented you for your deposition, that
2 Dr. Guldan had provided false testimony about that, and
3 that Sheila Scarbrough later recanted that and admitted
4 that there was indeed a Mayday record, and that they
5 had destroyed it; you didn't know any of that?

6 A. Actually, I did not. I'd be happy to tell you
7 what's usually on a Mayday record, but that may not be
8 --

9 Q. Well, that's not going to help us decide this
10 case. All right. Now, they also, when you gave your
11 deposition in June of last year, they hadn't provided
12 you with the audit trail that showed the changes that
13 Donna Embrey had made to the anesthesia record? They
14 didn't give you this either, did they?

15 A. No, sir.

16 Q. And, in fact, the first time that you realized
17 that the anesthesia record had been changed by Ms.
18 Embrey was when I pointed it out to you at your
19 deposition last summer; do you remember that?

20 A. Yes.

21 Q. And, in fact, you sort of got called out by
22 that, you were very surprised about that; do you
23 remember?

24 A. Well, only because in my experience, the way
25 anesthesia record entries are handled is different from

1 the way they're handled under the PICIS system.

2 Q. Yeah, in fact, you said, well, let's -- let's
3 look a second at what your reaction was to this. Okay.
4 So when I pointed out to you the changes that had been
5 made -- all right -- you said, "I'm still amazed that
6 that's even possible". And when I pointed to the
7 record that had been changed, you -- it says "No
8 response". That means you were speechless?

9 A. Well, I was -- I had never seen a system that
10 was designed that way.

11 Q. Right.

12 A. And, of course, my experience is limited to
13 the one system that I have seen. But it's -- it's
14 pretty robust in terms of being locked down and changes
15 not allowed.

16 Q. Right. And -- and the system that you are
17 referring to, that you're familiar with, is the one
18 that they have there at Vanderbilt where you work. And
19 on the Vanderbilt system, it's not possible for a nurse
20 anesthetist to enter the system and change the doctor's
21 entries; right?

22 A. Yes, that's correct.

23 Q. But, again, this is something that the Medical
24 University and the defense team, they -- they didn't
25 tell you about that before they presented you for a

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1 deposition? You didn't know that the record had been
2 changed because they didn't give you the audit trail?

3 A. That's correct.

4 Q. So just to kind of summarize this, Dr. Berry,
5 MUSC hired you to defend its anesthesia provider's
6 conduct in this case, and they presented you for a
7 deposition where I was to learn your final opinions.
8 They did that without telling you about the computer
9 software glitch, the text messages, the phone calls,
10 the audit trial, the altered anesthesia narrative, the
11 Mayday record, and the fact Dr. Guldan's testimony was
12 false? They didn't tell you any of that, did they?

13 A. That is correct. Fortunately, they were able
14 to clear it up later on. And I think you re-deposed
15 me.

16 Q. That's right. And, in fact, I think I -- I
17 was able to take your deposition again, I think it was
18 two weeks ago today?

19 A. Something like that.

20 Q. And as it turned out, I asked you at your
21 deposition about this text message log. And what you
22 told me two weeks ago was the first time you had ever
23 seen this document, in this case, was that day?

24 A. Yes, sir, that's correct.

25 Q. Has MUSC ever told you that Donna Embrey gave

1 Mr. Mikell the Propofol after she was aware of the
2 problem with the anesthesia software, but before she
3 had gotten it fixed?

4 A. I don't think they told me that, but I figured
5 it out.

6 Q. Has MUSC ever told you that according to Dr.
7 Reeves, Ms. Embrey should not have put Mr. Mikell to
8 sleep if she had known that there was a problem?

9 A. Problem with what?

10 Q. With the anesthesia software?

11 A. No. I was not aware that that was Dr. Reeves'
12 opinion.

13 Q. So they didn't tell you that, did they? All
14 right.

15 A. Is that -- was that from a deposition, because
16 I just don't recall ever seeing that?

17 Q. Well, you didn't see it because they didn't
18 tell you about it, because they didn't think that it
19 was important for you to know apparently, that the
20 chairman of the anesthesia department had said that it
21 would be a breach of the standard of care for the nurse
22 anesthetist to give the drug to the patient knowing
23 that the system wasn't working; they didn't tell you
24 that, did they?

25 A. No. I'm surprise that that's his opinion.

1 Q. I can put it up on the overhead if you would
2 like to see it.

3 A. Sure.

4 Q. I had asked him, "Shouldn't this sort of
5 linkage problem" -- and that's what -- forgive me,
6 there's been sort of a lot of different terms that
7 we've used to refer to it. One of the ways that has
8 been talked about was the computer wasn't linking with
9 the patient as he was moved from workstation to
10 workstation. So at the point I was taking this
11 testimony from Dr. Reeves, we were calling it a linkage
12 problem. I said, "Shouldn't this sort of linkage
13 problem be checked out and corrected before a patient
14 is put to sleep?" And he said, "I'm sure if she knew
15 it wasn't working, she wouldn't have put the patient
16 asleep, but that's not what actually happened". They
17 didn't tell you about that, did they?

18 A. I actually remember seeing that piece, but it
19 was in an interesting context where I don't think it
20 was clear to me exactly what problem they were talking
21 about. I do remember reading that in the deposition.

22 Q. Right. Do you remember Ms. Embrey's testimony
23 where she said that, in fact, she did give the Propofol
24 to Mr. Mikell knowing that there was a problem? I can
25 put this on the overhead.

1 A. Knowing that there was a communication
2 problem -- yes, I remember that.

3 Q. Yeah. "So, he came in after the Propofol had
4 already been administered, right?" -- and this is a
5 reference to Dr. Nelson coming in after the anesthetic
6 had been given -- she says, "I believe so. I believe
7 so."

8 "And the Propofol was administered after you
9 became aware of this problem, this is what you call a
10 communication problem? And, again, it's a
11 communication problem, software glitch, a linkage
12 problem?"

13 And she says, "In other words, 039 I paged
14 Annette; 042 we gave Propofol?"

15 I said, "That's right."

16 She said, "That sounds about right."

17 "So you gave Mr. Mikell the Propofol before the
18 problem was corrected?"

19 She said, "Yep, it appears so."

20 "And you gave him the Propofol when Dr. Nelson
21 wasn't in the room?"

22 And she said, "Yes."

23 Now, the Medical University told you that that's
24 what had happened?

25 A. Yes.

DR. BERRY -- CROSS

1 Q. And when did they tell you that --

2 A. I don't know --

3 Q. -- when you were getting ready to come and
4 testify?

5 A. No. Whenever I saw the deposition. I have no
6 problem with any of that. The linkage problem, not
7 having communication, giving Propofol, starting
8 Propofol without an attending in the room, this is all
9 regular old every day stuff.

10 Q. Yeah. And I think what you had said was, you
11 know, you do dozens, hundreds, thousands of these cases
12 and you just kind of fall into a routine; right?

13 A. No.

14 Q. That's not the word you used?

15 A. "Routine"?

16 Q. Just a moment ago, is that, you know, you just
17 do what you've always done?

18 A. That's -- I don't know if I used the word
19 "routine".

20 Q. Okay. Right, I mean, because the truth of the
21 matter is, somebody like Mr. Mikell is not a routine
22 patient, is he?

23 A. Mr. Mikell is one of many, many individual
24 sick people that we care for.

25 Q. A guy like Mr. Mikell, with the problems that

1 you've described, is somebody that needs more
2 attention, not less?

3 A. The routine I described was placing monitors
4 every time, before every patient is anesthetized.

5 Q. Well, let's talk -- let's talk about that for
6 a second, because actually the standard that they have
7 there at the Medical University isn't to just place the
8 monitors, it's to actually make sure that they are
9 working; right?

10 A. Yes. And they testified the monitors were
11 working.

12 Q. Right. Well -- and the standard also is to
13 make sure that not only the monitors are working, but
14 that the data is being recorded; right?

15 A. The standard says that an accurate chart will
16 be kept.

17 Q. Right.

18 A. And that might be by computer; it might be by
19 hand. In this case, they fell a little short of that.

20 Q. They sure did, didn't they?

21 A. Yes.

22 Q. And you would agree that if there is a breach
23 of one of those basic standards, where they've started
24 the procedure without checking out all the equipment to
25 make sure it's working properly, before they

1 administered the Propofol, I mean, that's not good, is
2 it?

3 A. I'm not sure that's the case here.

4 Q. You don't think that that's what they did?

5 A. No. That's the -- that's the line -- you keep
6 trying to think of the computer, which is a
7 computerized secretary, as a piece of essential
8 anesthesia equipment. It is not.

9 Q. Right. And that's -- that is my point, is
10 when Nurse Embrey is sending text messages and making
11 phone calls trying to fix --

12 A. Trying to fix the same computer that you're
13 complaining about, not --

14 Q. Trying to fix this glitch instead of doing
15 those things?

16 A. I think she's --

17 Q. -- which are nonessential, she should be --
18 instead of having her back to the patient, she should
19 be paying attention to Mr. Mikell because he's getting
20 into trouble; right?

21 A. I think Dr. Nelson described the ergonomics of
22 not having his back to the patient.

23 Q. Right. But you will recall that he wasn't
24 there, so he doesn't know?

25 A. The room doesn't get rearranged every time he

1 leaves the room. The ergonomics are the same.

2 Q. I mean, can you tell me what color suit the
3 man has on that's sitting out in the hallway right now?

4 A. Not at this moment.

5 Q. Right. So if Dr. Nelson is not in the room,
6 he doesn't know what the ergonomics are, so we can't
7 really rely upon him to tell us what they are; right?

8 A. I'm sorry, I don't understand. You're saying
9 that the people in the room were rearranging the
10 furniture while this was going on?

11 Q. No. I'm saying that Ms. Embrey has got her
12 back to her patient at the time that this is going on,
13 and that explains why she's not paying attention. And
14 the fact that she's not paying attention explains why
15 Mr. Mikell heads off the deep end.

16 Now, you come and want us to believe that this
17 is some hypersensitivity that he has, and that it turns
18 out he was just so much sicker than any of us thought;
19 that's your explanation; right?

20 A. Yes, sir.

21 Q. And that's the explanation that you've had to
22 come up with now that the folks at the Medical
23 University have finally given you all of the
24 information about what really actually happened; right?

25 A. Well, I think this -- these later disclosures,

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1 whatever their nature, didn't really have a lot of
2 bearing on my opinion.

3 Q. Okay. They sure didn't. We can agree about
4 that, because you didn't know any of it had happened.
5 Now, I wanted to ask you, you talked about this
6 business of -- what did you call it -- a little lump
7 you called it?

8 A. A little -- a little dip; that was my term.

9 Q. Okay. Now, just to make sure everybody is on
10 the same wave length here, Dr. Berry, this is page
11 504. You've got several of these real time graphs; is
12 this a little dip?

13 A. That's not the dip which I'm referring to.

14 Q. Yeah. The little dip that you're referring to
15 is the one that comes here --

16 A. Yes.

17 Q. -- before any of the monitoring equipment is
18 working correctly; right?

19 A. Well, it is -- in the minute by minute graph,
20 it is the first four values on that, so the monitoring
21 equipment was working.

22 Q. Uh-huh.

23 A. The point -- the dip you referred to is the
24 big dip where he tried to die.

25 Q. Right. So the thing that we know -- the thing

1 that we know is, that the Propofol is given -- and we
2 understand that the patient is going to have a delayed
3 response. Because as you have described, he's got to
4 get up to a level in his system before it really kind
5 of starts to affect him; right?

6 A. Right.

7 Q. And it's during that period of time that he
8 may make a couple of little dips. And I think what you
9 testified was it's also during this period of time --
10 by the way, I like your reference to the scales of
11 justice -- it's during that period of time that they're
12 balancing him out; right?

13 A. Yes.

14 Q. So this would be the period of time where
15 there's no data; right?

16 A. May I see?

17 Q. Yeah. We've got this. And I'm sorry -- we
18 keep shifting around with these boards. But this would
19 be the period of time between 7:41, when he's first
20 given the Propofol -- this is where they're balancing
21 him out and we're getting these little dips; right?

22 A. No, sir.

23 Q. No?

24 A. No. The dip I'm referring to starts at 7:48
25 and goes to 7:51. There's probably not enough Propofol

1 in his system before that. Because, again, we started
2 out with the little slow infusion. There's barely
3 anything for the first few minutes.

4 Q. Well, is -- is there enough for him to at
5 least be able to endure the colonoscopy comfortably?

6 A. You can do a colonoscopy with just Versed, so
7 possibly.

8 Q. Yeah.

9 A. That was already in his system. So if -- if
10 -- it's hard to know.

11 Q. And the -- what you're saying is that when
12 these little dips occur, you're going to be adjusting
13 the amount of Propofol in order to balance the patient?

14 A. Well, that's more once the procedure is really
15 underway. The first part is not terribly -- terribly
16 uncomfortable.

17 Q. When we -- when we actually look at the
18 record -- right -- this period of time -- I mean, it's
19 just straight 75s all the way across? There's no
20 balancing going on there, is there?

21 A. Because there's -- there's nothing to balance.
22 Okay. He's stable. He's still going to sleep. So
23 induction -- we talk about induction, like, bang, they
24 are asleep. This is a process. It takes five to eight
25 minutes to get an effective blood level, so there's no

1 titration or dialing up and down until you actually get
2 somewhere in the neighborhood of where you want to be.

3 Q. And, yeah, and that's kind of the key to this
4 whole thing, isn't it, you got to get to a blood level;
5 right?

6 A. Yes. But you don't know what it is. You
7 never know in advance what it is.

8 Q. But so with a guy like Mr. Mikell, let's talk
9 a little bit about the -- the way sleep apnea works.
10 Okay. Do you understand that?

11 A. Oh, yeah.

12 Q. Good. So what happens is, when he's at home
13 in bed asleep, and his airway obstructs, his oxygen
14 saturation starts to dip a little bit. And deep inside
15 his brain, it senses that. And what happens? It wakes
16 him up a little bit; right?

17 A. Yeah. It startles him --

18 Q. Right.

19 A. -- or he coughs.

20 Q. And so he'll take a big gulp of air, and the
21 O2 sats will shoot up for a second, and then he goes
22 back to sleep; right?

23 A. It's over in a matter of minutes. So you have
24 to start breathing before the sat comes up. And then
25 it takes a while to come up, so yeah, the general

1 concept.

2 Q. But this is the process, and this is why --
3 when you have obstructive sleep apnea, you can't get a
4 good night's rest. Because the autonomic nervous
5 system -- okay -- the brain stem, what it keeps doing
6 is it's sensing the low oxygen in your blood, and it
7 doesn't wake you all the way up to where you're awake,
8 but it keeps bringing you out of a deep sleep and
9 telling you, hey, wake up and breathe; right? That's
10 what it's doing?

11 A. You sound like an expert witness.

12 Q. Yeah. Well, listen, we've learned a little
13 bit. So the problem, though, that he has is when he
14 goes in to have this procedure done -- all right -- if
15 he's at home in bed asleep -- all right -- and let's
16 say he's snoring loud and he's bugging his wife, well,
17 she can shake him and wake him up; right?

18 A. Right.

19 Q. And if he's there in the colonoscopy suite,
20 and he's been given this Propofol, he's not going to
21 wake up when you shake him?

22 A. Well, we -- we are sort of a surrogate wife.

23 Q. Well, that's not the way it works, though.
24 Because what happens with Mr. Mikell is when he's
25 getting this Propofol going, you're right, it's slowly

1 building up in his blood stream; isn't it?

2 A. Yes.

3 Q. Because it's coming in 75 micrograms a minute,
4 and as you very nicely demonstrated with your -- with
5 your curve, the level is rising; right?

6 A. Yes.

7 Q. And at some point in time, the level gets to
8 where the part of his brain that, when he's at home in
9 bed and he quits breathing, the part of his brain it
10 kind of snaps him out of it and tells him to take the
11 next breath, that part of his brain has now been
12 rendered unconscious; right?

13 A. Well, no, we're talking about two different
14 things here. So, if I -- if I may, there's the urge to
15 breathe, which is a pretty deep seated urge. And then
16 there is the ability to clear one's airway, to pull
17 your tongue off the back of your throat, and those are
18 two different things. And you'll see that in people
19 who snore, because their tongue falls back, and they
20 are still making an effort to breathe, they just can't
21 because it's blocked.

22 And so, eventually -- so, it's not that they've
23 quit breathing, they still have that breathing reflex,
24 they just need to roll over and cough so that their
25 breathing unobstructs, so it's a subtle difference.

1 Q. Well, but my point is, when he's in the GI
2 suite, undergoing this colonoscopy with this continuous
3 Propofol infusion building up the levels in his blood,
4 at some point in time his ability to sort of arouse
5 himself and take that gasping breath is now
6 obliterated; right?

7 A. His ability to clear an obstruction is
8 obliterated. That's where we step in. We put in a
9 nasal airway. He's still got the urge to breathe.
10 Once we provide that clear airway -- he can do it with
11 as little as a tug on the jaw. He's still breathing.
12 We're just providing support for that tongue that fell
13 back because he is sedated. He's under anesthesia.

14 Q. Well, that's the whole point, isn't it? Is
15 when the guy with obstructive sleep apnea, he's there
16 in your endoscopy suite, and you've given him enough
17 Propofol that now he can't wake himself up, he is 100
18 percent dependent on you to make sure that he gets
19 enough air? And if you're at the terminal typing, if
20 you're on the telephone talking, or if you're down the
21 hall or across the way in another room, you can't help
22 him; can you?

23 A. This is a hypothetical?

24 Q. No. This is what happened.

25 A. Not in my opinion.

1 Q. Okay. And one of the things that you told me,
2 when I took your deposition, was you can't tell from
3 the medical record whether Mr. Mikell was stable or not
4 during the time that Nurse Embrey was sending the text
5 messages? You can't tell that from the record; do you
6 remember your testimony about that?

7 A. Not from the values because there were no
8 values there.

9 Q. And so what you had testified to was that all
10 we could do in trying to figure out what Mr. Mikell's
11 real condition was along in here, was to just place our
12 trust in the testimony of Donna Embrey?

13 A. That, and other individuals that were in the
14 room. I think --

15 Q. Well, she's the only one in the room whose
16 testimony speaks to this; right?

17 A. Well, had he been unstable, not breathing, no
18 heart beat, I think some of the others might have
19 noticed that.

20 Q. Well, but my point is --

21 A. Yes, primarily --

22 Q. -- she herself --

23 A. Her testimony --

24 Q. -- that the only person who can tell us what
25 really was going on is Donna Embrey. And you weren't

1 here to see her testify, were you?

2 A. No, sir.

3 Q. Okay. Thank you. I don't have any further
4 questions.

5 THE COURT: Redirect?

6 MS. FLEMING: No further questions. Thank you,
7 Dr. Berry.

8 THE COURT: Doctor, you may step down. Thank you
9 very much.

10 THE WITNESS: Thank you, sir.

11 THE COURT: Can I see the lawyers up here just a
12 second.

13 (WHEREUPON, a bench conference was held.)

14 THE COURT: All right. Madam Forelady, and ladies
15 and gentlemen of the jury, I have to take up certain
16 motions with the attorneys and take up certain other
17 matters, so we're going to adjourn -- I'm going to send
18 you home. We're not going to adjourn, but I'm going to
19 send you home now at this point in time, and ask you to
20 be back at 9:30 Monday morning. And I think we will
21 conclude the trial Monday morning, and it will go to
22 you probably Monday afternoon for deliberations.

23 So please leave your notepads in the chairs.
24 Please don't discuss the case with anyone. And as I
25 told you previously, don't do any type of investigation

1 or anything concerning the case. I'll see you Monday
2 morning at 9:30. Have a good weekend.

3 (WHEREUPON, the jury leaves the courtroom at
4 3:00 p.m.)

5 THE COURT: All right. I understand the only --
6 as far as the testimony, we got the deposition of the
7 deceased grandmother to be read Monday because -- it's
8 a video; right?

9 MR. RANSOM: It's audio.

10 THE COURT: Audio. Okay. It's audio/video that's
11 being modified based upon my rulings on what's
12 admissible and what's not. We'll do that Monday. How
13 long -- approximately how long?

14 MR. RANSOM: I would estimate it's about 30, 35
15 minutes.

16 THE COURT: All right. Okay. All right. Do you
17 have any objections to me hearing his summary -- his
18 directed verdict motions prior to you presenting that
19 testimony?

20 MR. RANSOM: I do not.

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

22 MR. COOKE: Thank you, Your Honor. Before we
23 rest, I was talking to the court reporter during the
24 break. I wanted to make sure we're clear on which
25 exhibits are in. Did you figure out which of ours are

1 not in?

2 THE COURT: The only one I don't have in is number
3 9 -- maybe I missed it. I've got 1 through 8 in by the
4 defendant, subject to some redactions -- being
5 redacted. Have y'all agreed on that?

6 MR. COOKE: No, we haven't. This is 8 --

7 THE COURT: All right. Then I'm going to have to
8 rule on that, and I will here shortly. Do you have
9 nine in?

10 COURT REPORTER: Do you have a 9?

11 THE COURT: Well, maybe they never offered 9. I
12 got -- you got 1 through 8?

13 COURT REPORTER: Yes.

14 THE COURT: I've got 1 through 8 that's been
15 admitted except for the redactions.

16 MR. COOKE: And I think you excluded one -- do you
17 remember the record from Ms. Scarbrough that she sent
18 to the American Heart Association, I think that's
19 number 2 -- 3, it's not in evidence, because the court
20 excluded that.

21 THE COURT: Number 3. Okay. I had number 3 being
22 Mayday -- blank Mayday card. Maybe I missed --

23 MR. COOKE: That's -- that's 2.

24 THE COURT: I thought it was 2.

25 MR. COOKE: Two is the Mayday card. Three was --

1 was this thing from Ms. Scarbrough where --

2 THE COURT: Okay. All right.

3 MR. COOKE: Where she had her data.

4 THE COURT: Okay. That was the data -- Mayday
5 data; right?

6 MR. COOKE: Right.

7 THE COURT: Okay. And I didn't let that in?

8 MR. COOKE: Correct.

9 THE COURT: All right. Do you have anything else
10 you're going to offer? So for the record 1, 2, 4, 5,
11 6, 7, and 8 are in?

12 MR. COOKE: Correct.

13 THE COURT: Is that correct?

14 MR. COOKE: Subject to the redactions.

15 THE COURT: Do you have anything else that you --

16 MR. COOKE: No, we would rest at that point.

17 THE COURT: Okay. All right. Let me hear you on
18 your motions, and I'll take a look at this redaction.

19 Can y'all agree on any portion of the redactions?

20 MS. FLEMING: No.

21 MR. COOKE: We haven't really discussed it yet,
22 but there are quite a few disagreements.

23 THE COURT: All right. Well, let's hear your
24 motions.

25 MR. COOKE: All right. Thank you. We would move

1 for a --

2 THE COURT: And as you said, you might not have an
3 opportunity to even discuss it --

4 MR. COOKE: That's right. It might be moot.

5 THE COURT: Right.

6 MR. COOKE: Rob, any motions from you?

7 MR. RANSOM: I suppose for the record I'll make a
8 motion for directed verdict. I think the evidence is
9 all in and -- and the jury can only return a verdict
10 for the plaintiff.

11 THE COURT: Motion denied.

12 MR. RANSOM: Thank you.

13 MR. COOKE: Your Honor, we move for directed
14 verdict based on the failure of proof on breach of the
15 standard of care, and also as to proximate cause.

16 And we would also, at this time, make a motion
17 for partial summary judgment as to any negligence on
18 the part of a licensed physician, and that would -- of
19 course, I have consequences under the Tort Claims Act
20 should there be a recovery. But I'd like to address
21 each of those, if I may briefly.

22 THE COURT: Yes, sir.

23 MR. COOKE: One other thing I would like to do is
24 to adopt the arguments that we've made in our written
25 motion -- in our written memorandum. And do we file

1 that with the clerk?

2 THE COURT: You can mark it as a Court's Exhibit.
3 I think it will be Court's Exhibit No. 2.

4 COURT REPORTER: It will be number four, because
5 we marked three depositions.

6 THE COURT: Number what?

7 COURT REPORTER: Four.

8 THE COURT: We got that many -- okay.

9 COURT REPORTER: We marked three depositions.

10 THE COURT: Huh?

11 COURT REPORTER: We have three depositions marked.

12 THE COURT: Court's Exhibit No. 4.

13 (WHEREUPON, Court's Exhibit No. 4 marked and
14 made a part of the record.)

15 THE COURT: I just prefer marking it. That way
16 rather than -- so it doesn't get confused and go back
17 to the jury.

18 MR. COOKE: Right. And then I won't have to read
19 the whole thing to you.

20 THE COURT: Right.

21 MR. COOKE: But we would adopt -- we would adopt
22 this. But in summary, the -- the evidence -- the
23 expert testimony --

24 THE COURT: I had previously read it. Okay. I
25 previously read it on other arguments.

1 MR. COOKE: Right. It's the same one that we had
2 at the close of the plaintiff's case. So under
3 Fletcher vs. MUSC, the court described a rule, which
4 essentially the Supreme Court adopted in the legal
5 malpractice context in the Harris Teeter vs. the Moore
6 Van Allen case. And that is that, one, the plaintiff,
7 in a professional liability case, cannot meet the
8 burden -- meet its burden of proof simply by saying
9 there was a bad result, and you must have done
10 something wrong for that bad result to occur. And
11 that's essentially what Dr. Kofke said.

12 He said, I can't make heads or tails of the
13 records. I don't understand the records. I don't know
14 when Dr. Nelson was in or not in, but he must not have
15 been in enough because they -- had he been there, they
16 could have resuscitated the patient.

17 Yet he concedes, and everybody else concedes,
18 that there were risk factors that make -- that made
19 Mr. Mikell subject to having a cardiac arrest even in
20 the absence of negligence. So this puts this case
21 squarely within Fletcher vs. Medical University.

22 Because there, just like here, there was an
23 expert who said I believe that the doctor was negligent
24 in injuring the phrenic nerve, and there was something
25 else that -- another complication that occurred. I --

1 I believe to a reasonable degree of medical certainty,
2 he was negligent for that.

3 And the judge granted a directed verdict, and
4 said you have to be able to say what they did wrong.
5 You can't just say -- I think he must have done
6 something wrong because he was not supposed to -- not
7 supposed to damage the phrenic nerve.

8 And that's exactly right, you can't say I think
9 he did something wrong, because you wouldn't have
10 had -- you probably wouldn't have had a cardiac arrest
11 without it. And then, at the same time, admit that you
12 can have a cardiac arrest without negligence. And then
13 when he says, I can't interpret the records to
14 determine when he was in and when he wasn't out.

15 And then as to, as -- in -- in addition, we
16 don't have the Caption of the Ship Doctrine in South
17 Carolina. And so any arguments that flow from his --
18 his responsibility over all responsibility for
19 anesthesia, for what happens. It does not impose legal
20 liability on him for any acts of Donna Embrey.

21 Turning to Donna Embrey, there -- his one theory
22 is I believe that she must have been distracted at an
23 earlier time, when even though there are no records of
24 the vital signs, I believe he must have been headed
25 towards a cardiac arrest then. And so that is totally

1 lacking in any foundation, just to say I conclude that
2 because he had a cardiac arrest later, even though I
3 admit that that can happen in the absence of negligence
4 because there's a risk of -- of that with this
5 particular patient -- with any patient, but
6 particularly this one, that's -- that's -- that's a
7 logical fallacy which the court refused to indulge in,
8 in the Fletcher case. The Supreme Court refused to
9 indulge that in the Harris Teeter case. So we would
10 submit to you that there's not sufficient evidence to
11 breach the standard of care.

12 We know from an absolute fact -- it's been
13 undisputed -- that Dr. Nelson was in the room at 7:49,
14 because the -- the audit trail says he was there
15 entering his attestations at that time.

16 When he left the room at 7:51, the saturation
17 rate was 90 percent which everybody has testified is --
18 is acceptable. So whatever made have happened up until
19 7:46, when the last text went from Ms. Embrey to the --
20 to the IT was superceded by the airway being placed in,
21 his -- the Propofol being reduced, Dr. Nelson being
22 present, certifying that the patient was okay for him
23 to leave, and then he leaves with the saturation at 90
24 percent.

25 The testimony of the -- of the expert now is the

1 first one that's really addressed that says it's going
2 to take you five to eight minutes to get full sedation
3 from the Propofol anyway, which would negate any
4 inference that there was some big catastrophe that
5 occurred during that -- that time that the machine
6 wasn't recording.

7 In turning to causation, Your Honor, again we
8 would -- we would submit that there's insufficient
9 evidence of proximate cause between any acts of
10 negligence of the defendants and the arrest, because of
11 the fact that it was conceded by the plaintiff's expert
12 that you could have an arrest in the absence of any
13 negligence. And in this particular case, this patient
14 had additional risk factors.

15 But particularly on the wrongful death cause of
16 action, we don't have the cause of death. In the
17 Sherer vs. James case at least -- at least the court
18 knew that the bad outcome had occurred. And I think
19 that was the testicle case, so we that that poor boy
20 had had a necrotic testicle. And you know the delay in
21 diagnosing that makes it more likely that it's going to
22 become necrotic once it becomes avascular.

23 And so they had that testimony in the record
24 that said that had you diagnosed it sooner, it would
25 have been less likely to occur. At least there we knew

1 what "it" was. In this case, we don't know the cause
2 of death. And so the fact that he was more susceptible
3 -- might have been more susceptible to having a
4 pulmonary embolism or a stroke is irrelevant if he
5 didn't have a pulmonary embolism or a stroke.

6 Even if he was -- even if he is at 80 percent
7 risk of having a pulmonary embolism or stroke, if he
8 didn't have one, it didn't make any difference. And,
9 likewise, for the arrhythmia.

10 His cardiologist testified, since we moved for
11 directed verdict, that he was in no more risk before
12 October -- I mean after his discharge from -- from care
13 in December of 2010, than he had been prior to going
14 into the hospital.

15 He testified there was no need for him -- he had
16 not had any evidence of arrhythmias that required him
17 to be on any arrhythmia medicine. And we don't have
18 any evidence that he died of a cardiac arrhythmia.

19 So for all those reasons, Your Honor, we
20 respectfully submit that the plaintiff has failed to
21 prove that -- prove that element of the case.

22 In addition to Sherer vs. James, the court also
23 addressed that issue in the Harris Teeter vs. Moore Van
24 Allen case, and also in the Martison vs. The Hilton
25 Head Health System case.

1 THE COURT: Thank you, sir. Mr. Ransom.

2 MR. RANSOM: Judge, I think the court has already
3 ruled on each of these at various other stages.

4 THE COURT: I just want to give you an opportunity
5 to say whatever you want to say. If you don't want to
6 say anything, have a seat.

7 MR. RANSOM: Well, I feel like I want to give my
8 best, but very briefly, Judge --

9 THE COURT: I guess I should ask your compadre,
10 does he have anything to say?

11 MR. RANSOM: You got anything to say, Alex?

12 THE COURT: Okay. I mean, if you want to add
13 something, that's fine. If you don't, that's fine.

14 MR. RANSOM: Well, I'm not quite sure that I need
15 to argue on the issues of --

16 THE COURT: All right. Well, let me ask you a
17 question; okay?

18 MR. RANSOM: Yes, sir.

19 THE COURT: I'd like to hear you on the partial
20 summary judgment concerning Dr. Nelson, which basically
21 won't affect your liability on MUSC, but it would
22 affect the caps under the state Tort Claim Act. And I
23 -- based upon everything I've heard, since you made --
24 since his directed verdict at the close of the
25 plaintiff's case --

1 MR. RANSOM: Yes.

2 THE COURT: I do want to hear that because --
3 because that does concern me some.

4 MR. RANSOM: All right. So if I could frame this
5 issue in the way that it's been presented by Mr.
6 Cooke -- and forgive me, I used to be able to remember
7 the names of cases, but I can't anymore.

8 But he cited a case, I think, in his pretrial
9 brief that the proposition that the State of South
10 Carolina does not recognize the Captain of the Ship
11 Doctrine -- right -- which is, in essence, vicarious
12 liability by one medical care provider for the conduct
13 of another medical care provider.

14 And the important facts in that case, Judge, it
15 took place up at Richland Memorial Hospital in
16 Columbia, where I live. And they got this fellow there
17 who is a world renown trauma surgeon, his name is Dr.
18 Raymond Bynoe.

19 And they had a patient who came into the
20 emergency room all busted up from some accident. And
21 the issue was whether or not the -- Dr. Bynoe's trauma
22 team, much like a Mayday team, whether or not the
23 trauma team had adequately responded to this
24 individual's injuries by bringing in all the necessary
25 specialists to attend to him.

1 And Dr. Bynoe, himself, as I understand the
2 facts of the case, was not even in the building at the
3 time. And they were attempting to show that because he
4 was the head of the trauma team, and thus the Captain
5 of the Ship, that he had some vicarious liability for
6 the actions of the medical care providers who were
7 actually there working on the patient. Okay.

8 And in that case, the Supreme Court said,
9 listen, we're not going to impose that kind of a
10 liability on our medical care providers because that's
11 basically unprecedented. That's the case that Mr.
12 Cooke relies upon for this argument, but there's no
13 Captain of the Ship Doctrine, and I don't disagree with
14 that.

15 But what we have in this case --

16 THE COURT: Well, where is the liability on Dr.
17 Nelson?

18 MR. RANSOM: Well, the liability is first --

19 THE COURT: I mean, that's what I want to hear.

20 MR. RANSOM: First and foremost, South Carolina
21 State law says that Nurse Embrey cannot give an
22 anesthetic agent to a patient unless she is being
23 directly supervised by a medical doctor, and the
24 statute actually defines the term supervision as the
25 process of critically observing, directing and

1 evaluating another's performance.

2 THE COURT: Critically observing, evaluating and
3 directing?

4 MR. RANSOM: That's right.

5 THE COURT: Well, does that -- does that mean he
6 goes to -- he testified that they went over the plan.
7 He approved the plan. They went over what she was
8 going to do and how she was going to do it.

9 MR. RANSOM: Right.

10 THE COURT: Does that meet the statute?

11 MR. RANSOM: Well --

12 THE COURT: I know you're going to say "no, but
13 tell me why that meets that statute?

14 MR. RANSOM: But he also -- Dr. Nelson, himself,
15 also admitted, as did several other witnesses in
16 conjunction with the basic policies of anesthesia --

17 THE COURT: The statute doesn't say he's got to be
18 physically there and watching her administer
19 Propofol -- or do you think he does?

20 MR. RANSOM: No. But what I'm telling you, Judge,
21 is he is responsible for making sure that those who are
22 his subordinates perform their duties in a safe
23 fashion.

24 THE COURT: Well, he testified he did that. I
25 haven't heard anything different.

1 MR. RANSOM: No. He testified -- or there's been
2 an abundance of evidence that he didn't do that.
3 Because one of the obligations that he has, under the
4 standards and basic policies of the hospital are, he's
5 supposed to make sure -- all right -- that when
6 somebody is being given anesthesia under his direction
7 and supervision, through whatever designee he may wish
8 to use, that the equipment is properly functioning.
9 The vital signs data is being adequately recorded.

10 And so if he, through his own supervisory
11 failure, has not made sure that these things that we
12 call computer glitches and linkage problems, aren't
13 taking place and aren't going to affect the patient's
14 care. And, in fact, somebody who's under his
15 supervision gets distracted --

16 THE COURT: If I follow your theory, he can never
17 delegate anything. I mean, he testified that, yes,
18 that is his responsibility, and he expected the nurses
19 and the people in the -- whatever you want to call
20 it -- a room -- it's not an OR, but the room where they
21 did the colonoscopy, to make sure that's done.

22 MR. RANSOM: Well, but he also testified --

23 THE COURT: He can never delegate anything under
24 your theory.

25 MR. RANSOM: Judge, it's not a matter of

1 delegating, it's a question of he's not even in the
2 room to see to it that these things have been
3 accomplished. All right. And that's what we talk
4 about when say supervising --

5 THE COURT: I mean, under your theory -- if he's
6 got a nurse anesthetist that goes in and makes -- if
7 he's got a nurse anesthetist that goes in and makes
8 sure the monitoring equipment is proper, the computer
9 is proper, and everything is proper. Under your
10 theory, he's going to have to go behind her and check
11 it himself.

12 MR. RANSOM: No, but he could -- under my theory,
13 Judge, he's at least got to ask her is everything
14 working.

15 THE COURT: I'm sorry, what?

16 MR. RANSOM: He's at least got to ask her is
17 everything working. Have we done the inspection. Are
18 we meeting our guidelines. Is everything safe to
19 proceed with this patient? And instead, the evidence
20 in this case is not only does he not do that, he's not
21 even there when they give him the anesthetic.

22 But equally as important, there's -- and I
23 understand this is disputed evidence -- all right --
24 but there's also evidence that at a point in time,
25 where his patient is at a level on the oxygen

1 saturations that his own nurse anesthetist said merit
2 something being done, he's at the terminal and he's out
3 the door --

4 THE COURT: And your expert didn't address that.

5 MR. RANSOM: My expert doesn't have to address it
6 under the Cox vs. Lund case if -- if they set the
7 standard themselves, then I don't need expert
8 testimony.

9 THE COURT: So you're saying now, he was on the
10 computer, not paying attention?

11 MR. RANSOM: That's right. And, in fact, Dr.
12 Kofke's criticism of him in its simplist formulation
13 was, he's going in and out when his patient was sick.
14 He's in and out of the room when the patient is sick
15 and needs attention, and needs help.

16 THE COURT: Okay. Anything else? Mr. Apostolou,
17 instead of whispering, just tell me -- okay --

18 MR. APOSTOLOU: I'll address the court.

19 THE COURT: Just tell me what you want to tell me
20 rather than whispering to him. He might get it wrong.

21 MR. APOSTOLOU: I appreciate that.

22 MR. RANSOM: I usually do.

23 THE COURT: Okay

24 MR. APOSTOLOU: Well, Judge, the doctor originally
25 put his time leaving the room at 7:50. She backed it

1 up to 7:51, that's a question of fact for the jury.
2 But the 7:51 time, the number was at 90 when he left.
3 The 7:50 time was far below 90, which is what the nurse
4 had testified that was the trouble sign. So that's a
5 question of fact, is whether he left at 7:50 or 7:51,
6 that they're going to have to make a decision on.

7 Dr. Kofke testified that the breach of the
8 standard of care, which got us past summary judgment
9 when the case initially got to that point, was that he
10 breached the standard of care by leaving when his
11 client -- when his patient was in trouble, and was
12 sick, and he ended up leaving the room.

13 But if you look at the numbers in -- in the
14 charts across there, those numbers are tanking badly
15 when he walks out of that room. And the -- again, that
16 goes to another fact dispute, between the 7:55 and the
17 8:00 time.

18 If he leaves at 8:00, that increases the chances
19 that the jury would find that he breached the standard
20 of care as delineated by the expert, Dr. Kofke. He
21 said that was a breach of the standard of care to leave
22 him.

23 And he comes back -- if he doesn't come back in
24 until eight minutes, then they can determine that he
25 was out of the room too long, and I think that that's a

1 question of fact that they can decide.

2 And the numbers on that -- that chart are
3 trending. We've seen the real time graph and he's
4 trending down, so I think that's a question of fact for
5 the jury to determine.

6 The expert had said, it's a breach of the
7 standard of care. And then they have to apply the
8 facts and make the choice on who they believe. Because
9 he's testified -- he's also testified that he believed
10 the 8:00 time was correct. So I think that's a
11 question of fact.

12 THE COURT: Okay. Thank you very much.

13 MR. RANSOM: And one last thing I would add is Dr.
14 Nelson, himself, said that he would have to see numbers
15 fairly consistently in the 90s before he left the room.
16 And it's obvious, when you look at the numbers on these
17 exhibits, those -- they are not consistently in the 90s
18 and he's leaving the room.

19 THE COURT: Okay. Thank y'all very much. I'm
20 going to take that -- as far as your directed verdict
21 is concerned, it's denied. As far as the partial
22 directed verdict on the liabilities -- the liability
23 issue, but to adjust the cap in the Tort Claim Act, as
24 far as that, I'm going to take that under advisement.

25 MR. COOKE: Thank you.

1 THE COURT: Okay. All right. Anything else? Can
2 y'all -- I'm going to take a short break. And during
3 the break, can y'all look at those records to see if
4 y'all can agree? If you can't agree, I'll make a
5 decision on it. Okay?

6 MR. COOKE: And we --

7 THE COURT: And let me just -- before you don't
8 agree, I tend to agree with his argument about putting
9 out -- not putting extraneous medical records before
10 the jury just because they are medical records.
11 Okay.

12 MR. COOKE: Also, we did -- we emailed the jury
13 charge, but I brought some hard copies. Do you want
14 the hard copies?

15 THE COURT: Please. Has the defense got any?
16 Have y'all got any charges you want?

17 MR. RANSOM: Judge, the -- again, I don't have any
18 charges separate from what's set forth in my pretrial
19 brief.

20 THE COURT: Well, your pretrial brief doesn't
21 really -- well, okay. All right. That's fine. All
22 right, y'all take a look at these records. I'm going
23 to take about a 10 minute break.

24 (WHEREUPON, a brief recess was had.)

25 (Jury charge conference held off the record.)

1 (WHEREUPON, Court's Exhibit 5 was marked.)

2 (WHEREUPON, Court was adjourned for the day.)

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* * * Monday, April 25, 2016 * * *

THE COURT: Let me see the attorneys up here.

(WHEREUPON, a bench conference was had.)

(After a recess, court reconvened.)

THE COURT: Please be seated. All right. At the end of the plaintiff's case -- excuse me -- at the end of the defendant's case and the plaintiff's case, the defense made a motion for a partial directed verdict as to Dr. Nelson.

And I heard arguments very briefly, and I took that under advisement. And, Mr. Cooke, I'd like to hear your argument on that issue, and I'd like to hear from the plaintiff's attorney.

MR. COOKE: Thank you, Your Honor. As we -- as we've -- not to beat a dead horse, but as you recall Dr. Kofke had no opinions about Dr. Nelson until trial. And what he's testified were -- was that he believes that he was negligent because he was not in the room enough, even though he said he couldn't tell when he was in the room, or how often he was in the room.

But his thesis was that he was not there when the patient was in trouble, because it would -- it took -- it would have taken two hands to clear the airway -- or two sets of hands to clear the airway.

1 Now, that -- that -- that is insufficient to
2 create a deviation from the standard of care, both
3 factually and legally. He admitted that it's
4 permissible for an anesthesiologist to not be in the
5 room at all times. In fact, you can supervise up to
6 four CNRAs. He says it's reasonable. It's within the
7 accepted standard of care for the anesthesiologist to
8 rely upon the CRNA to observe the patient, and to call
9 him when help is needed.

10 And we know that Dr. Nelson was in the room at
11 7:49, because we've got the audit trail that shows he
12 was making his attestations at that -- at that time.
13 The note says that he left the room at 7:51 when the
14 sat was 90.1 percent. He was back in the room --

15 THE COURT: Well, didn't -- didn't their expert
16 say that the following -- he couldn't tell when he was
17 in and out because of the lag in the changing of the
18 records?

19 MR. COOKE: Well, he said that the records are
20 goofy. But the uncontested testimony we had, John
21 Fisher, who is the IT person, who says these numbers at
22 the top of the chart are not goofy. These numbers are
23 input by the computer, by the machine, directly into
24 the computer. It can't be changed, have not been
25 changed by human hands.

1 And we have the audit trail that says
2 uncontestedly at 7:49, Dr. Nelson was typing on the
3 machine there, which is what he's supposed to be doing.
4 And he's typing his 7:48 notes, where it says, I'm
5 present -- what they call attestations were -- which
6 the head anesthesiologist has to put into the record.
7 We know that he physically put those in the record from
8 the room at 7:49.

9 His testimony was that there was a dip in the
10 saturations at 7:48, according to that irrefutable
11 chart. The saturation was 96 percent, and it dipped
12 after that, at which point the -- the Propofol was cut
13 down from 75 to 50.

14 His testimony, and hers as well, was that they
15 inserted a nasal airway which is just -- like a stint
16 to allow him to breathe better. And that his sats came
17 up to 90 percent, which it did. At 7:51, when Dr.
18 Nelson left the room, it was -- it was 90 percent, 90.1
19 percent.

20 And it's -- it's -- then the next two minutes
21 what happens is that the sat dips down to about 80
22 percent, and it comes up to 88 percent. At that point,
23 the nurse cuts off the -- at 7:53, she cuts off the
24 Propofol, so she's saying this procedure is over and
25 she calls for Dr. Nelson.

1 He is in there -- we don't know whether it's
2 exactly 7:55 -- his note says 7:56. Again, that note
3 could have been changed, but the note that --

4 THE COURT: That note originally was 8:00; isn't
5 that right?

6 MR. COOKE: That's the one that he originally said
7 was 8:00, although her note right next to it, she has a
8 7:55 note in which she says he's being bagged. And
9 then his note is 7:56, he says, I'm in the room and
10 we're doing the resuscitations and so forth, and it's a
11 junctional rhythm which, again, and the record shows
12 that.

13 But here's the one thing that nobody could have
14 changed was do you remember we kept talking about the
15 PIP, the positive inspirational pressure, and the FIO2,
16 which all a sudden both of those go from very low, from
17 zero, up to 95 percent oxygen and 28 pressures right at
18 7:55 and 7:56, which everybody has testified that can
19 only mean that they were starting the bagging and the
20 resuscitation at that time, so that's a complete
21 corroboration.

22 All we -- all we have is -- is rank speculation
23 beyond that, that they were not resuscitating this
24 patient at -- between 7:55 and --

25 THE COURT: Well, let me back up and ask you this

1 question if I may: The way I understand the testimony,
2 from the plaintiff's perspective, is the -- if the
3 switch off from the one -- one part of the computer to
4 another part of the -- section on the computer had not
5 been made, and she administered Propofol before that
6 was resolved, if she was paying attention and trying to
7 get a computer glitch straightened out by texting and
8 talking on the telephone and not paying proper
9 attention to the patient -- to the patient --

10 MR. COOKE: Right.

11 THE COURT: It's as simple I can put it, as short
12 as I can put it, that's sort of his theory of liability
13 as to --

14 MR. COOKE: Her?

15 THE COURT: The -- the CRNA. Now, I don't think
16 there's any question the doctor has the right to assume
17 responsibility and duty under the statute of common law
18 to supervise the nurse anesthetist. Okay.

19 And he testified that he went over the plan. He
20 went over the risk of this particular patient; approved
21 the type of plan that was going to be instituted by the
22 nurse anesthetist. Made sure everything was proper and
23 then left the room, and she started the procedure.

24 I think you said he was supervising two rooms
25 that day. Their experts say he can supervise up to

1 four.

2 Now, my question, if in fact their theory is
3 correct, and the jury believes it's correct, why
4 wouldn't he be negligent for making sure the computer
5 system was not working -- was working properly before
6 he left the room initially?

7 Because everything that happened after he
8 basically had the cardiac arrest, or was on the way to
9 the cardiac arrest, really doesn't affect their theory
10 of liability.

11 MR. COOKE: All right. There are two answers to
12 that: One, is superceding events. And the other is
13 what the scope of -- of his duty to supervise it. And
14 you said this on Friday -- or whenever we were arguing
15 this before -- he says if we accept the plaintiff's
16 argument, then you can't supervise CRNAs. How could
17 you possibly --

18 THE COURT: Well, if you accept their argument,
19 the doctor has got to be in there all the time.

20 MR. COOKE: Have to be there all the time. And
21 they've already said, you don't have to be there --

22 THE COURT: Well, why -- why isn't he
23 responsible -- before they start the procedure, making
24 sure everything is at least working properly?

25 MR. COOKE: Because his -- his testimony and

1 everybody's testimony --

2 THE COURT: I'm not worried about his testimony.
3 I'm taking about in theory. Okay. Why shouldn't he be
4 responsible to make sure all the equipment is working
5 properly before they start the procedure?

6 MR. COOKE: Because that's not equipment. The --
7 the --

8 THE COURT: It is equipment. I disagree with
9 that. I know you've tried to say that, but I think it
10 is equipment.

11 MR. COOKE: Well, they said that all the
12 monitoring equipment was working appropriately --

13 THE COURT: But it wasn't because there was a
14 glitch, and I -- that's where I disagree with you. I
15 know you got the monitors and you got the computer, but
16 I think the computer is there, and it should have been
17 working. He should have made sure it was working.

18 MR. COOKE: All right. I'll say what I'm going to
19 say, then I'm going to go to the next argument --

20 THE COURT: Okay.

21 MR. COOKE: Because you don't agree with me.

22 THE COURT: All right.

23 MR. COOKE: What I'm going to say is -- all the
24 testimony, 100 percent of the testimony is that that's
25 not a patient care issue. That's a recordkeeping

1 issue. And that even if -- even if it was not working
2 at all, you could have taken out a paper chart and
3 started charting. There's none -- nobody has said that
4 you have to stop the procedure because that's going on.

5 Even -- I think even Dr. Kofke said that they
6 had things where the equipment -- where the recording
7 wasn't working, they just take out paper charts and
8 start charting. I'm going to stop and get away from
9 that because you don't agree with it.

10 THE COURT: I just don't agree with that. I mean,
11 if that was the case, why did they do it? That's after
12 the fact though --

13 MR. COOKE: Well, the federal government tells
14 them they have to keep these records.

15 THE COURT: Okay.

16 MR. COOKE: But anyway, I'll move on.

17 THE COURT: All right.

18 MR. COOKE: What we do know is that the last text
19 she made was the one -- the little one liner text at
20 7:46. And we know that the IT person did whatever
21 button she has to do, and it was working at 7:48. And
22 the saturation was 96 percent at 7:48. Nobody can
23 change that. Nobody can ever change that because the
24 machine reported 96 percent.

25 The note -- the note -- the narrative note says

1 Dr. Nelson is in, airway -- nasal airway is placed,
2 sats are up to 94 percent. So that's consistent with
3 that.

4 We know that there was a -- that there was a dip
5 between 7:49 and 7:50, but it's back up and Dr. Nelson
6 is in the room, physically in the room. At 7:49,
7 everything is working. The sat is back to 90 percent
8 at 7:51. And that's absolutely objective and
9 uncontested. Those are things that come straight out
10 of the machine that nobody could possibly change.

11 And so -- so we know that whatever problems may
12 have happened back at 7:46 or 7:47 are over with. He
13 has -- he's had his Propofol reduced to 50. He's had a
14 nasal airway put in. His saturations are up to 90
15 percent. And Dr. Nelson leaves the room under that
16 circumstance.

17 And there's not one iota of testimony that --
18 that Mr. Mikell was in distress at that time. I mean,
19 every -- Dr. Kofke, or anybody else, can't point to any
20 parameters that were in -- in effect at 7:51 that
21 showed that there is any room -- any reason why Dr.
22 Nelson had to be there, standing there, looking over
23 the nurse's shoulder, so that's it.

24 Even if you don't agree with my saying that he
25 didn't have to make sure that it was recording, it was

1 superceded by the fact that everything was fine by the
2 time he left the room.

3 THE COURT: Okay. Mr. Ransom?

4 MR. RANSOM: Judge, if I could just grab this one
5 exhibit, this may help us to walk through this.

6 Now, the most -- for the record, this is page 36
7 of 99 -- all right -- you know, Judge, one of the most
8 important pieces of testimony that came into this case
9 was from Dr. Nelson, himself. And he said -- and I
10 wrote this down -- "I would have had to see fairly
11 consistent sats in the 90s before I left the room".

12 Now, what we know is, that he's at the terminal
13 at 7:49, and the sat is 75. At 7:50, which is the time
14 at which Nurse Embrey first puts him leaving the room,
15 the sats are at 69.2. As you look across here 49, 50,
16 51, 52, 53, 54, these numbers are not consistently in
17 the 90s. All right.

18 Now, in the Cox vs. Lund case -- and this is 334
19 SE 2nd, 116, from 1985, it says "Expert testimony is
20 not required to establish negligence when the act
21 complained of was done in the face of a proscription
22 known to the actor." That's a colonoscopy case where
23 the gastroenterologist himself can testify if I wasn't
24 able to see, I shouldn't have advanced the scope, and
25 the evidence showed that he wasn't able to see.

1 That's what we are talking about here, is Dr.
2 Nelson, himself, has said I shouldn't leave the room
3 unless I'm seeing sats that are consistently in the
4 90s.

5 All right. Now, Mr. Cooke keeps hanging his hat
6 on, this 96.7 here, but keep in mind the testimony from
7 Mr. Fisher was he could tell us that that number had
8 not been tampered with -- or he couldn't tell us that
9 it was accurate. And what we know from another spot in
10 this record is that the description we are given is
11 that sats are up to 94 --

12 THE COURT: What did -- what did your expert --
13 what did your -- so he wasn't in the room. Okay?

14 MR. RANSOM: Yeah.

15 THE COURT: What did your expert say how does that
16 violate the standard of care? They had a CRNA there.

17 MR. RANSOM: Well, what Dr. --

18 THE COURT: They are perfectly capable of dealing
19 with the situation. So how was -- assuming your
20 argument is correct, how does that equate to medical
21 malpractice on behalf of Dr. Nelson?

22 MR. RANSOM: Because what Dr. Kofke said was it
23 would be malpractice -- it would be malpractice if the
24 doctor is in and out of the room while his patient is
25 sick, because the maneuvers that are necessary in order

1 to prevent Mr. Mikell from going down, you know, I call
2 it Death Valley, down the Matterhorn into Death Valley,
3 require more than two hands. And that's what Dr. Kofke
4 is saying is, look -- I'm not sure exactly when it is
5 that he leaves the room. And part of the reason we --
6 we say that, Judge, is when you look at the audit
7 trail -- okay -- which is Exhibit 10 -- Plaintiff's
8 Exhibit 10. When --

9 THE COURT: Well, tell me what your expert said.
10 That's what I'm concerned with.

11 MR. RANSOM: Well, he's -- look, he's saying, I
12 don't know whether he left the room at 7:50 or at 7:51,
13 but if he left while his patient was sick -- all right
14 -- then that's malpractice because he needs to be there
15 assisting with the patient who is not stable, with a
16 patient who is desaturating, with a patient who is
17 sick. He needs to be there instead of leaving the
18 room.

19 And we think that there is certainly a factual
20 issue as to what's going on at the point in time when
21 the records have got him leaving the room. And, again,
22 you know -- and so what we see in this record, Judge,
23 is there's considerable dispute, I think, about what
24 time was it when he left the room, and what time was it
25 when he came back in the room. And that's what Dr.

1 Kofke is saying is, look, I'm not here to be able to
2 resolve the dispute as to when he came in and when he
3 left. That's not my role as an expert.

4 He's saying, but if he's going in and out of the
5 room during this period of time that his patient is
6 headed down the Matterhorn, that's malpractice. No
7 question about it.

8 THE COURT: Okay. Very briefly.

9 MR. COOKE: But that's -- that was an if. And you
10 can't establish standard of care -- deviation from
11 standard of care by saying if he did that. You have to
12 have something more -- more than the absence of
13 negligence. The testimony --

14 THE COURT: Well, what about these others -- I
15 can't see them from here -- but the ones he was
16 pointing out to me?

17 MR. COOKE: This is the --

18 THE COURT: Where are -- you are saying it was,
19 what, 98 or something?

20 MR. COOKE: Well, when he started at 7:48, it was
21 96.7. Again, these are just snapshots. Because --
22 they're -- they're actually saying with every heart
23 beat, they're seeing a number. But this was the
24 snapshot, it was 96.7 at 7:48. That's great. But then
25 it dips down to 75 at 7:49; 69.2 at 7:50 --

1 THE COURT: Because it was deteriorating.

2 MR. COOKE: For the moment. And then the
3 testimony was they -- she reduced the Propofol and they
4 inserted the nasal airway. And it's right there in the
5 note that says that. And the sat comes back up, just
6 like they expected it to, to 90.1. And that's at 7:51;
7 90.1. That's acceptable.

8 In other words, to -- to their observation by
9 putting that nasal airway in, and reducing the
10 Propofol, it had done just what they expected it to do.

11 THE COURT: All right. Well, I guess, Mr. Ransom,
12 my problem is your expert didn't testify to what the
13 nurse anesthetist did at that time was improper, and
14 tie that in to what the doctor would have done
15 different. That's where I have difficulty with your
16 case -- okay -- based on your argument.

17 MR. RANSOM: Well, I think Dr. Kofke's testimony
18 --

19 THE COURT: In other words, what else could the
20 doctor have done, assuming he was there watching her do
21 that, is my point? And your doctor didn't say he was
22 -- he should have done something different, and the
23 nurse did it wrong or didn't do enough. He never said
24 that, and that's my problem. I don't question when he
25 was there or not there, or whatever. Assuming he was

1 there to watch everything --

2 MR. RANSOM: This is where my recollection was Dr.
3 Kofke said, based on the other two procedures that
4 Mr. Mikell had had where he underwent anesthesia,
5 nobody else in his hospital stay had any difficulty
6 ventilating him. He didn't have some allergic reaction
7 to the Propofol; point number one.

8 He says, so when I look at this record, and I
9 see this man's sats going down the Matterhorn, I can't
10 understand why two competent anesthesia providers are
11 not able to prevent that because it's a fairly simple
12 process with the chin lift and the head tilt in order
13 to open that airway back up and stop this whole process
14 from taking place.

15 And what he testified was since they obviously
16 were unable to do that -- all right -- the only thing
17 that he could conclude was that either she's
18 distracted -- all right -- by what has happened with
19 this recordkeeping system, or -- and/or Dr. Nelson is
20 not in the room. Okay. Because, again, what we
21 have -- to see the real problem that we have is --

22 THE COURT: Well, what did he -- what did he say
23 she did wrong at this point in time? She reduced the
24 Propofol. She put in a breathing tube. What else
25 could she have done according to him other than adjust

1 the jaw?

2 MR. RANSOM: Have two hands on -- on her patient
3 in order to be able to manipulate the airway, to
4 prevent this obstruction from sending his sats down the
5 cliff. That was what his testimony was.

6 And, again, the problem -- see, where everybody,
7 Judge, is getting tripped up is we don't know exactly
8 what the sequence of events is, because it's all been
9 reverse engineered by Nurse Embrey after the fact.

10 THE COURT: Well, I understand all that. But
11 assuming the doctor was there the whole time is what --

12 MR. RANSOM: Yeah.

13 THE COURT: The point I'm trying to make is --
14 assuming he was there, what could he have done
15 differently?

16 MR. RANSOM: Well, again, with --

17 THE COURT: Other than manipulate the jaw with the
18 breathing tube, I think he said if they work, and then
19 you put in a breathing tube. Well, she put in a
20 breathing tube.

21 MR. RANSOM: Right, but not until 8:00.

22 THE COURT: So what difference does it make? She
23 didn't manipulate the jaw, she put the breathing tube
24 in.

25 MR. RANSOM: Well, remember Dr. Kofke said -- not

1 only minutes, but seconds are important. And if she's
2 fiddling around, calling for help --

3 THE COURT: There was no way she was doing that at
4 that time at 48 and 50, was it? When was the last
5 call?

6 MR. RANSOM: Well, I think the last text message
7 was at 7:46.

8 THE COURT: So, I mean, that was all done after
9 the you -- oh, you're talking about all this was done
10 afterwards?

11 MR. RANSOM: Right. Well --

12 THE COURT: I understand that she should have --
13 maybe noticed it before, because she was tied up and
14 busy, but -- all that occurred while the text and the
15 phone calls theoretically was going on. But once she
16 realized it, she did what she should have done and
17 there's no difference than what the doctor would have
18 done, assuming he would have been in the room.

19 MR. RANSOM: But, by that point, it's too late.
20 Remember the questions I said -- now, by this time,
21 he's already gone. His ship has left the shore. I
22 mean, you see, Judge, what we don't know is -- we don't
23 know what any of these values are before 7:48. All we
24 know is that as soon as that graph starts plotting,
25 it's going downhill. All right.

1 And I guess everybody on the defense side wants
2 you to believe that the numbers before it starts
3 heading downhill were perfectly normal and fine, but
4 that's not necessarily true. Because if, in fact, he's
5 been given the Propofol way back here at 7:41 --

6 THE COURT: That's beside the point. I just have
7 a real difficulty in figuring out what Dr. Nelson did
8 wrong to be honest with you. I'm going to grant the
9 motion. Thank you very much.

10 Now, that changes this charge somewhat, as far
11 as a request for charge. I will add in the medical
12 definition of medical malpractice. Okay.

13 Is there anything else you think I need to add
14 in from the plaintiff's standpoint, based upon your
15 request or the defense's request? Or the negligent per
16 se, that would apply to Dr. Nelson only; right?

17 MR. RANSOM: I'm sorry, Your Honor?

18 THE COURT: Negligent per se would just apply to
19 Dr. Nelson only; right? Not the nurse?

20 MR. RANSOM: I think if she violated -- I think if
21 she violated any of the hospital's own policies, that
22 would be negligence per se.

23 THE COURT: Okay. All right. I'll get a charge
24 together. And we're going to have to read the -- you
25 ready for the audio on the mother's deposition?

1 MR. RANSOM: Yes, Your Honor.

2 THE COURT: Pardon?

3 MR. RANSOM: Yes, Your Honor.

4 THE COURT: Are we ready to do that? Can I bring
5 the jury in and do that, or do we want to take a short
6 break until y'all have an opportunity to get ready for
7 closing arguments?

8 MR. RANSOM: Yeah. We are ready to play the audio
9 then.

10 MR. APOSTOLOU: But we will need a few moments,
11 Judge, based off these rulings, that's going to change
12 our closing.

13 THE COURT: Well, I'm going -- let's do the audio,
14 and I'll give you time to get your thoughts back
15 together. Okay. All right. Can we do that?

16 MR. APOSTOLOU: Yes, sir.

17 THE COURT: I'll give you 10 or 15 minutes before
18 you go to closing arguments, or however long you want,
19 I'll give you 20 minutes. Whatever you need; okay?

20 MR. APOSTOLOU: We are ready to go on the audio,
21 Judge.

22 THE COURT: All right. Bring us the jury, please.

23 (WHEREUPON, the jury enters the courtroom at
24 approximately 10:24 a.m.)

25 THE BAILIFF: All jurors are present, Your Honor.

1 THE COURT: Thank you very much. Madam Forelady,
2 ladies and gentlemen of the jury, this is going to be
3 out of order because it was not ready to be presented
4 to you. The plaintiff is going to play an audio from a
5 deposition that was taken by the -- of Mr. Mikell's
6 mother, who is now deceased.

7 This was taken prior to her death and they are
8 going to play that video for you -- or the recording of
9 the deposition at this time. Please proceed.

10 (The audio of Jewel Miller Mikell's deposition
11 was played for the jury.)

12 MS. FLEMING: This was excluded. This portion was
13 excluded from being allowed to be read.

14 (Audio stopped.)

15 THE COURT: Come up here if you would.

16 (WHEREUPON, a bench conference was had.)

17 THE COURT: Okay.

18 (Audio continued.)

19 MS. FLEMING: This portion wasn't designated, I
20 don't believe.

21 (Audio stopped.)

22 MR. RANSOM: I apologize, folks. It is the
23 editing department. It didn't go as seamlessly as we
24 had hoped.

25 THE COURT: How many lines are we talking about?

1 MR. RANSOM: Like about a page.

2 THE COURT: Can you just turn the volume down like
3 you did on the other, if you please.

4 MR. RANSOM: Yes, sir. Just wait for me to show
5 where we can start back up.

6 THE COURT: Take your time to get it straight.
7 Okay.

8 MR. RANSOM: Thank you.

9 (PAUSE.)

10 (Audio continued.)

11 MS. FLEMING: Objection. Objection again.
12 Objection.

13 MR. RANSOM: Yes.

14 MS. FLEMING: That is all all supposed to be out.

15 (Audio stopped.)

16 (Audio continued.)

17 MR. RANSOM: That's all, Your Honor.

18 THE COURT: Is that all?

19 MR. RANSOM: Yes.

20 THE COURT: Okay. Madam Forelady, ladies and
21 gentlemen of the jury, I'm going to have to ask you to
22 leave the jury (ph) room. The only thing left will be
23 closing arguments and charge. I'm going to give the
24 attorneys a chance to get organized before they give
25 the closing arguments. And please don't discuss the

1 case amongst yourselves. Leave your notepads in your
2 chairs. I'll get you back just as soon as everyone is
3 ready. Thank you very much.

4 (WHEREUPON, the jury leaves the courtroom at
5 11:09 a.m.)

6 THE COURT: How much time do you all need?

7 MR. RANSOM: Thirty minutes.

8 THE COURT: Okay. All right. We'll take about a
9 30 minute break.

10 (WHEREUPON, a brief recess was taken.)

11 THE COURT: Please be seated. Let me see the
12 attorneys up here just a second.

13 (WHEREUPON, a bench conference was had.)

14 MR. APOSTOLOU: Judge, could I go on the record
15 briefly with --- to address the subject of your earlier
16 ruling?

17 THE COURT: I mean, if you want to put something
18 on the record, I mean, that's fine. I'll be glad for
19 you to do that. I'm not trying to -- I thought we had
20 sort of covered that in great detail before and again
21 this morning.

22 MR. APOSTOLOU: I understand, Judge. I will be
23 brief --

24 THE COURT: I hadn't made up my mind until I
25 listened to your argument this morning, to be perfectly

1 honest with you. But right or wrong, that's my
2 decision.

3 MR. APOSTOLOU: I understand.

4 THE COURT: I'll be glad for you to put whatever
5 you want to put on the record.

6 MR. APOSTOLOU: Okay. Judge, basically our
7 analysis on the -- Dr. Nelson has been kind of a two
8 fold analysis. One is the supervision of the nurse.
9 And we think that's supported by the statute, and we
10 think it's also supported by the provisions in the
11 records, the policies of MUSC itself.

12 The second is his actual treatment of the
13 patient himself. We feel that the supervision that
14 we've addressed, Judge, does reflect medical
15 negligence. We think that -- I know that the court had
16 drawn a distinction between negligent supervision and
17 medical negligence. We feel that negligent supervision
18 would be medical malpractice under the case.

19 We also feel like if -- if after having all the
20 evidence in light of kind of the tortuous past of the
21 discovery that we've had in the case, we can always
22 conform the pleadings to reflect that evidence and
23 submit a negligent supervision charge to the jury.
24 Also, just procedurally if we throw --

25 THE COURT: You are doing what now? You're asking

1 for a cause of action for negligent supervision?

2 MR. APOSTOLOU: We could conform the pleadings to
3 include a negligent supervision.

4 THE COURT: Okay. All right.

5 MR. APOSTOLOU: And just -- if we're -- if we're
6 going to excuse the doctor at this point, Judge, we
7 would suggest that perhaps that we submit both to the
8 jury. And if they do come back -- if they don't come
9 back with the doctor, it's a moot point and we
10 haven't -- procedurally handicapped the case at all.

11 If they do come back with the doctor, then it's
12 not a matter of coming -- having to retry the entire
13 case. It's just a matter of a JNOV, and you can always
14 excuse the doctor yourself. And then that would just
15 be an appealable issue that we could have, but we
16 wouldn't have to come back and retry the whole case if
17 we did go to an appeal, and they overturned it. The
18 only remedies is to come back and go back and retry the
19 entire matter.

20 So we would ask you to consider both of them..
21 You can always remedy and elect your option to JNOV, if
22 they do come back against the doctor. If they don't,
23 then it's really a moot point. And it ends that
24 procedural outlet.

25 The other part was just looking through Dr.

1 Kofke's testimony, going through my notes, he said that
2 Dr. Nelson did breach the standard of care. He said it
3 to a reasonable degree of medical certainty. He said
4 that Dr. Nelson recognized that Mr. Mikell was a risky
5 patient that has med sats in the 80s. He said that he
6 breached the standard of care. He said he left his
7 patient was what he had physically said that the doctor
8 had done.

9 There is the discrepancy between whether he left
10 at 7:51, which is the 90 reading on the sats, or he
11 left at 7:50, which he initially put, which is the 69.
12 He said that both of them, the nurse and the doctor,
13 had breached the standard of care in that if -- if one,
14 but not both, had breached the standard of care,
15 Mr. Mikell could have survived and would not have had
16 the cardiac situation.

17 He said that if -- if only one of them had been
18 there -- that if both of them had been there, that the
19 the hands could have prevented the cardiac, and that
20 was what his testimony was. He said that the doctor
21 should only be away for a few minutes, that's going to
22 be an issue of fact as to when he came in, at 7:56 or
23 8:00. He said two minutes is kind of a standard. He
24 said that the infusion was a -- was a decent plan, but
25 it was poorly executed.

1 So I do think that there is enough evidence that
2 the jury could find perhaps against the doctor, but not
3 against the nurse, or either way.

4 But just, procedurally, we'd ask you to consider
5 submitting it -- both of them to the jury, and that
6 would allow you to remedy with the JNOV and just
7 procedurally save us some extra steps.

8 THE COURT: What's the defense's position on
9 submitting -- I think we had a special interrogatory
10 that addressed that. What's your position on dealing
11 with it in that aspect, basically a special
12 interrogatory, do you find Dr. Nelson negligent or not
13 negligent? Yes or no. I think that's what was on the
14 original verdict form, but you had presented -- do you
15 have any objection to doing that?

16 MR. COOKE: We do, Your Honor. Because it affects
17 the way that we would argue in closing, and the court's
18 responsibility is to not send things to the jury if
19 there's not sufficient evidence to go to the jury. And
20 the court has done that, did that with other causes of
21 action at the directed verdict stage, and we submit
22 properly did so here. I'm not going to respond to the
23 rest of the argument. I think it's the same.

24 THE COURT: I'm sorry -- what?

25 MR. COOKE: I said I'm not going to respond to the

1 rest of the argument.

2 THE COURT: I understand. He just wanted to put
3 something on record, and I allowed him to do that. But
4 JNOV, that came up I wasn't anticipating. I thought --
5 I'd thought I asked if you were in agreement with it.
6 If you're not, I don't think I can do it unless it's by
7 agreement. Okay.

8 MR. APOSTOLOU: Okay.

9 THE COURT: Anything else?

10 MR. RANSOM: Judge, I'm just -- excuse me -- I'm
11 not sure that I fully understand the basis of your
12 ruling in regard to what you were saying about the
13 difference between the medical malpractice cause of
14 action and what you were perceiving to be a negligent
15 supervision claim. And I gather that -- the impression
16 I'm getting is that you don't think since we've not
17 pled a negligent supervision claim, that that wouldn't
18 go to the jury in any event. And that's why we were
19 saying, well, but since the theory of the case was
20 negligent supervision --

21 THE COURT: I -- I just don't think you have
22 proven it against Dr. Nelson, okay, medical
23 malpractice. I don't -- I can't state it any simpler
24 than that. Okay. Based upon the entire case, and
25 everything that has been presented, I think you do have

1 a case against the nurse. I do not think you have a
2 case against the doctor. I don't think that's been
3 proven. I don't know how else to say that. Okay. If
4 that -- does that answer your question?

5 MR. RANSOM: Yes, sir. In terms of moving to
6 conform the pleadings to the proof, that was just all
7 my confusion --

8 THE COURT: Well, as far as that's concerned,
9 based upon -- I mean, I think that -- I think the
10 doctor -- your expert, where they hadn't said that
11 negligent sup -- that negligent supervision amounted to
12 medical malpractice. And to be perfectly honest with
13 you -- so, as far as conforming to the pleadings, that
14 motion is denied. Okay.

15 MR. RANSOM: Yes, sir.

16 THE COURT: All right. Anything else?

17 MR. APOSTOLOU: No, Your Honor.

18 MR. COOKE: Nothing, thank you.

19 THE COURT: All right. Bring us the jury, please.

20 (WHEREUPON, the jury enters the courtroom at
21 approximately 11:52 a.m.)

22 THE COURT: Yes, sir.

23 MR. RANSOM: Thank you, Your Honor. May it please
24 the court. Good morning, ladies and gentlemen. So
25 folks, in just a few minutes, you're going to retire to

1 your deliberation room where Judge Nicholson is going
2 to give you two important jobs: The first is going to
3 be for you to fill out the verdict form that he's going
4 to give you.

5 And the second job, equally important, is going
6 to be for you to explain to one another why you think
7 that form should be filled out the way you do. So for
8 the next couple of minutes, I want to spend some time
9 helping you with some ideas about how you can do that.

10 So if during your deliberations, somebody should
11 ask, well, what exactly is it that MUSC did wrong. All
12 right. You can explain to them that, first off, they
13 knocked Chuck out before the equipment was checked.
14 Secondly, that Chuck was down and out while the
15 providers were in and out.

16 And if they should ask, well, what harm came to
17 Chuck as a result of that? You remind them that he
18 suffered an injury to his kidneys that required his
19 important heart medications to be changed.

20 And, lastly, keep in mind, one of the most
21 important aspects of this case is many of the records
22 that tell us, or would have told us what actually took
23 place, are either lost, altered or been destroyed.

24 Now, it's important for y'all to understand,
25 with respect to this case, the scale of justice is an

1 analogy or metaphor that we use for weighing evidence.
2 And in this case, you've got to decide whether what
3 happened to Mr. Mikell was simply a bad outcome, as
4 opposed to being medical malpractice.

5 And so you're going to have to take the evidence
6 that you heard from the witness stand and seen on the
7 screen, and what's contained in the exhibits, and
8 you've got to put that into the balance, and you've got
9 determine -- all right -- which way does it tip.

10 And it's important for you to keep in mind in a
11 case like this, in a civil case -- it's not a criminal
12 case -- in a civil case like this, the burden of proof
13 that's on my client is to prove our case by a
14 preponderance of the evidence. All right.

15 And what that means is, when you've got the
16 evidence and the scale, if it tips ever so slightly in
17 the plaintiff's favor, then your verdict should be for
18 the plaintiff.

19 A preponderance simply means it's more likely
20 than not. All right. Now, this means under a
21 preponderance standard, unlike a criminal standard --
22 you are all familiar with television in a criminal
23 case, the standard is beyond a reasonable doubt. All
24 right. And it's beyond a reasonable doubt in a
25 criminal case because somebody's life and liberty is

1 often at stake. But in a civil case, it's just a
2 preponderance. And that means more likely than not.
3 That means 51 percent is enough to tip the scale in
4 favor of one party or the other.

5 And you can have some doubts in your mind. You
6 can be unsure. All right. But if you think that we've
7 met our burden, that we've proven to you that it's more
8 likely than not that malpractice was committed -- even
9 though you may have some doubts, your verdict should
10 still be for the plaintiff.

11 And in making the decision about how to weigh
12 the evidence, one of the most important things I think
13 that you've got to take into account, is whether or not
14 MUSC has been honest in the way that it's proceeded in
15 this case.

16 Now, think about what the evidence has shown.
17 First off, there's the computer software glitch. And
18 then there's the phone calls, and the text messages,
19 and the audit trail, and the altered anesthesia
20 narrative, and the Mayday record. All right. And
21 these are all things where the folks at MUSC, when this
22 case got started, they just weren't honest with us
23 about that.

24 They didn't want to tell us that there had been
25 a computer glitch. They didn't want to tell us that

1 there had been phone calls and text messages. They
2 didn't want us to see the audit trail. They didn't
3 want to tell us that the anesthesia record narrative
4 had been altered. And most importantly, they didn't
5 even want us to know that there was a Mayday record,
6 let alone tell us what that Mayday record would have
7 shown.

8 And the question that you've got to ask
9 yourselves, ladies and gentlemen, is why not? Why
10 didn't they want us to know all these things. If this
11 were a simple case, where Mr. Mikell suddenly had an
12 unexpected reaction to the anesthesia, and things got
13 away from these folks, well, why wouldn't they just
14 come and tell us that the first time that we asked
15 them? Why would they lie to us about the software
16 glitch, and the phone calls, and the text messages and
17 the audit trail, and all of these other things?

18 And keep in mind, too, it's not just one act of
19 deception, it's a whole series of acts of deception.
20 You know, the old adage is, once, it's an accident.
21 Twice, it's an accident? So we might be able to
22 understand or forgive them for losing the Mayday
23 record. All right. But what about not telling us that
24 there's an audit trail. What about not telling us that
25 they were on the phone and sending text messages? What

1 about not telling us anything about this computer
2 software glitch? Okay.

3 You know, the other old adage is that only the
4 guilty flee when no one pursues. And ask yourselves --
5 remember, the first witness that we heard from was Dr.
6 Scheurer. And she was in charge of quality control and
7 she talked very briefly, but very importantly sort of
8 about what the culture there was at MUSC.

9 She said, we tell people don't ever admit fault.
10 Don't ever point fingers at one another. Don't ever
11 write anything in a chart that you don't want a lawyer
12 to see. And, perhaps, most importantly, and most
13 interestingly, she also said, don't alter
14 documentation.

15 And remember she said, of course, with
16 electronic medical records, it's almost impossible to
17 do that because there is an audit trail that will show
18 what you have been doing. Of course, that's one of the
19 more important aspects of why was it that MUSC
20 initially didn't want us to know that there was an
21 audit trail.

22 Okay. So think about the testimony in terms of
23 the credibility of MUSC's position, and whether or not
24 they are following this culture of what I sort of call
25 the culture of don't tell. Okay. Don't volunteer

1 information.

2 Remember the testimony that we got from Donna
3 Embrey.

4 (WHEREUPON, testimony was played in open court.)

5 MR. RANSOM: Now, of course, what we know is that
6 there were problems with the way the machine was
7 recording the oxygen saturation levels in the chart.
8 This was the software glitch that took place.

9 And here we are back in August of 2014, where
10 I'm asking her these questions -- and how difficult
11 would it have been for Donna Embrey, right here at this
12 moment -- I mean, August 26, 2014, at 10:39 in the
13 morning, to say you know what, Mr. Ransom, there was a
14 problem. There had been a software glitch. I had
15 realized that the machine wasn't working correctly
16 because I hadn't checked it out yet that morning before
17 we got started. All right. And just explain to me
18 this whole series of events that were withheld from us.
19 All right. How easy would that would have been?

20 The next thing is keep in mind, too, when she
21 goes back to change the anesthesia record, and it's
22 initially an entry that's been made by Dr. Nelson, as
23 we saw here on the board, Dr. Nelson first comes in and
24 makes an entry that he came into the room at 8:00.
25 Okay. And what we know is, that Nurse Embrey later

1 went back and changed that entry so that it was an
2 entry made under her name. And she changed it so that
3 it was Dr. Nelson coming back in at 7:56. So it's an
4 entry that's initially made under his initials, and she
5 goes back and changes it. And remember, I asked her if
6 she told us three different times about that.

7 (WHEREUPON, testimony was played in open court.)

8 MR. RANSOM: So, you see, I mean she's fairly
9 emphatic three separate times in a row, she's
10 explaining this entry by saying that's Dr. Nelson
11 charting under my name. Folks, that's -- that's
12 absolutely false. I mean, that's Dr. Nelson charting
13 under his own name, and her coming back and changing
14 it.

15 So, again, the question that you need to ask
16 yourselves is why all this subterfuge? Why all this
17 deception? Why all this lying if, in fact, this was
18 just an unexpected instance of Mr. Mikell having some
19 sort of a bad reaction to the anesthetic? That's what
20 they want you to believe. But if that's true, why do
21 they keep trying to lie and cover up these other
22 things? It doesn't make sense.

23 So think about Dr. Berry's testimony. All
24 right. And we asked Dr. Berry -- remember, I asked him
25 I said was the information that they sent to you

1 truthful, accurate and complete? And instead MUSC,
2 when I first took Dr. Berry's deposition back in June
3 of 2015, when they told me they were ready to present
4 his final opinions in the case, what we now know is
5 that they hadn't told him about the computer glitch.
6 They hadn't told him about the text messages. They
7 hadn't told him about the phone calls. He had never
8 seen the audit trail.

9 He was quite surprised when I pointed out to him
10 that the narrative had been altered. And he also
11 didn't know anything about the Mayday record. So,
12 again, why -- why the deception? If they've got a
13 legitimate defense, why are they playing hide the ball
14 with their own witness? Their own witness.

15 And so what Dr. Berry said was, I've just got to
16 rely on Donna Embrey. All right. And he said, what I
17 find when I look at these reports is there was just
18 something very unusual that happened. But you'll
19 remember when we asked Dr. Nelson what happened, he
20 told us that it was just an airway collapse or an
21 airway obstruction as a result of Mr. Mikell's
22 obstructive sleep apnea, that they were well aware of
23 before they even gave him the anesthetic agent. It's
24 not something unusual that took place.

25 Dr. Berry, he's confused, if at all -- because

1 they haven't been truthful with him about what really
2 took place. That Dr. Nelson admits that what happened
3 to Mr. Mikell was, what we've all learned about during
4 this case, is when they knock him out, his airway
5 collapses and his brain is unconscious. He can't wake
6 himself up. And he stops breathing. Down go the sats.

7 Now, keep in mind that Donna Embrey has got to
8 come up with some explanation for all of this. Because
9 as we know, there's going to be an investigation by the
10 anesthesia department there at MUSC. So after she gets
11 off her shift, and she's had some time to think about
12 it, she's going to go back and she's going to create
13 this very detailed narrative to try to explain to
14 people looking over her shoulder. All right. What --
15 what happened.

16 And there are a couple of things that she's got
17 to figure out. The first is, when did Dr. Nelson leave
18 the room? Should it be at 7:50 or should it be at
19 7:51? And we know from the audit trail, which is
20 Plaintiff's Exhibit 10, that this is one of the issues
21 that she's graveling with. Because if you'll look and
22 see on the last page, that initially she puts down that
23 Dr. Nelson leaves at 7:50. Then she later changes that
24 to say that Dr. Nelson is leaving at 7:51.

25 She's also got to come up with some explanation

1 for when it is that Dr. Nelson comes back into the
2 room. Does he come back in at 8:00, which is what Dr.
3 Nelson himself charted, or does he come back in at
4 7:56. All right.

5 And what we know is she's trying to make these
6 decisions as to how she's going to handle this. First
7 off, the audit trail shows Dr. Nelson is at the
8 keyboard at 7:49. And she's also got this vital signs
9 information, part of which is on this one board. Okay.

10 And you'll see this is page 36 of 99. The whole
11 chart has been entered into evidence. And it's page
12 38, and it has the vital signs information going out
13 for the rest of the time, 7:55 to 8:03. But -- so if
14 she's looking at this information -- okay -- and
15 remember when she goes and gets Mr. Mikell's chart off
16 of his bedside, when she's at the ICU, and she goes to
17 the terminal and sits down to create this narrative,
18 these values as John Fisher told us -- these values are
19 in the system and they can't be changed.

20 All right. So what she's got to make sure, as
21 she's trying to explain this, knowing that somebody is
22 going to be looking it over, she's got to figure out
23 how am I going to explain what happened in the context
24 of this vital signs information that can't be changed.
25 And she looks and she sees, well, at 7:50, the 02 sats

1 are 69.

2 Remember what she said -- Donna Embrey said that
3 if the sats are below 90, somebody needs to be doing
4 something. All right. And remember what Dr. Nelson
5 said, that I'm not going to leave the room until I'm
6 seeing sats that are pretty consistently in the 90s.

7 So when she looks at 7:50 -- all right -- she
8 realizes, wait a minute, if he's leaving the room at
9 7:50, that's not so good. But at 7:51, the sats popped
10 up for a minute, so I'll go ahead then and put down
11 that he left the room at 7:51. And the next thing
12 she's got to figure out is, well, when does he come
13 back in.

14 And what we know is that he's made this entry at
15 8:00 saying he's come in at 8:00. And one of the
16 things that his entry says is that there's no palpable
17 pulse. All right.

18 Well, when you look through the vital signs
19 data -- all right -- we see -- and there's another
20 column that's not part of this board, but it's in
21 evidence where it describes Mr. Mikell's heart rate, we
22 see that at 7:58, that's when he's in pulseless
23 electrical activity. That would be no palpable pulse.

24 But we also see the same record says that he's
25 beginning his junctional rhythm at 7:56. All right.

1 So, again, she's constrained by these values in trying
2 to reverse engineer this record and tell us what's
3 going on. So she decides, okay, I'll put him down
4 coming in at 7:56. Because that's just at the very
5 start of the trouble.

6 But think about this folks, again, look at these
7 values. So 7:57, the sats are 41.2. And at 8:01, the
8 sats are 88.1. So if Dr. Nelson comes in at 7:56, why
9 are the sats then dropping another 30 points if he's
10 there helping her?

11 Alternatively, if he comes in at 8:00, well, the
12 sats go from 67 to 88. Well, that looks like maybe
13 she's getting some help, doesn't it?

14 So my point is, folks, when you start looking at
15 all this information -- all right -- you got to kind of
16 scratch your head and think, hummm, do I really want to
17 believe Donna Embrey, who's told all of these other
18 lies when she sit downs and reverse engineers this
19 record?

20 And the most important part of all of this of
21 course, folks, is the Mayday record. What is it that
22 she tells us that she's using when she tries to
23 reconstruct all of this? I was looking at the code
24 sheet. That's how I synced when the CPR started and
25 everything else.

1 It's this Mayday record that, remember, she
2 couldn't even tell us there was a Mayday record.

3 (WHEREUPON, testimony was played in open court.)

4 MR. RANSOM: Now, once again, this is her answer
5 in August of 2014. And if this whole explanation that
6 she's reverse engineered is legitimate, folks, I mean
7 why isn't she just truthfully answering the question.
8 Mr. Ransom, let me tell you about the Mayday record.
9 It was in his chart. I used it in order to be able to
10 establish the timeline of events, and that's now what
11 we find in the narrative.

12 Well, she doesn't tell us that. I mean, that's
13 what actually -- that's what actually happened. So,
14 you know, why is she lying? She's lying because she
15 knows and we now know that she's making all of this up.
16 Now, we look at this -- this real time graph, and we
17 looked at it a lot in this case. All right. And this
18 is sort of part of the record that can't be changed,
19 and it's really inescapable in what it shows. Keep in
20 mind that the text message, the last text message is at
21 7:46. And it's at 7:48 that the data starts flowing
22 across.

23 All right. What we don't know, and what we've
24 never going to know is what actually fills these boxes
25 here from the point in time where the Propofol is first

1 given at 7:41, all the way up until the record starts
2 populating the data at 7:48.

3 Well, you know, the Medical University wants you
4 to believe that the values that goes into these boxes
5 here, they are all just perfectly fine. Mr. Mikell is
6 doing great. No problems whatsoever.

7 And Dr. Berry tells you that oh, well, you know,
8 when you first give the patient the anesthetic, there's
9 this process. They're going to get relaxed and their
10 heart rate will slow down, and maybe they'll stop
11 breathing as quickly, and their sats might drop a
12 little. And you're doing this balancing act and you're
13 adjusting the amounts of the medication that you give.

14 Well, once again, as we know from other parts of
15 the record that show us the Propofol that's being
16 given, there's no adjustments being made. There's no
17 balancing act taking place there.

18 So at the end of the day, we don't really know
19 what comes before 7:48. Well, what we know is that as
20 soon as that software starts capturing and plotting
21 data, it's going straight down here. All right.

22 And if Dr. Nelson is in around at 7:50 or 7:51,
23 it's still going downhill. And if he's coming into the
24 room at 7:56, it's still going downhill. And if
25 it's -- when he goes into pulseless electrical

1 activity, it's still down there in what I -- what I
2 refer to as Death Valley. And if he comes in at
3 8:00 -- all right -- that's where he's finally starting
4 to move back upward. Okay.

5 And keep in mind, Donna Embrey, herself said
6 that if the sats are below 90, you better be doing
7 something. And we don't see those sats anywhere but
8 below 90 as that graph begins to plot.

9 And Dr. Nelson said that before he left, he
10 would want to see sats consistently in the 90s. I
11 don't see any sats that are consistently in the 90s
12 either.

13 So what happens is, they get distracted. They
14 get started with a procedure where they've given him
15 the Propofol before they've gotten the system checked
16 out and something -- Mr. Mikell, not surprisingly, he
17 obstructs -- as soon as they put him to sleep, he
18 obstructs. All right. He takes a couple of gasping
19 breaths. That may explain some of these higher 02 sat
20 values, if they're actually accurate. But he begins
21 heading down this slope. Okay.

22 He's headed down the slope. Where he crashes --
23 and remember what I think Dr. Nelson himself said, it's
24 like, look, once this thing gets away from you, it's
25 ballgame over. Okay. It's not a question of being

1 able to come running into the room, somewhere where
2 this precipitous decline in his sats has begun. It's
3 like once -- because, you know, once his heart -- this
4 fragile heart that they want to tell you, he's got such
5 a bad heart, once his heart gets a lack of oxygen and
6 the blood carbon dioxide starts coming up, it's too
7 late for Mr. Mikell. And they know that when they get
8 started with this procedure.

9 We asked Donna Embrey why didn't you check the
10 system out? So you had to check to make sure that part
11 of the system was working correctly. And she said, no.
12 And I asked her, why not? Well, look what she says.
13 I'm busy. Kind of busy. Checking the equipment to
14 make sure that it's working correctly. It's the last
15 thing that I do.

16 But this is what the policies and procedures
17 there at the Medical University require and there's no
18 ambiguity and there's no uncertainty whatsoever. It
19 says that they are responsible for making sure that all
20 of the equipment is properly functioning before they
21 begin the procedure, and that includes making sure that
22 all information is accurately recorded on the
23 anesthetic record.

24 And you know, folks, one of the things that I
25 hope -- you know, it's been an interesting process in

1 this trial of exposing each of you to this -- to this
2 science, if you will, to the medicine. And I hope what
3 you've discovered is this is not beyond your
4 understanding, every one of y'all is able to get what's
5 going on here.

6 You know, this idea about obstructing his
7 airway, and the oxygen levels in his blood dropping,
8 and the carbon dioxide levels in his blood are coming
9 up, I mean, you don't have to be Einstein to be able to
10 understand this. Okay.

11 And think about your own lives. You know, when
12 you're going through a process, and you understand that
13 the first thing you are supposed to do is check out a
14 piece of equipment to make sure it's functioning
15 properly -- I mean, you know, when you get the lawn
16 mower out, guys, on Saturday, do you check it to make
17 sure that it's going to work safely before you crank it
18 up?

19 Ladies, I mean, when you're in the kitchen, and
20 you go to turn on the stove, do you check to make sure
21 that the little cap that sits on the burner is on there
22 correctly before you light it, or after it blows up?
23 So we all understand how this works in life.

24 And it's unfortunate in this case because it
25 could have been so very, very simple for Nurse Embry or

1 Dr. Nelson, or somebody there, to discharge their
2 obligation under these policies to just check things
3 out before they get started, to make sure that
4 everything is working.

5 And, listen, what do they say? So, I'm busy and
6 I'm in a hurry, and we've got a whole bunch of patients
7 coming in that day. We don't want to get behind the
8 eight ball on the schedule. And so that's why we start
9 getting a little bit slack.

10 And, folks, this case is the perfect example of
11 why you can't get sloppy with the safety rules.
12 Because when you do that, somebody like Mr. Mikell
13 comes along. And he might be the one guy in a hundred
14 or the one guy in a thousand -- all right -- but he's
15 still entitled to safe medical care.

16 And just because you did it, and nobody got hurt
17 the first hundred times, just because you did it and
18 nobody got hurt the next hundred times, Mr. Mikell is
19 still entitled to have the policies followed. The
20 procedures have to be carried out. The safety check
21 has to be made before you get started.

22 And there is no question in this case, that they
23 gave him the Propofol before they checked to make sure
24 that this system was working correctly. And everything
25 else that happened from that point forward, follows

1 upon that one mistake because something happens -- all
2 right -- something happens before that data starts
3 being recorded, and while she's on the phone and
4 sending text messages that results in this right
5 here -- this didn't come out of nowhere. All right.
6 And, of course, what Dr. Nelson said was his airway
7 obstructed because of his sleep apnea.

8 So when you put all that in the scale, folks,
9 when you balance that out -- okay -- all of the lies,
10 all of the deception, all of the altered records --
11 okay -- the mistakes, the malfunctions, the glitches --
12 okay -- we haven't just -- the plaintiff hasn't just
13 tipped the scale in Mr. Turner's favor, I mean, we
14 knocked the scale over, and your verdict should be for
15 Mr. Turner.

16 Now, you see Chuck. Okay. He's in his early
17 50s. I'm 52. So he's my age. Okay. He's got family.
18 He's got a job. He's got connections in his community.
19 He's involved with the church. He's involved with the
20 mentoring program. He's doing all of these things.

21 And you've got to figure out, folks, again using
22 this scale of justice, how do we compensate for the
23 harm that's come to Mr. Mikell? And this is an
24 important part of the case, because all that you're
25 entitled to do is put the harm and loss that he

1 suffered on one side of the scale, and balance that out
2 with money. Okay.

3 And only the harms and loss go in the scale.
4 And, unfortunately, all we can balance it with is
5 money. Nothing outside of that. And what do I mean by
6 outside of that?

7 Well, for example, you're not allowed to put
8 into the scale some idea about, well, what would his
9 kid do with the money? Maybe they'd go out and blow
10 it. Okay. Or maybe you like the Medical University,
11 and you'd worry that some day you might have to get
12 medical care there yourself.

13 Those are outside reasons, folks. Those types
14 of considerations don't go in the balance. They don't
15 belong in the scale. It's harms and losses on one
16 side, money needed to balance it out on the other side.
17 And when you do that, okay, I think in this case you're
18 going to find that the harms and losses are really
19 pretty significant.

20 Now, remember at the beginning of the case, I
21 told you that the harms and losses that we have here,
22 they don't come with a price tag, or with an invoice.
23 And so the value of these harms and losses is something
24 that's a little bit difficult to compute.

25 And I recognize that y'all don't have any

1 experience in doing that. So I want to give you some
2 ideas when you go back to your deliberation room for
3 how you can actually place a value on these things.

4 Take into consideration a couple of different
5 factors. The first one is, well, how bad was the harm?
6 Okay. The second one is, how long did it last? Okay..
7 And then the third one is, how much did it interfere?
8 Okay. So let's talk about those questions in the
9 context of what happened to Chuck. Okay. How bad was
10 the harm?

11 Well, he spent 49 days in the hospital and
12 another month getting home health care. All right. He
13 had -- he was in a coma. He was put into a hypothermic
14 state. He had to have a tracheostomy. Remember, he
15 had to have those procedures to have all those evasive
16 lines placed so that they could give him the
17 medications that he needed. He had to be fed through a
18 tube that went up his nose and down into his stomach.

19 You heard the testimony from his children and
20 his friends. I mean, it was unsettling to walk into
21 the room and see this poor guy. All right. Imagine
22 what that was all like. You got to compensate for that
23 harm.

24 After -- after all of that care that was
25 provided, we've got in evidence the medical expenses

1 that were incurred. And this is Plaintiff's Exhibit
2 48 -- or rather 47. It's \$338,407.63. That's what the
3 bill was by the time he left the hospital and received
4 all of this care, that it took to bring him back to the
5 point where he died.

6 And it's interesting, too, because the Medical
7 University wants to sort of pat themselves on the back
8 about what a wonderful job they did reviving him from
9 this diaster that never should have happened. Okay.
10 And they may have done a great job, but that's sort of
11 like crowing about the fact that after you ran the ship
12 up on the rocks, and it sank, what a wonderful job you
13 did evacuating all the passengers.

14 So how bad was the harm? How long did it last?
15 And keep in mind, you know, the injuries that Chuck
16 suffered, they basically -- I mean, let's be real about
17 this, they lasted for the rest of his life. Because
18 his life was over less than three months later. Okay.

19 How much did it interfere with his enjoyment of
20 his life? You've heard some testimony from Dr. Zile
21 and from Dr. Van Bakel, and you got their medical
22 records. You know, it's very interesting to me because
23 the last time that Dr. Zile saw Chuck on April 30,
24 2010, we've got that note in the record. It's
25 Plaintiff's Exhibit 37. He says, "I believe this-

1 patient is doing exceedingly well at that point". And
2 he's swimming. He's exercising. He's spending time
3 with his kids. He's going to church. He's in this
4 mentoring program. He's got a fairly active life. And
5 all of that comes to an immediate stop on October 1,
6 2010. And none of that ever starts again before he
7 dies.

8 Now, how do you place a value on all that? Let
9 me give you some more ideas. So the idea, folks, when
10 you're using the balances -- okay -- so a small amount
11 of harm, well that's balanced out with a small amount
12 of money. Right? So we might be talking about a
13 couple -- \$10,000.

14 And then a medium amount of harm -- okay --
15 well, that's got to be balanced out with a medium
16 amount of money, maybe fifty or a hundred thousand
17 dollars. A large amount of harm, that's got to be
18 balanced out with a large amount of money. Okay. We
19 are talking hundreds of thousands of dollars.

20 And then lastly, you've got huge amounts of
21 harm -- all right. And that's what we have in this
22 case. Right. And it is a huge amount of harm. And,
23 look, that's got to be balanced out with a huge amount
24 of money.

25 So what's appropriate? Well, is it thousands,

1 tens of thousands, hundreds of thousands, or is it
2 millions?

3 Now, your experience in life is going to inform
4 you about this value. Okay. Everybody in this room
5 has a mother and a father. Okay. Everybody in this
6 room either in the past, or sometime in the future,
7 will have experience with the loss of a parent.

8 You heard the testimony of the kids from the
9 witness stand. To this day, they still can't come to
10 grips with what happened to Dad. All right. And think
11 about the problems going forward, I mean, I tell you,
12 Madison says one of the biggest issues that she has is
13 the future events in her life. The future successes
14 that she won't be able to share with her dad. All
15 right.

16 And Dadrian talked about my dad was the guy that
17 I used to be able to go to, you know, and he's just a
18 kid when this happens. I think he's 12 years old when
19 his father dies, 12 years old.

20 We all know somebody -- we all got a buddy or a
21 friend or an acquaintance who lost a parent when they
22 were a child. All right. You know and you understand
23 the impact that that has on somebody moving forward in
24 life. So these are huge losses. All right.

25 I mean Chuck lost everything. He went from

1 this, you know, guy with a bad heart and diabetes, but
2 he's got an active lifestyle and he's doing a lot of
3 things. You heard the testimony from his friends, to
4 doing nothing but sitting on the couch.

5 And you also heard from the children. Okay. So
6 the judge is going to charge you, there are two causes
7 of action in this case. One is what's called a
8 survival cause of action, and the other is called a
9 wrongful death cause of action.

10 Now, the survival action, this is where you
11 compensate Chuck for the conscious pain and the
12 suffering that he experienced after the wrongful act,
13 leading up to his death. So from the point in time of
14 the colonoscopy until his death, that's the period of
15 time that Chuck should be entitled to compensation in
16 his own right. And that includes the medical expenses.

17 Again, you put these things in the scales of
18 justice -- okay -- 49 days in the hospital and a
19 \$338,000 medical bill, that's got to be balanced out
20 with money. And keep in mind that if all you do is
21 award the medical expenses, all you're really doing is
22 paying the people who took care of him. You're not
23 giving anything to Chuck.

24 The second cause of action is for what's called
25 wrongful death. All right. And the damages that are

1 recoverable in a wrongful death action include mental
2 shock and suffering, wounded feelings, grief and
3 sorrow, loss of companionship. And the last one, the
4 language is a little bit stilted, but it's the most
5 important: Deprivation of the use and comfort of the
6 intestate's society, include the loss of his
7 experience, knowledge and judgment in managing the
8 affairs of himself and his beneficiaries.

9 Now, it is important for y'all to keep in mind,
10 even though Shon is Chuck's stepson, and he's the
11 personal representative of the estate, the
12 beneficiaries of his estate are Dadrian and Madison.
13 Okay. Dadrian and Madison are the beneficiaries of his
14 estate, not Shon.

15 And think about now when we talk about mental
16 shock and suffering. All right. Who -- have you ever
17 gotten that phone call, Dad is dead. Okay. I mean,
18 you go weak in the knees and you got to sit down. So
19 the wounded feelings, the grief, and the sorrow -- I
20 mean, we can all understand that; right? I mean, and
21 it can be -- it can be life changing.

22 If you've ever suffered from depression or
23 something like that, and something really bad happens,
24 I mean, it affects your ability to, you know, to get
25 along for days, weeks, months. There's crying up here

1 on the witness stand.

2 The loss of companionship. Okay. They don't
3 get to hang out with their dad anymore. No more
4 football games. No more of these activities that they
5 were with -- you know, Dadrian said that he was
6 driving -- riding in the bus with his father. Okay. I
7 mean, those are things that when you grow up and later
8 in life, you look back on those experiences that you
9 have with your parents, and they are very meaningful
10 because you learn lessons in life from that kind of
11 interaction. That's all over and done with for him.
12 Okay. He's only 18. She's only 22.

13 You know, I remember when I was that age, I
14 thought that I knew everything. And I was ready for
15 anything that life might throw at me. And now that I'm
16 52, I realize, whoa, there's a whole lot of growing
17 that goes on after that age, especially after -- you
18 know, keep in mind they were 12 and, you know, 16 when
19 this happened. All right.

20 So they don't have his experience or his
21 knowledge or his judgment. He doesn't get to teach
22 them. He doesn't get to mentor to them. They don't
23 have that to rely upon anymore in their lives. That's
24 all gone.

25 So, how do you balance that in the scale? No

1 more Dad. That's got to be balanced with money. And,
2 again, I would submit to you, folks, that the harms and
3 losses that we've seen, that we've heard about in this
4 case, these are huge life changing -- huge and life
5 changing, so they can only be balanced with a huge life
6 changing amount of money. All right.

7 Now, you know, the judge is going to tell you
8 that actual damages are intended to compensate somebody
9 for the harm that they have suffered. And this is
10 something we all understand. I mean, an easy example
11 is suppose that a thief breaks into your house, and he
12 steals your television set. Okay. Well, the law of
13 actual damages for compensation tells us that you're
14 entitled to get your TV set back. Okay. That's what
15 we're talking about with compensation.

16 And if the thief drops the set in the driveway,
17 and smashes it and it breaks, well, then you're
18 entitled to get the amount of money that it takes to
19 replace the television set. This is the type of
20 compensation we are talking about in this case, but the
21 losses are far more severe than losing a television
22 set.

23 We are talking about hundreds of thousands of
24 dollars in medical expense. We are talking about
25 months in the hospital. We are talking about the loss

1 of a loved parent. Those are huge losses and they've
2 got to be balance with huge amounts of money.

3 Now, it's important to keep in mind we got two
4 different kinds of harm and loss in this case. The
5 first is the financial, and the second is what I call
6 the personal. And you see I got this picture of an
7 iceberg because it's a good metaphor for what happens.

8 You know, when you're out in the water on your
9 boat -- not that any of us has ever seen this -- but
10 the top of the iceberg is what you see from the boat.
11 Okay. But what we know is, the top of the iceberg --
12 you know the phrase, it's just the tip of the iceberg.
13 Well, what that means is the ice that's below the
14 water, that you can't see, is far more massive than the
15 tip of the iceberg that you can't see. And that's the
16 way the damages are in this case.

17 So the tip of the iceberg is the financial loss
18 that we can put into evidence, and it comes with a
19 dollar figure attached to it. Those are invoices --
20 all right -- that need to be paid.

21 But what's below the surface, beyond the
22 invoice, are the personal losses to Chuck, his pain and
23 his suffering. And to Dadrian and Madison, the mental
24 shock, the wounded feelings, the grief and sorrow.
25 Right. The loss of companionship and those other

1 things. So keep that in mind as you're trying to
2 balance out the scale in determining how much is
3 enough, that the financial harms is often just a
4 fraction of the personal harm that take place.

5 Now, there's going to be a verdict form in this
6 case. All right. Judge Nicholson is going to submit a
7 verdict form to you. Okay. And I don't want to send
8 you into your deliberation room without knowing quite
9 clearly, well, what is it that the plaintiff wants.
10 What does Mr. Turner want?

11 And this is -- keep in mind, all I can do is
12 make a suggestion. It's up to you to exercise your
13 discretion and to use your life experiences in
14 determining how much money is enough to balance these
15 harms and losses. So I'm making a suggestion. Okay.
16 But again, I don't want y'all to go into the jury room
17 and wonder, well, what do they want? Okay.

18 So the form of the verdict has got a couple of
19 questions. The first one it's going to ask you, do you
20 unanimously find by the preponderance of the evidence
21 that the defendant was negligent in its care of
22 Mr. Mikell? Again, I would submit that we haven't just
23 tipped the scale in our favor, we've knocked it over in
24 our favor. And your verdict should be for Shon.

25 The second question is, do you unanimously find

1 by the preponderance of the evidence that the
2 defendant's negligence proximately caused injury to Mr.
3 Mikell? Once again, I think the evidence not only tips
4 the scale ever so slightly in our favor, it knocks it
5 over in our favor, and you should answer that question
6 yes. Your verdict should be for Shon.

7 And then the third question asks, the amount of
8 damages that Mr. Mikell suffered -- all right -- as a
9 result of the defendant's negligence, and that's in
10 this survival action, so you'll see -- I suggested the
11 figure of \$2,338,227.63. That's the medical expense
12 and \$2,000,000. Because that's an amount of money that
13 balances out the huge loss that Chuck suffered. All
14 right.

15 And then you'll see -- the fourth question is,
16 do you -- do you unanimously find by the preponderance
17 of the evidence that the defendant's negligence
18 proximately caused Mr. Mikell's death? Again, remember
19 what Dr. Kofke said, he said they changed all the guy's
20 medications. Okay. Those were the things that were
21 keeping his heart from going into arrhythmia. Those
22 were the things that were keeping him from developing a
23 clot.

24 And he said, these types of patients -- these
25 critical care patients, these patients who spend weeks,

1 if not months in the hospital, Dr. Kofke is a critical
2 care specialist. Those are the people he takes care
3 of.

4 And his testimony was, he's like look, I see
5 this time and time again. Something happens. All
6 right. Low profusion, low blood to the kidneys. The
7 kidneys get damaged. You got to take him off of the
8 heart medications because they can affect the kidney
9 function. All right. And then what happens?

10 When Dr. Kofke says is, the patient dies. It's
11 either an arrhythmia or a blood clot. Those are the
12 two most likely explanations. And he said -- his words
13 were, it's obvious to me that what happened on October
14 1st caused his death.

15 And use your common sense in that regard, folks.
16 I mean, you know, think about this. Think about what
17 that -- what Chuck went through. Okay. I mean, seven
18 weeks in the hospital, a tracheostomy, a feeding tube,
19 hypothermia, a ventilator, all of that.

20 The Medical University wants you to believe, and
21 I think what Mr. Cooke had said in his opening
22 statement last week, was if the evidence shows that he
23 fully and completely recovered from all of that -- no,
24 he didn't. No where near fully and completely
25 recovered.

1 He was tired. He was fatigued. He wasn't back
2 to his usual level of activity. You heard just this
3 morning, his mother, Jewel, who is living with him
4 after all this went down, he wasn't doing much of
5 anything. Okay. He said, he was feeling poorly, had a
6 bad cough.

7 So I think that we have not only just tipped the
8 scale in our favor on number four, once again, we've
9 knocked it over. You verdict should be for Shon.

10 And on question number five, which is the amount
11 of damages suffered by Mr. Mikell's statutory
12 beneficiaries, that's Dadrian and Madison, \$2,000,000
13 each, for a total of \$4,000,000 to adequately
14 compensate them for the loss of their father at a young
15 age. And not just any father, but a guy who spent time
16 with them, had fun with them -- was a bigger than life
17 person for them, that they relied upon and shared
18 life's experiences with. Okay. So that's what I want
19 you to do with the verdict.

20 Now, the last thing that I'd like to get you to
21 do is just indulge me here in a little kind of an
22 exercise -- I don't know if any of y'all have ever been
23 up to Ceasar's Head, which is just north of Greenville.
24 If you know your geography here in South Carolina, is
25 once you get up into what we call the Piedmont area,

1 it's where the Blue Ridge Mountains start coming down.
2 And you can go up to Ceasar's Head, and it's about
3 2,000 feet above the valley floor. And the view up
4 there is incredible. You can see almost five miles.

5 And this is part of the view that's Table Rock
6 Lake right there. Okay. So pretend with me for just a
7 second, that we are up at the top of the mountain.
8 Okay. And when we look off to the west, okay, we can
9 see the future, what the future is like where you have
10 given a verdict to Shon.

11 And in that future, okay, the folks at MUSC,
12 they check the systems out before they knock their
13 patients out. And in that future, they don't lose,
14 alter and destroy records anymore. They don't lie.
15 Instead they tell the truth and accept responsibility.
16 That's the future that can be created with a fair and
17 just verdict that fully compensates for all the harm
18 and losses that's in this case.

19 But now, imagine if we look over to the other
20 side of the mountain, and we try to envision a future
21 where you haven't given a verdict, or where your
22 verdict doesn't adequately compensate. Well, what's in
23 that future?

24 Well, that's the future that we got right now,
25 where the Medical University says we didn't do anything

1 wrong. We don't care that all of our records are a
2 mess. We don't care that our people, who've lied under
3 oath, we are going to keep on doing everything exactly
4 as we have.

5 That's where we are. Remember, I made sure that
6 I asked Dr. Reeves -- Dr. Reeves, have y'all changed
7 anything over there as a result of what happened? All
8 these lies and evidence destruction? No, they didn't.
9 Ladies and gentlemen, that future is in your hands.

10 THE COURT: Mr. Cooke.

11 MR. COOKE: Thank you, Your Honor. Good
12 afternoon. We've spent a lot of time together for the
13 past week, and I want to start by thanking you for your
14 attention. We look over and we're always trying to
15 read jurors, but we can never do it. I don't have any
16 idea what you're thinking.

17 But what we do see is that you're watching,
18 you're making notes as we go; you're listening and
19 you're trying to participate in your part of this
20 process, and for that -- however your verdict is at the
21 end of day, I want to thank you for that. I appreciate
22 it.

23 This is a very solemn responsibility for me.
24 It's a very solemn responsibility for you as well. I'm
25 going to do like Mr. Ransom did, and everything I say

1 is not evidence in this case, it is simply my
2 suggestion of how to organize the evidence that's been
3 put in front of you over the last week.

4 Not to be flippant or make light, but I had a
5 law professor when I was in law school, and he had a
6 saying, he said, when the facts are on your side,
7 hammer on the facts. When the law is on your side,
8 hammer on the law. But when neither is on your side,
9 hammer on the table. With all due respect to Mr.
10 Ransom, I feel like over the last week we've seen a lot
11 the hammering on the table, and it comes right down and
12 continues with this power point that you saw.

13 The plaintiff has the burden of providing you
14 with the evidence that will allow you or force you to
15 conclude by a preponderance of the evidence, that's 51
16 percent or more, that's after you've weighed all the
17 the evidence on both sides, that the defendant is
18 guilty of malpractice. And that that malpractice
19 caused the injuries that the plaintiff is suing for.

20 They cannot do that simply by asking you to be
21 cynical and skeptical, and by accusing everybody that
22 comes into the courtroom with lying, cheating, stealing
23 and changing records. The plaintiff still has the
24 burden of giving you the evidence from which, at the
25 end of the day when you're out there deliberating, when

1 you reach a conclusion and the collusion is, I think
2 that Donna Embrey was guilty of malpractice. And I
3 think that her malpractice caused the cardiac arrest
4 and I think the cardiac arrest caused Mr. Mikell's
5 death to the detriment of this family.

6 For you to find that, you have to be able to
7 assure yourselves and each other that I'm not guessing
8 about that. I'm not basing that upon speculation. I'm
9 basing that upon the evidence in the record. And the
10 evidence in the record can be records like you've seen,
11 it can be testimony under oath of witnesses.

12 Now, everybody who testified here -- and let's
13 get this off the -- off the table. Everybody who
14 testified before you has some interest in this case.
15 They either were higher in the case of expert witnesses
16 to give testimony to support one side or the other, or
17 they work for the Medical University and had an
18 interest in the Medical University, or they were part
19 of Mr. Mikell's family and had an interest in their
20 side of it.

21 So let's -- let's just admit all that. Let's
22 admit that every single person that gets on that
23 witness stand, you have an obligation and it makes
24 perfect sense for you to do this, to scrutinize that
25 person and figure out what are -- what are they up to,

1 what do they have to lose, what do they have to gain.
2 And -- and giving them the devil their due, and
3 understanding that everybody up here who testified has
4 a perspective and an interest in this case, you still
5 have to parse through what they said.

6 It's the -- it's the -- if you've ever heard of
7 an expression, it's called an ad hominem argument.
8 It's when your argument is based not upon what the
9 person did or what the evidence shows, but who that
10 person is or how that person acted. It's -- it's
11 banging on the table instead of banging on the evidence
12 or the law.

13 Judge Nicholson will be responsible for
14 instructing you on what the law is. So instead of
15 talking about what actually happened that day, instead
16 we've heard all about lost records, a lost Mayday
17 record, the changed entry -- entry in the narrative.
18 And there were lots of them. By the way, there are
19 lots of entries that were added and changed just like
20 they are supposed to be.

21 The 12 minutes when the PICIS software was not
22 collecting data, somehow that's all part of the
23 conspiracy to lie to you and to lie to the family and
24 to cover everything up.

25 We heard a lot about a supposed difference

1 between the way the record was printed out in 2010, and
2 the way the record was printed out in 2013. How many
3 times did you hear Mr. Ransom ask somebody about that,
4 did you change that record? Did you make these entries
5 come out in a different order than when the record was
6 printed in 2013, than when in 2010 -- all of that --
7 all of that is intended to plant seeds of doubt in your
8 mind, and to see the Medical University as an evil
9 empire, the cover up, the liars.

10 I submit to you that not a single person that
11 you heard testify deliberately lied. You saw a video
12 tape of the deposition of Donna Embrey. That was taken
13 August 24th of 2014, almost four years after she had
14 last had anything to do with the records in this case,
15 or with what happened that day.

16 And so what happens is she goes into a
17 conference room with a court reporter and Mr. Ransom,
18 and Mr. Ransom has had plenty of time to pour through
19 these records and figure out what he wants to ask
20 about. So he sticks it under her nose, this narrative
21 summary. And there's an entry right here that says at
22 7:56, "DBE Memo: Came into the room, patient hypoxic,
23 junctional rhythm and no palpable pulse. ACLS protocol
24 maintained -- initiated, Mayday team called."

25 Now, he doesn't show her the other record from

1 the PACU where it -- where it said 8:00. He doesn't
2 give her any possible explanation of what happened. He
3 just wants her to remember, as she's sitting there that
4 day on August 24, 2014, how did that record get to be
5 there?

6 And so she looks at it, and she says exactly
7 what it appears to be, her initials are on it. Her
8 initials are on it, but it says "Memo, came into room."
9 Well, that has to be Dr. Nelson. It can't be her
10 because she's already been in the room. She's been in
11 the room the whole time.

12 So from the context of this, she infers that --
13 the only think I can think is that Dr. Nelson is
14 charting under my -- under my initials, and that's
15 exactly -- that's exactly what it looks like.

16 Now, we had the luxury of investigating this
17 case since it was filed more than three years ago. We
18 have -- you heard John Fisher he has spent 500 hours
19 digging through the computer databases. So now in the
20 clear light of hindsight, we all know exactly what
21 happened. We know because we have an audit trail that
22 Donna went back in later that day, just like she was
23 supposed to do, and filled in all the gaps in the
24 record. She made sure that everything coordinated with
25 everything else. That's what she's supposed to do.

1 So I submit to you, that even though it would be
2 perfectly within your right and your provinces to say,
3 I'm going to be suspicious about this record -- because
4 Donna Embrey did change that record -- and so I -- and
5 she does know, just like Mr. Ransom said, she knows
6 that it's going to be scrutinized. She knows it's
7 going to be peer reviewed. If something happened on
8 her watch, she's going to be called to answer for it.
9 So, therefore, and this is -- follow me on this: So,
10 therefore, she must have lied.

11 Does anybody see a leap in reasoning with that
12 because of the fact that she was there, because of the
13 fact that her job requires her to go in and make sure
14 that the records are right after the fact. Because of
15 the fact that she didn't want to be blamed for things
16 that -- that happened on her watch; therefore, she must
17 have lied about what she did in the records. That's
18 the plaintiff's case. That is the plaintiff's case.

19 And I submit to you that that is no better than
20 banging on the -- on the table, and saying she lied.
21 She lied. She lied. She must have cheated. She must
22 have changed the records. She must have been guilty of
23 malpractice. She must have not been paying any
24 attention that day because she was too busy texting and
25 talking to people on the telephone. And, therefore,

1 you should find her guilty of malpractice.

2 Well, you know what, sitting here in the bright
3 light of hindsight, there's some appeal to that. You
4 know, we all like to believe that bad things don't
5 happen to good people. We all like to believe that if
6 you were on that table next month, that people would be
7 more careful, and that that bad thing that happened to
8 Mr. Mikell, wouldn't happen to you. That's very
9 natural. And so it's very natural for you to leap at
10 the opportunity to accept that banging on the table,
11 that ad hominem argument, that -- that because she
12 changed records, she must be lying about what she did.
13 And, therefore, she must be guilty of malpractice.

14 Well, I'm going to try -- I'm going to try to
15 turn the tables a little bit. As we go in this case,
16 and go through the actual evidence in this case, I'm
17 going to talk about why this inference doesn't make
18 sense here. And Judge Nicholson is going to tell you
19 that when somebody loses a record, even if it's
20 completely well intentioned, or if they change a
21 record -- even if it's completely well intentioned, you
22 may -- you may conclude that that record was adverse to
23 them. That makes perfect sense. If I lose a record, I
24 should be responsible for negative inferences that can
25 be drawn from that.

1 Because you, as a juror, don't have any way of
2 knowing why that record disappeared, the Mayday record
3 was a perfect example of that. If the circumstances
4 warranted, you could find that because that record was
5 gone, we have to -- to give the benefit of the doubt to
6 the plaintiffs, rather than to the Medical University.
7 But I'm going to explain to you in just a few minutes
8 why I think that that would be unfair and -- and not
9 supported by the evidence in this case.

10 But this -- these inferences are also a two way
11 street. It's fair for you to ask yourselves why didn't
12 Mr. Ransom present us -- you with any actual evidence
13 that Donna Embrey was negligent on that day?

14 When he called -- when he called Ms. Embrey to
15 the witness stand, does anybody here remember him even
16 asking her what happened that day? All the questions
17 that he asked her were about what did you do to the
18 records? I didn't hear him give her one opportunity to
19 explain how she took care of -- of Mr. Mikell that day.

20 The plaintiff didn't even call the other key
21 witness to the case, Dr. Nelson. He didn't even call
22 him as a witness. Didn't even call him as a witness.
23 Didn't ask Dr. Payne, the other person who was in the
24 room that day, what he saw and what Donna Embrey did
25 that day. They -- they -- he did not -- he did not

1 submit into evidence the one minute analysis that we
2 have now spent a lot of time talking about in this
3 case.

4 He kept showing you this -- this graph without
5 explaining -- without explaining the scale of this is
6 completely wrong and completely unreliable and
7 completely no basis. Even today -- even today in his
8 closing statement, he was still showing you this graph
9 and saying, look, it was a steady decline the whole
10 way, not mentioning that we actually do have a one
11 minute record. We can go and look -- we're going to
12 look at those in just a few minutes. We have a one
13 minute record to show you exactly how the vital signs
14 progressed.

15 Does anybody here -- you know, this is a
16 rhetorical question. You don't have to answer -- does
17 anybody here have any idea what would be on a Mayday
18 sheet if there was -- if we had the Mayday sheet? Your
19 imagination is probably going wild with what -- what
20 could have been on that sheet that's gone now, because
21 we've heard about it.

22 MR. RANSOM: I'm going to object if he is going to
23 start telling them what he thinks is in the Mayday
24 record.

25 THE COURT: I'm sorry, what?

1 MR. RANSOM: I said I'm going to object if we're
2 about to start telling the jury what's in the Mayday
3 record.

4 THE COURT: I think he's going -- not specific
5 information, just what -- what should be on there.

6 MR. COOKE: Correct.

7 THE COURT: Overruled.

8 MR. COOKE: The form is in the record.

9 THE COURT: If he starts going into specific
10 information, I'll let you renew your objection. Okay.

11 MR. COOKE: I'm going to show you, and you're
12 going to have in the jury room, a blank Mayday record,
13 a form. And it got spaces all over it for information.
14 And not one of those blanks has any place to put
15 information about what happened before the Mayday
16 begins. There's not a box that you check on there and
17 say, was this your fault, yes or no.

18 There was not a place where you put in there,
19 how did Mr. Mikell -- how did the patient get into this
20 situation in the first place. That is not on that
21 form.

22 And I can only imagine what you folks have --
23 have been required to imagine as this week has gone on,
24 what must be in that Mayday form that makes it so
25 important. The only piece of information that Donna

1 Embrey could have gotten off of that form would have
2 been when the Mayday began. That's what everybody has
3 testified to that knows anything about a form.

4 But why do we lie about the form? Why did --
5 why did we, all parts of the evil empire, why did we
6 lie about there not being a Mayday form? Well, you saw
7 Dr. Guldan. He was the other cardiac anesthesiologist
8 who came with the Mayday team.

9 To this very day, he believes with all of his
10 heart that there wasn't a Mayday record, that there
11 shouldn't be a Mayday record. Because when you have a
12 Mayday in a suite that has anesthesia, that the
13 anesthesia personnel keep the same information that
14 would be on the Mayday record in the anesthesia record,
15 which is exactly what did happen in this case. All of
16 that information is recorded in the anesthesia record.

17 So he believes with his heart of hearts that
18 there was not and should not have been a Mayday record,
19 and that it's -- and that it's superfluous. We think
20 he's wrong about that because Ms. Scarbrough came and
21 she actually had seen the record. Donna Embrey now
22 remembers that she had seen the record. And so we
23 believe that one did exist. It didn't need to exist,
24 but one did exist.

25 Is that lying? Is that a cover up? If you

1 think that Dr. Guldan lied, then I can't -- I don't
2 think anything I can say would convince you otherwise.
3 But I submit to you that he was earnest and very honest
4 in his belief that there was not a record, and didn't
5 need to be a record, and that nothing was -- no record
6 was lost.

7 Remember a few minutes ago, Mr. Ransom talked to
8 you about the anesthesia policy and the procedure
9 manual. And it's here. And as you sat there and
10 listened to him, I wonder if any of you thought --
11 well, it's here somewhere -- Plaintiff's Exhibit 8, do
12 you remember what he said? He said the policy manual
13 says that "prior to administering anesthesia, the
14 practitioner administering anesthesia will check and
15 document the readiness, availability, cleanliness,
16 sterility where indicated, working condition and the
17 alarm systems of all the equipment to be used, and that
18 includes that all information is to be accurately
19 recorded on the anesthetic record. This shall at least
20 include monitoring data" blah blah blah blah.

21 Now, another rhetorical question -- you don't
22 have to answer this -- but how many of you thought that
23 he was talking about the same provision? That there
24 was something in this manual that said that you're
25 supposed to check at the beginning of the procedure to

1 make sure all important information was being recorded.
2 It does not say that.

3 There was a completely different page and a
4 different section here on section two, it says "prior
5 to administering anesthesia, the practitioner
6 administering anesthesia will check and document the
7 readiness, availability, cleanliness, sterility where
8 indicated, working condition and the alarm systems of
9 all equipment to be used. The availability of the
10 equipment necessary to conduct anesthetic procedure
11 includes, but is not limited to, a functioning
12 laryngoscope, and the tracheal tubes, airway and masks,
13 functioning suction, and means of artificial
14 ventilation will be determined". It doesn't say
15 anywhere in there that you're supposed to check to see
16 that the PICIS system is up and running.

17 We heard Dr. Reeves say this policy was inactive
18 even before that system existed, and it's not until you
19 go through items three -- that was item two, three,
20 four, five, six, seven, eight and nine do you get to a
21 separate requirement. This has nothing to do with
22 pre-anesthesia checks. It has nothing to do with
23 checking your equipment. It just says all information
24 is to be accurately recorded on the anesthetic record.
25 That could be a paper record, that could be the

1 electronic record.

2 So I submit to you that it's a bit misleading,
3 it's a bit deceptive to suggest that Ms. Embrey was
4 negligent because she didn't boot up the PICIS system
5 and make sure that it was running smoothly and
6 recording everything before this procedure began. In
7 fact, to the contrary, the testimony that you heard was
8 that the -- the recording of that data is completely
9 independent of the patient care. That all of the
10 monitors were hooked up, all the monitors were working.

11 Dr. Payne, who was the gastroenterologist,
12 testified that he won't begin the procedure unless all
13 of the monitors are up, running, and everything is
14 going. The patient is -- is stable.

15 I told you that I was going to show you the
16 blank form, and here it is. This is Defendant's
17 Exhibit 2. You'll have this in the jury room with you.
18 And you'll see exactly as Donna Embrey testified, this
19 would be very helpful in recreating what happened
20 during the resuscitation, but it has no information
21 whatsoever about what happened before that. And I
22 would remind you, I'm sure you know this, the
23 plaintiffs have -- the plaintiff's expert, Dr. Kofke,
24 had no criticism whatsoever about what happened during
25 the resuscitation.

1 The two exhibits here you should take a look at,
2 Plaintiff's Exhibit 3, Plaintiff's Exhibit 5, these are
3 the two -- you'll see there's some highlighting on
4 it -- there's Plaintiff's Exhibit 3. This is the form
5 that's called an anesthesia record that was printed
6 out, according to this, on October 2, 2010. This is
7 the record that was printed out on April 2, 2013.

8 Several times during the trial, Mr. Ransom
9 actually accused people at MUSC of changing the record.
10 Do you remember he -- he had Donna Embrey on the stand,
11 and said didn't you go into the record, after this
12 lawsuit was filed, and change it so that when it
13 printed out in April of 2013, after this lawsuit was
14 started, that it was now different -- now different.
15 Because the 7:48 entries are in a different order.

16 I invite you to take these, this is page -- it
17 says down here at the bottom, 3 of 16, or 1 of 8
18 depending on which number you look at, it's Plaintiff's
19 Exhibit 3, it's an anesthesia record. This is a
20 different record that you're going to be comparing it
21 to, the first page of Plaintiff's Exhibit 5. This one
22 is called an Anesthesia PACU record.

23 And you remember Mr. Fisher explained that it
24 could very well be that the computer is going to print
25 things out in a different order when you print it in a

1 different record from one time to the next.

2 Printing the record does not change the record.
3 What's in the computer is in the computer. You can
4 print it a hundred times, and shred every single copy,
5 it's not going to change anything. And I defy anybody
6 here to find any difference between the times or the
7 text of what was written here at 7:48.

8 And then when you -- when you notice that, you
9 are free to ask each other, why would Mr. Ransom have
10 waved that around in front of us when we've never seen
11 it before, and -- and assert that that represents a
12 change by that evil empire, the Medical University, or
13 that -- or that liar, Donna Embrey, that she must have
14 gone into that record and somehow changed it between
15 2010 and 2013. That's a very fair question for you to
16 ask yourselves before you find her guilty of medical
17 malpractice.

18 The real time graph, how times have you seen Mr.
19 Ransom point at that graph, or make marks on that
20 graph, and say this proves that we were going down the
21 Matterhorn into Death Valley. I'm going to ask you to,
22 when the time comes, that you compare a couple of
23 documents just to understand how this thing works.

24 First, is that same exhibit that I just told you
25 about, Plaintiff's Exhibit 3 -- and if you'll open it

1 up to -- down at the bottom it says 6 of 8 -- I think
2 that's an 8. And you'll see this is what we call the
3 15 minute graph. I'm going to put it up here so you
4 will recognize it.

5 All right. Do you see, this is the way this
6 graph is intended to be printed out, but you can
7 readily see that because this is printed out in 15
8 minute intervals, that you can't tell anything about
9 the microtrend, the minute to minute variations. But
10 what Mr. Ransom wants to tell you is that what this
11 does prove, is that it was all downhill right from the
12 beginning. We know that this begins at 7:48, and it's
13 all right downhill until it hits the rock bottom. And
14 then only after the resuscitation does it come back up
15 again.

16 Well, guess what, we know that that's not true.
17 We absolutely know that's not true. And I'm going to
18 show you in a few minutes why on the minute to minute
19 record, we absolutely know it's not true.

20 Mr. Ransom knows it's not true. He's known it's
21 not true since they got the one minute records at the
22 beginning of this case, but yet he insists every time
23 he shows a witness, and every time he shows you, who
24 hasn't had the opportunity to study the records like we
25 have, that that record -- that that little V there

1 proves that it was a downhill course right from the
2 very beginning. And it was obviously because of the
3 negligence of Donna Embrey.

4 So then I'm going to ask you to compare that to
5 Plaintiff's Exhibit 5, and this is -- this has the one
6 minute record. And you can see there, in this version
7 of it, obviously the chart -- the graph is shaped
8 exactly the same way -- exactly the same way as it is
9 on the other, the same scale. But now we have one
10 minute intervals instead of 15 minute intervals. It
11 can't be right.

12 Mr. Ransom knows it can't be right. It's unfair
13 when he puts that up here, and his expert looks at
14 that, and says ladies and gentlemen of the jury, this
15 proves that Mr. Mikell was in distress when Donna
16 Embrey was busy sending text messages. That is
17 misleading. It's unfair to you. It's unfair to
18 Mr. Mikell's family for crying out loud, to use
19 something like this as a piece of evidence.

20 If you still are in doubt about it, flip to the
21 next page. There's that exact same graph, and there's
22 nothing. The whole page is blank except -- except for
23 that graph. So I submit to you that if somebody really
24 wanted you to understand what happened here, instead of
25 Dr. Kofke sitting on the witness stand and just saying

1 these numbers are all goofy, that he would acknowledge
2 that, no, it's in fact -- in fact, if we look at the
3 records that we know are objectively correct, that
4 are -- that cannot be changed by any human being, that
5 they 100 percent support what Donna Embrey and what
6 Eric Nelson, and what everybody else said happened.

7 Let's look at the -- what I think they probably
8 made the biggest point about, and that is the change of
9 the 7:56 note. And it does make a big difference. It
10 does make a big difference if -- if Mr. -- if Dr.
11 Nelson came back into the room at 8:00, you'd be --
12 you'd be well within your rights to wonder well, what
13 happened in that extra four minutes. Why couldn't he
14 have gotten in sooner? Why didn't she call him sooner?
15 What was she doing to try to help the patient? So it
16 is important. It is important that if it wasn't 8:00,
17 that it not say 8:00. If it was 7:56, that it say
18 7:56.

19 Now, we know that -- what happened. We know
20 that at about 8:33, after the resuscitation was
21 completed, Dr. Nelson when into the system and he put
22 down information, and he put in there that exact same
23 narrative -- "memo, came into room, patient hypoxic,
24 with junctional rhythm, and palpable pulse. ACLS
25 protocol initiated. Mayday team called."

1 Now, I'm trying to remember each of those
2 things -- in fact, I'm going to set this up, and just
3 leave this here. How do we know that Donna Embrey
4 didn't fix that to make herself look better? Because
5 she knew -- she didn't know there was going to be a
6 lawsuit. She didn't know -- she didn't know that Mr.
7 Mikell was going to pass away later, but she knows --
8 she's been around long enough to know that everybody is
9 going to want to know how did this cardiac arrest
10 happen on your watch.

11 So what we know is that she goes back in about
12 5:30 that afternoon, and she adds other notes in here.
13 There's one for herself that says, "Memo: Patient
14 turned supine from lateral to establish better assisted
15 bag mask ventilation. Nasal airway out; oral airway
16 in." And that's just the tube that goes in to -- comes
17 out your nose and goes into your throat to the allow
18 you to breathe better.

19 And then right behind that is 7:56, "Memo: Came
20 into room, patient hypoxic". So what she did was she
21 made that one instead of saying 8:00, she just made it
22 say 7:56. And because she was making that change, the
23 computer, 7:56, puts it under her initials. We know
24 that that's exactly what happened. So what you've got
25 is you've got these two notes, the one that was her

1 note right together, "Memo: Patient turned supine from
2 lateral to establish better assisted bag mask
3 ventilation. Nasal airway out; oral airway in. Memo
4 came into room, patient hypoxic with junctional rhythm
5 and no palpable pulse. ACLS protocol initiated.
6 Mayday team called". At 7:57, no palpable pulse; 7:57
7 chest compressions and continuous until noted; 7:57,
8 patient oxygenated with a 100 percent O2 or bag mask."

9 So how do we know that she didn't just make all
10 that up, as Mr. Ransom says that she did. She just
11 made the whole thing up to make it look she didn't do
12 anything wrong. Well, she could have done that. She
13 could have done that.

14 If she were -- if she were a diabolical genius,
15 and she knew everything that was in this computer, and
16 all the data, she could have somehow fixed the facts,
17 fabricated them to -- to fit what she thinks her
18 version of history should be.

19 Fortunately, fortunately there are things that
20 she could not have changed that prove -- not just
21 suggest, but prove that what she wrote there is exactly
22 right. And I want to take a minute to -- to -- to go
23 through that with you.

24 Let's go back to Plaintiff's Exhibit 5, when
25 you're looking for this, this is what it looks like.

1 It's Plaintiff's Exhibit 5. It's -- it's got the memos
2 there. And this is the one minute -- this is what
3 we're calling the one minute version. That if you go
4 to where it's printed at the bottom, it says page 36
5 out of 99, you'll hit -- you'll see something that
6 looks like this.

7 All right. The two things that I want you to
8 pay attention to are this one down here, PIP, and this
9 one here FI02. When you follow these across, do you
10 remember what the testimony on those that -- that
11 indicates the effort that's being -- the pressure
12 that's being put into oxygenating Mr. Mikell. Do you
13 remember that when -- even when the nasal airway was
14 put in, he was not being given air, he was breathing
15 essentially room air. So this PIP number down there
16 would be either zero, or a very small number, because
17 he's not -- air is not being -- being forced into him.

18 Likewise, the air that's being made available to
19 him has a FI02, or the percentage of oxygen is running
20 35, 26, 29, 24, 26, 29, that's up until 7:54.

21 But then what happens when you turn the page,
22 now all of a sudden between 7:54 and 7:55, what's
23 happened? The FI02 has gone from 29, 28, to 95. And
24 then it stays there, 95, 99, 98, 99, 100, 100. Do you
25 remember what the memo says? It says he was placed on

1 a 100 percent oxygen.

2 Then we see down here the PIP, the pressure
3 under which the air is being placed -- it's being given
4 to him. It goes from 3 to 27, to 28, 28, 30, 30, 7:56.
5 There's only one way that that could happen. And Donna
6 Embrey, and all the computer engineers in the world
7 can't change it.

8 The testimony of John Fisher, he spent 500 hours
9 on that computer trying to figure out if there was a
10 way to fudge this, and there's no way to fudge this.
11 Mr. Ransom hasn't shown you any way to fudge this.

12 His expert can call it goofy all he wants, but
13 these are the numbers. And Donna Embrey couldn't do a
14 thing about it at 5:30 on the afternoon of October 1,
15 2010, when she was in there making these numbers right.

16 So what she said, in her words here, is exactly
17 what -- what the machine and the computer and the
18 numbers say, and the numbers up there. And that is
19 that at 7:55, patient turns supine from on his back for
20 lateral -- to establish better assisted bag mask
21 ventilation, nasal airway was taken out. Oral airway
22 was in. Dr. Nelson came into the room, the patient was
23 hypoxic with junctional rhythm and no palpable pulse.
24 ACLS protocol initiated. The Mayday team called.

25 There's one other little bit of corroboration.

1 And that's at -- you see up here -- the SR, that's
2 sinus rhythm. That's -- where it says EKG rhythm sinus
3 rhythm -- sinus rhythm, all the way up to 7:54.

4 Then at 7:55, sinus rhythm; 7:56, junctional
5 rhythm; 7:56 junctional rhythm, sure enough, 7:56:

6 "Memo: Came into room. Patient hypoxic with
7 junctional rhythm, and no palpable pulse. Suppose he
8 had come in at 8:00, as his original note said. What
9 would he have seen, not junctional rhythm, he wouldn't
10 have seen junctional rhythm after 7:57. It turns to
11 PEA, which we now know means pulseless electric
12 activity 7:58, 7:59, 8:00. So if Dr. Nelson had come
13 in at 8:00, like his original note said, his memo here
14 would have said hypoxic with PEA, pulseless electric
15 activity rather than junctional rhythm.

16 So what he says here, and what Donna Embrey
17 changed the time to, reflects exactly what the
18 objective evidence in this record is. Sadly, Mr.
19 Ransom knows that as well as I do. But you haven't
20 been given that information. You have been asked
21 instead to conclude that Donna Embrey monkeyed with
22 these records at Medical University. She lost records.
23 She hid records. She destroyed records, all to try to
24 deceive you -- all to try to lie.

25 Who -- who lied to Mr. Ransom about their being

1 an audit trail? Do you remember any witness -- any
2 witness being called to the stand to say MUSC lied
3 about that, or even hid it from him? Not a single
4 person.

5 Discovery -- discovery in a civil case is a long
6 process. Any time you have an institution involved,
7 there are literally millions of pieces of data. You
8 have an electronic record here. But I submit to you
9 that it's a bit unfair. It's a bit reckless to accuse
10 the Medical University of lying about there being an
11 audit trail; lying about there being a Mayday record;
12 lying about the reasons why these records have changed,
13 when there's not one iota evidence other than banging
14 on this table to suggest to you, or to prove to you
15 this is what the Plaintiff has to do that. Those
16 records are exactly as they are here, are not correct
17 and don't tell the exact story of what Donna Embrey and
18 the other health care professionals did that day.

19 I'm going to take a few minutes, and let's try
20 to reconstruct exactly what did happen that day. Dr.
21 Kofke admitted that it's within accepted -- accepted
22 standard of care for a CRNA to be in charge of
23 monitoring and -- and -- and regulating the flow of
24 oxygen, and taking other measures.

25 And what is she supposed to do if something

1 comes up that she can't handle, she calls the doctor.
2 And he's supposed to be -- rule of thumb is, he should
3 be reachable within two minutes after you call him.
4 All of that happened here. All of that happened here.
5 Exactly as Dr. Kofke, himself, admitted that it is
6 supposed to happen.

7 We have Dr. Nelson's note that says that at
8 7:48, he was in the room. We know from the audit
9 trail, just as Mr. Ransom has acknowledged, that that
10 was physically typed. Those notes were physically
11 entered by Dr. Nelson at 7:49. So we know he was there
12 at 7:49. His note says -- it says MDA, that's him, was
13 in. Nasal airway in; O2 sat up to 94 percent. Do we
14 know that that's correct? Yes, we do. Because it says
15 right there 7:48, 96.7 percent. That's the oxygen
16 saturation rate at -- at 7:48, so that matches exactly
17 what that note says at 7:49.

18 Note says: Nelson is out at 7:51. Says, "DBE",
19 we know that Donna Embrey entered that. Nelson out.
20 So do we have any evidence that matches up with that
21 being true? Well, what about the fact that in his
22 note, he says "assessed patient, reviewed chart,
23 anesthesiologist present for induction, Nelson out".
24 Nelson MDA in, nasal airway in -- we know that that was
25 done; O2 sat up to 94 percent. Patient remains

1 lateral". Again, coordinates exactly with what the
2 record says there at 7:48.

3 I want to talk for a few minutes about the claim
4 that Donna Embrey was somehow distracted, because she
5 was so busy texting. And I wonder if any of you caught
6 how times she texted or talked on the phone that
7 morning. When I -- when I hear it being described by
8 Mr. Ransom, I sort of get the picture of my teenage
9 daughter, who was constantly texting and talking to
10 people on her cell phone. And it wouldn't surprise me
11 if some of you may have gotten the impression that
12 that's exactly what Donna Embrey was doing that
13 morning. But it's right here in Plaintiff's Exhibit
14 12. This is what it looks like in discovery, got a
15 couple of yellow highlighted things on it. This is
16 what that -- this is what that record looks like when
17 you blow it up a little bit for you.

18 This is not a part of the patient's chart, but
19 it's a document that the Medical University was able to
20 retrieve from its computer system. Do you see right
21 there, 7:39, page Q, and there's the text of the page
22 even, "hey, call me regarding NORA patient -- NORA pt,
23 not in transfer bucket. Tx".

24 Now, the suggestion has been made to you that
25 that entry of that text was so distracting to Donna

1 Embrey, that she was no longer able to concentrate on
2 what she was doing. And then at 7:46, here's the
3 second one. "hey, can u" -- letter u -- "call me back
4 tx, Donna."

5 Now, bear in mind that this charting system is
6 designed for the nurse who's there and the physician,
7 as the case may be, to enter memos throughout the day.
8 Now -- throughout the procedure.

9 We know -- we know that it's not always possible
10 to enter things contemporaneously. And that's why
11 everybody agrees that it's the standard -- it's within
12 the standard of care to go back in after the fact and
13 add things. But nevertheless, the system is designed
14 with this keyboard right there. Right there, that
15 will -- it'll swing in so that you can be entering your
16 notes, or you can be entering a text like that, while
17 you're monitoring this equipment.

18 And the testimony was undisputed that not only
19 is that equipment working, and it's giving a continuous
20 read out of the saturation rates and the heart rhythm
21 and everything else that she's supposed to be watching,
22 but there's an audible tone as well. In case she
23 somehow fell asleep at the switch, and wasn't paying
24 attention, there's an audible tone. And the testimony
25 was that the tone gets higher when the oxygen

1 saturation is high, and it gets lower when the oxygen
2 saturation is low. So that not only does she hear it,
3 Dr. Payne hears it and Dr. Nelson is in the room. Dr.
4 Nelson hears it. And if Dr. Payne's assistant is in
5 the room, she hears it -- or he hears it.

6 Donna Embrey is somebody who has spent her
7 entire professional career becoming a Certified
8 Registered Nurse Anesthetist. She is trained and
9 certified in advance cardiac life support. Her entire
10 professional existence is devoted to one thing, and
11 that is to be there and to do everything humanly
12 possible to make sure that each and every one of her
13 patients wakes up. And at the end of the procedure in
14 as good a condition as he was in when he came into that
15 hospital.

16 All of her training, everything she thinks
17 about, day in and day out, is devoted to that. Yet
18 Dr. -- Dr. Kofke and Mr. Ransom come in here, and look
19 you right in the eye, and say I conclude that she was
20 too distracted. That's the only thing we can come up
21 with because we know -- we know that there is not a
22 record available of what the saturation rate was before
23 7:48. And, therefore, we have to conclude, and we want
24 you to conclude, that she must have been distracted and
25 not noticed bad things happening.

1 Do you remember at one time, Dr. Kofke even said
2 that little -- that little -- the V in the chart proves
3 that. Proves that she must have -- that he must have
4 crashed while she was busy texting.

5 Before you find that, I would just ask that you
6 spend as much time as you need to discussing that with
7 each other. And I want you to ask yourselves the
8 question, are we being asked to assume the worst -- the
9 worst in Donna Embrey in concluding that? Are we going
10 to assume the worst in everybody else that was in the
11 room that day?

12 They would have stood by -- all these people,
13 who knew that they were dealing with a delicate
14 patient, one who is being anesthetized, who is -- who
15 is -- the management of their airway was being -- was
16 being entrusted to them, that they would have just all
17 fallen asleep at the switch, and let him decompensate
18 and desaturation, and go into cardiac arrest because
19 Donna Embrey was too busy that morning. Because she
20 was too busy to pay attention to that, to the most
21 important thing in her professional life, I just ask
22 you to think to yourselves and discuss among yourselves
23 whether that is a practical explanation for what
24 happened that day.

25 I want you to consider the fact that the

1 procedure began according to the notes at 7:42. Dr.
2 Payne testified that he would not start the procedure
3 if the patient was unstable. He knows how to determine
4 if the patient is stable or not. So we know, even
5 though that there's a gap in the recorded record, that
6 by 7:42 he was fine.

7 We know that there was a dip in the saturations,
8 and it's described by Dr. Nelson and it's described --
9 excuse me -- and here it is, the first phone call 7:39.
10 The first text message, 7:39. The second text message,
11 7:46. The system is working. By 7:48, the first
12 saturation that's recorded is 96.7. The note that's
13 written there says that the doctor is in, and the sats
14 is up to 94 percent.

15 Dr. Nelson testified that -- as did Donna
16 Embrey -- that it's not uncommon to have a dip in
17 saturation, and there you have it, 75, 69. And then
18 it's back up to 90.1 at 7:51 when Dr. Nelson leaves the
19 room. It's back up to 90.1.

20 And, again, remember, this is just a one minute
21 snapshot. They've got the monitors right there in the
22 room with them, recording every single heart beat, and
23 every single movement of that up and down. And you've
24 heard that it's not uncommon for it to waver up and
25 down, but it's recorded. We know it's recorded at

1 90.1, so why can't we believe Donna Nelson -- Donna
2 Embrey and Dr. Eric Nelson when they say that -- when
3 they -- when they put the nasal airway in, and she --
4 by the way, also reduced the -- the Propofol from 75 to
5 50, she did that right at 7:53. And I'll show you that
6 in the record in a little while as well.

7 It's at Defense Exhibit 6, and this is the one
8 minute version of the medication chart. This line --
9 this line right here is Propofol. You'll see it was
10 started at 7:41. And then it was continued at 75, 75,
11 75, 75, until you get to 7:50. I'm sorry. I think I
12 said 7:53 -- but at 7:50, you see that it reduces from
13 75 to 50, and it stays at 50 until she discontinues it
14 later.

15 So what happened was when we had this little dip
16 in the saturations, she reduces the Propofol. Dr.
17 Nelson is there. We know he's there at 7:49. They put
18 the nasal airway in and saturation goes back up to 90.
19 And Dr. Nelson leaves.

20 His heart rate remains sinus rhythm until 7:56,
21 when it becomes junctional. He's being bagged and
22 successfully resuscitated by 7:55 and 7:56. Their
23 experts, and all the people who testified, have no
24 criticism whatsoever of that resuscitation.

25 So let's take a minute. And I know this is

1 getting tedious, but let's take a minute and just look
2 at the timeline. Do you see those two little ones up
3 there, where it says Versed. That means that there was
4 one dose given at 7:35, and one given at 7:36. So I'm
5 going to start with the timeline with that.

6 Versed, 7:39, a text. And you see what the text
7 says, 7:41 Propofol started at 75 drips; 7:42, this is
8 a number that was entered by humans, so it can be off a
9 minute or two, but the procedure began. I knew my
10 writing wasn't going to be good, but you've got the
11 records.

12 At 7:46, the second text; 7:48, data recording,
13 sat is 96.7; 7:49 -- 7:48, 7:49, we know that Dr.
14 Nelson is in the room; 7:50 Propofol reduced down to
15 50; 7:51, sats back up to 90.1 percent, and Dr. Nelson
16 out.

17 At 7:52, sats drop to 80.7. 7:53 Propofol
18 stopped, and that's here by the way. You see that
19 little -- do see that -- do you see that little mark
20 there under the 7:53, where it goes 50, 50, 50 to zero?
21 And it stays that way when you go to the next page,
22 7:54, five, six, seven, seven. No numbers there. It's
23 all discontinued.

24 And the sat at 7:53 was back up to 88. 7:54,
25 sat is back down to 73 percent. So what happens?

1 7:55, I'm going to put a slash here, and call this 7:55
2 and 7:56. Because we've got the two notes. We've got
3 Donna Embrey's note and then we've got Dr. Nelson's
4 note, and they sort of run together. But this is what
5 happened, patient was turned on his back. The nasal
6 airway was taken out, and oral airway was put in. This
7 is a bigger version of the nasal airway.

8 He's prepared for bag masking. Dr. Nelson is
9 in, and you remember the PIP and the FI02 go up right
10 then. They indicate that he is being bagged.

11 A junctional rhythm observed at 8:11, then chest
12 compressions. We call it CPR, they call it chest
13 compressions. This is what circulates the blood. At
14 8:11, he was defibrillated, and at 8:12 CPR stopped,
15 and a palpable pulse was present.

16 So my point, ladies and gentlemen, of all of
17 this is that without any cheating, stealing, changing
18 of records, loss of records, whatever you want to call
19 it, virtually every minute is accounted for, from the
20 time that the procedure began with the first dosage of
21 Versed until successful CPR and resuscitation has taken
22 place, and the pulse has returned. Virtually every
23 minute was accounted for in one way or the other by
24 some part of this record that Donna Embrey, as evil
25 hearted as she might possibly be, could not have

1 changed to deceive.

2 I'm going to ask you, when you go back to the
3 consider your verdict in this case -- and I know you're
4 going to do this anyway -- just to spend the time that
5 you need with these records.

6 I have been living with this case for years now,
7 since it began. You guys have been trying to absorb it
8 for the shortest time, just the last week. You haven't
9 had documents in your hands to look at, that puts you
10 at a disadvantage, but I thought it was worth it, even
11 though it was tedious to do that, to show you what we
12 have from a minute by minute by minute basis.

13 And what we have here, when you're deciding
14 whether Donna Embrey was negligent and guilty of
15 medical malpractice, what we have is a -- a --
16 basically a four minute interval from 7:51, when the
17 saturation we know was 90.1 percent, and everything
18 looks good, it drops to 80.7, it's back up at 7:53 to
19 88 percent, and then it drops at 7:54 to 73 percent.

20 This is very important here, Propofol stopped at
21 7:53. This is Donna Embrey saying it's over, gang.
22 We're not doing this procedure anymore. She's no
23 longer comfortable that she is able to do the things
24 that she was trained to do to take care of Mr. Mikell,
25 and so she's calling it off. The procedure is going to

1 stop because I'm not giving him Propofol anymore.

2 At 7:53, this was -- this was two minutes --
3 this was within two minutes after Dr. Nelson was in the
4 room, everything seemed to be going just the way they
5 wanted it to go, you got a saturation at 90.1 percent.
6 In two minutes, she says we need Dr. Nelson. We're not
7 doing this procedure anymore, and all these
8 resuscitative measures began to take place at 7:55 and
9 7:56.

10 And I submit to you that far from that being
11 evidence, let alone proof, by a preponderance of the
12 evidence of malpractice on -- on the part of anybody at
13 the Medical University South Carolina, that what that
14 shows you is that it was a true professional, who was
15 doing the best that she could do in using her
16 knowledge, training and experience to try to ensure
17 that Mr. Mikell came out of this procedure in at least
18 as good of condition as he when into it.

19 There's some other elements to proof of the
20 malpractice case, what -- what is malpractice?
21 Malpractice is not experiencing a bad result. It's not
22 experiencing a bad outcome. It's not even making an
23 error in judgment or a mistake, or not being as sharp
24 or as good as a -- as a doctor could be. It is not to
25 be judged in the clear light of hindsight. It's to be

1 judged by the circumstances that existed at the time
2 that the care was being rendered.

3 And malpractice is the failure to exercise the
4 degree of care that a -- that a reasonable, competent
5 practitioner of your specialty or your training would
6 exercise under the same or similar circumstances.

7 If you find that -- that Donna Embrey did
8 exercise professional judgment, professional care, she
9 did act reasonably promptly, then even though it was a
10 bad result, and even if you conclude that had she been
11 a little faster, or done something a little
12 differently, this event would not have occurred, she's
13 not guilty of -- she's not guilty of medical
14 malpractice.

15 You don't have to take my word for that, Judge
16 Nicholson is going to instruct you on the -- on the
17 standard of proving malpractice. And there's a reason
18 for that. You know, when you drive a car, we have
19 rules of the road and they are pretty much black and
20 white. You stay on your side of the road. You'll stop
21 at stop signs at a certain place. And you only go a
22 certain speed. And a lot of life is that way, it's
23 pretty cut and dry.

24 But the law recognizes in its wisdom, that
25 medicine isn't an exact science. That we want our

1 health care professionals to take care of sick people.
2 It would be very convenient for the doctors if they
3 only had to take care of the strongest and the
4 healthiest among us, but we want people to take care of
5 people that are at risk.

6 So we -- so we, in the law, and the judges --
7 and Judge Nicholson will struck you, we allow them a
8 leeway. We allow them a margin for error before we
9 find them guilty of malpractice. And that is simply
10 that they must exercise reasonably prudent judgment,
11 understanding, and knowledge as other competent people.
12 Not -- not -- not the best professionals in the world,
13 and people who have the benefit of hindsight, but
14 people who are like them in -- in similar situations,
15 to what they would do, and how that person would act.

16 If the plaintiff hasn't proven to you by the
17 greater weight or the preponderance of the evidence,
18 that Donna Embrey fell below the accepted standard of
19 care, then as -- as -- as much sympathy as we might
20 reasonably have for Mr. Mikell's family, it's your duty
21 as the finders of fact, under the oath that you have
22 taken, to return a verdict for the defendant in this
23 case.

24 There's another element of -- of -- of proof in
25 a malpractice case, and it has to do with what we call

1 proximate cause. Even if the plaintiff were to prove
2 by a preponderance of the evidence, that there was a
3 slam dunk case of -- of idiotic malpractice, you still
4 have to return a verdict for the defendant. If the
5 plaintiff has not proven by -- again, by the
6 preponderance of the evidence, that that negligence was
7 the -- what Judge Nicholson will tell you is the
8 proximate cause of the injury.

9 In this case, there were two different types of
10 injury. I'm going to talk about that just very
11 briefly. One is the injury that Mr. Mikell suffered
12 while he was alive. It's what we call conscious pain
13 and suffering. It's -- it's what Mr. Ransom described,
14 correctly I think, as the survival cause of action.

15 Now, the reason it's called the survival cause
16 of action is -- because that claim is -- was
17 Mr. Mikell's claim, and it's survives his death. It
18 has nothing to do with whether he survived -- who the
19 people who survived him. It has to do with what he
20 could have sued for himself had he not passed away.
21 And you can do that -- you can bring that, whether he
22 died as a result of the negligence from the Medical
23 University or for another reason, he could still -- his
24 estate can still bring a survival action for his
25 injuries that he suffered before he died.

1 It does not include his injury for his death.
2 It includes injuries he would have up to that point.
3 If -- if -- if the plaintiff has proved, to your
4 satisfaction, by a greater weight or the preponderance
5 of the evidence that but for the negligence of Donna
6 Embrey and the Medical University, that the injuries
7 would not have -- in other words, in essentially in
8 this case, she would have to find that despite the risk
9 that he had, despite the risk factor and his heart
10 condition, and the weaknesses that he had, that more
11 probably than not he would not have had a cardiac
12 arrest if Donna had not been negligent.

13 And then the second claim that the plaintiffs
14 have is what we call a wrongful death. And that's a
15 whole different claim. That's a claim that belongs to
16 the beneficiaries. And as Mr. Ransom correctly said,
17 it's the two -- his two biological children. And so if
18 you conclude that what Donna Embrey did that day caused
19 his death three months later, then you would be
20 entitled to return a verdict for wrongful death.

21 And it's the -- it's the things that Mr. Ransom
22 described to you. It's the -- basically the emotional
23 loss. There's no evidence that any pecuniary loss to
24 the children, but it's the -- it's the loss of
25 companionship, society, wisdom, and so forth that they

1 would have suffered.

2 I'm not even going to venture to suggest to you
3 what your verdicts would be in those claims. I frankly
4 don't have any wisdom that I could possibly share with
5 you on that subject. That's something that is strictly
6 in your province. I would ask you simply that if
7 you -- if you do go that way, and if you should find
8 the plaintiff has met the burden of proving
9 malpractice, and malpractice was the cause of his
10 injuries, that you -- that you just be mindful that
11 money is not a substitute for companionship and for
12 one's father, no matter how much it is. No matter how
13 much you decided to award, you know that the family
14 would give it back in a heart beat if we could make
15 this not have happened.

16 So this is an imperfection that we have in our
17 legal system. And that imperfection is simply that
18 there is no way to truly compensate somebody for a
19 severe loss like that. And -- and so I just ask you
20 to -- to relate to your own common experience.

21 Mr. Ransom has asked you to award millions of
22 dollars. How many millionaires do you know in your
23 lives? How many people do you know who despite
24 whatever they may have been through in their lives, how
25 hard they work, have ever been able to amass even one

1 million dollars. That's a lot of money. That is a lot
2 of money.

3 And without my trying to suggest to you how much
4 you should award if you get to that point, I -- I would
5 simply ask you to keep in mind, that when we're talking
6 about money, it's real money, it's not imaginary.

7 I'm going to ask you to conclude that the
8 plaintiffs have failed to prove that what happened
9 to -- to Mr. Mikell on October 1st of 2010 caused his
10 death. Judge Nicholson will struck you on the burden
11 of proof and proximate cause. And essentially, once
12 again, the plaintiffs have to prove by competent
13 medical evidence and that -- that Mr. Mikell, more
14 probably than not, would not have died -- would not
15 have died but for the negligence of Donna Embrey. And
16 I submit to you that they can't do that. They can't do
17 that.

18 Even if your gut says, well, it seems like an
19 awful coincidence if he would have just died
20 unexpectedly three months after this trauma, and just a
21 a month or so after he got out of the hospital, even if
22 your gut tells you that, we don't know what he died
23 from.

24 Dr. Kofke's testimony was that, well, there are
25 a couple -- there are a lot of medications, this

1 Tikosyn and anticoagulant that he was taken off of
2 because of his acute kidney injury, and those would
3 have made him more susceptible to an arrhythmia type
4 problem or to a blood clot related problem. Because
5 anticoagulants are supposed to keep you from having
6 blood clots, and having blood clots breaks loose can
7 cause pulmonary embolism, which means the blood clot
8 goes into your lung and keeps you from breathing, or
9 you can have a stroke, which means the blood clot go
10 into your brain and keeps the blood from getting into
11 your brain.

12 And his testimony was as follows: I believe
13 that Mr. Mikell was more susceptible to those problems
14 when he left the hospital in -- and -- and was in that
15 debilitated condition, and more susceptible to those
16 problems when he was off that medication. And he was
17 off that medication because he had injuries to his
18 kidneys. And he had the problems with his kidneys
19 because of what happened on October 1st. But we don't
20 know what he died of.

21 We don't know -- there's no way, there's no way
22 of knowing whether Mr. Mikell passed away because of a
23 blood clot, or he passed away because of an arrhythmia,
24 or whether he choked, or whether he had a heart attack,
25 or whether he fell asleep without his CPAP machine and

1 obstructed, not having people there to rescue him that
2 day. We don't know.

3 And so if you get to the point where you're
4 deciding whether what happened on October 1st of 2010
5 caused him to pass away on the 2nd of January, I would
6 just ask you to ask each other, and ask yourselves, are
7 we being asked to make suppositions here? Are we being
8 asked to make a leap of faith, including what we
9 think -- what our hunch is that -- that Mr. Mikell
10 might have died from.

11 And I submit to you that there's -- without even
12 knowing the cause of death, there's no way that you
13 could find with a preponderance of evidence that proves
14 that what happened to him on October 1st caused him to
15 die.

16 He was at risk -- his own -- his own
17 cardiologist testified that he was on a medical regimen
18 that they wanted him to be on when they -- when they
19 last saw him. It was not being dictated by his -- his
20 kidney injury at that time.

21 Those drugs were not indicated for him based on
22 the fact that he had not had any arrhythmias recently
23 and he was, therefore, not subject to the -- the blood
24 clot problems that he had before. That's why he was
25 off the medication.

1 They also testified that he was at no greater
2 risk of dying of a heart related ailment after -- after
3 this ordeal than he had been before that ordeal. And
4 that's the testimony of his treating physicians.

5 Judge Nicholson is going to instruct you too
6 that it's enough for the plaintiff simply to show that
7 the negligence placed Mr. Mikell at a greater risk of
8 dying, they would have to prove that, in fact, the risk
9 that they placed him at is the one that actually came
10 to the conclusion.

11 I'm almost done. You've had to absorb a lot of
12 information. In conclusion, I want to acknowledge that
13 it's fair for you to question the motive of everybody
14 who testified before you, and that's why I have
15 belabored the point to try to show that there is
16 objective evidence to support each and everything that
17 Eric Nelson and Donna Embrey testified to, and there's
18 not one shred of evidence to the contrary.

19 Of all the things you've seen, you know, the --
20 the knowing looks and the -- the skeptical tone of
21 voice that Mr. Ransom is so adept at, not once did he
22 offer you a piece of evidence that contradicts the
23 story I that just told you, minute by minute; the story
24 that Donna Embrey told you minute by minute; the story
25 that Eric Nelson told you minute by minute.

1 I'm going to ask you to give consideration to
2 the one thing above all else, and that is that -- the
3 reason must prevail in the end. You know, you may want
4 to help this family out. I want to help this family
5 out. You would not be human if you didn't sit here and
6 listen to the story that they told, and the wonderful
7 things about their dad, Chuckie Mikell, was and wish
8 that we could turn the clock back and that he could
9 still be back here today for them. Every single person
10 that, if you have half of a heart, would want that to
11 be the case.

12 But there are real people on the other side of
13 this equation, too. There are -- there are the
14 professionals that devoted their careers, their
15 education, every minute of their working lives to try
16 to see that the patients, including Mr. Mikell, who are
17 under their care, beat the odds.

18 But I ask you -- ask you to consider whether Mr.
19 Ransom and Dr. Kofke had been fair to Donna Embrey and
20 to the Medical University when he acknowledges, on the
21 one hand, that everybody who undergoes anesthesia has a
22 risk. And that -- that Mr. Mikell, in particular, had
23 a greater risk. He had a greater risk.

24 And then when he goes on to admit that -- and by
25 risk, that means that he is subject to the possibility

1 that despite how careful everybody is in every
2 procedure being taken, that could possibly minimize
3 that risk, there's still a risk. If you -- if you --
4 if you put enough people under anesthesia, no matter
5 how careful you are, some of them are going to have an
6 event just like this cardiac arrest.

7 And the best that we can do is to lay it in
8 front of you, and say this is what we did. We are
9 going to explain it minute by minute.

10 You know, we live in a different age now.
11 We've -- we've sort of become accustomed to there being
12 photographic evidence of every single thing. You know,
13 somebody -- somebody is there with a security camera.
14 Somebody is there with a cell phone recording what
15 happened. Somebody's pager records -- I think the
16 latest thing I saw was Fit Bits now. They're looking
17 at people's Fit Bits so they can confirm where they've
18 been, what they've done, how many steps they've taken.

19 Your cell phone can track you and messages.
20 They are all there. We're so used to now being able to
21 account for every single minute of everybody's life.
22 And I submit to you that we've done the best we could
23 possibly do.

24 And this was -- this was five years ago. We've
25 done the best we could do of producing to you all of

1 the objective evidence, all of the subjective evidence.
2 There was some testimony -- sworn testimony of the
3 people who were there. And I hope that -- I hope
4 you'll take Dr. Kofke at his word when he admits that
5 risk means risk. If you can eliminate all risks from
6 medical procedures, you're going win a Nobel Prize, I
7 think I said back on Monday. If you can eliminate all
8 risk from -- from medical procedures, you're going to
9 win yourself a Nobel Prize.

10 Dr. Kofke says, you know, I don't really know
11 what happened then, these records are all goofy.
12 There's too many holes in them. I can't tell you, but
13 I just tell you -- I don't think this could have
14 happened without Donna Embrey being negligent. Well,
15 that's not true. He already admitted that that is not
16 true. He admitted that it can happen, that it's going
17 to happen. It's going to happen in a certain number of
18 patients, no matter how careful everybody there is.

19 And we've explained to you exactly what we've
20 done. He has no criticism of the anesthesia plan of
21 the -- using the using drip in the Propofol. He has no
22 criticism of not intubating him in -- in anticipation
23 of there being a problem, that's -- that's not done.

24 He had no criticism of reducing the Propofol
25 when there was a dip in the saturation. He had no

1 criticism of placing the nasal airway to help
2 Mr. Mikell breathe better. He had no criticism of
3 keeping him lateral with his head elevated so that he
4 could keep his airway open. And he had no criticism
5 whatsoever of the resuscitation.

6 Instead he asked you to conclude, by the greater
7 weight of the preponderance of the evidence, that
8 somehow Donna Embrey couldn't pay attention, she
9 couldn't -- she couldn't get over the fact that the
10 computer was not recording the data that day, and she
11 couldn't get off the phone and quit texting long enough
12 to pay attention to that tone that she heard in her ear
13 and the numbers that were scrolling across the monitors
14 right in front of her, and the patient that was sitting
15 right in front of her.

16 And I ask you to -- if you find yourself even
17 tempted to reach that conclusion, I hope you'll just
18 talk it through with each other. And say is that the
19 more reasonable -- as we're sitting here with these
20 scales of justice, and we're weighing the evidence, is
21 it more reasonable to conclude that she just completely
22 spaced out and let this thing happen that her whole
23 life was devoted to keeping it from happening, or is it
24 more likely that this was a complication that everybody
25 who's been involved in this case, acknowledges it can

1 happen.

2 I'm going leave you with one final thought. You
3 know, we've talked about fairness to Mikell family.
4 And I'm -- I'm sure that they would welcome
5 compensation, anybody would. It's human nature to do
6 that. But I submit to you that it would be unfair to
7 them, as well as to the Medical University and the
8 others who were were involved in Mr. Mikell's care, it
9 would be unfair to them if you're not sure, if you
10 don't think that the plaintiffs have sustained their
11 burden of proof. It would be unfair to that family to
12 tell them -- to send them a message and says, you know
13 what, your father didn't have to have a cardiac arrest
14 that day. It was done by negligence. It was done by
15 malpractice. Imagine having to live with that for the
16 rest of your life.

17 So I -- I submit to you in closing, that I
18 really do appreciate your attention. I appreciate your
19 having kept your eyes open in the hour or so that I've
20 kept you here. And I promise you the end is in sight.

21 I don't get to talk with you again. Mr. Ransom
22 does. And he's really good at that. So I ask you to
23 give him the same courtesy that you gave me. Listen --
24 listen to what he says, but listen critically as well.

25 When you go back to the jury room, I would ask

1 you simply to ask yourselves, what would Mr. Cooke say,
2 what would the record say, what would Donna Embrey say,
3 and what would the others from MUSC say in response to
4 this. And I ask you to take as much time as you need.
5 We're not going anywhere. We'll be right here. And --
6 and listen carefully to the -- to the charge. I do ask
7 that -- that you return a verdict for the defendant.
8 Thank you very much.

9 THE COURT: Madam Forelady, ladies and gentlemen
10 of the jury, we're going to take a very short break.
11 If you'll leave your notepads in the chair, and I'll
12 get you back in about 10 minutes, whenever you are
13 ready to come back. Don't discuss the case amongst
14 yourselves.

15 (WHEREUPON, the jury leaves the courtroom at
16 2:12 p.m.)

17 THE COURT: We'll take about a five or ten minute
18 break.

19 (WHEREUPON, a brief recess was taken.)

20 THE COURT: All right. The Forelady says that
21 they want to have -- it's 2:15, they want to have
22 lunch. Lunch has been here for two hours. So I'm
23 going to let them eat lunch, and then when we come back
24 and have your reply, and then I'll do the charge. I
25 told the Forelady as soon as they finished eating, let

1 me know and we would finish up the trial.

2 So if you grab a sandwich real quick, that's
3 fine. If you don't, that's fine. I don't know how
4 long it's going to take all 15 of them to eat. But
5 they're giving them lunch right now.

6 MR. RANSOM: They're delivering food to them --

7 THE COURT: Pardon?

8 MR. RANSOM: I mean, they're giving them --

9 THE COURT: Yeah. Their lunch is here. They are
10 taking it to them right now.

11 MR. RANSOM: Sure. That's great.

12 MR. COOKE: Will the courtroom be open?

13 THE COURT: Pardon?

14 MR. COOKE: So we can go out and come back in.

15 DEPUTY: Sure.

16 (WHEREUPON, a lunch break was taken.)

17 THE COURT: Mr. Ransom, are you ready?

18 MR. RANSOM: I am ready, Your Honor. Thank you.

19 THE COURT: Bring us the jury, please.

20 (WHEREUPON, the jury enters the courtroom at
21 approximately 2:58 p.m.)

22 THE BAILIFF: The jury are all present, Your
23 Honor.

24 THE COURT: Thank you very much. Mr. Ransom.

25 MR. RANSOM: Thank you, Your Honor. If it please

1 the court. Ladies and gentlemen, I have an opportunity
2 now to respond to some of the things that Mr. Cooke was
3 saying. And I want to do this as quickly as I can.

4 Now, Mr. Cooke went through this process here
5 with this board of writing this timeline out. And what
6 I'd like you to do is just keep in mind that some of
7 these things we only know from the narrative. So if I
8 take the razor and erase everything that's coming from
9 the narrative, it's a little bit different of the time.

10 Now, -- and one of the things that Mr. Cooke
11 pointed out, he said that -- he sort of suggested, I
12 guess, that the plaintiff doesn't want you to see the
13 one second record. And this is the one that's 99 pages
14 long. The truth of the matter is we've got that record
15 identified and one of the Plaintiff's Exhibit,
16 Plaintiff's Exhibit 5. We are not trying to hide
17 anything from you.

18 Now, you'll remember at the beginning of the
19 case, one of the little challenges that I laid down
20 with Mr. Cooke, when we were taking the testimony of
21 Ms. Embrey, we've got marked as the first couple of
22 exhibits, Exhibit 1, Exhibit 2, Exhibit 3, 4, 5, and 6.
23 These are all of the different versions of the
24 anesthesia record in this case.

25 And as I told you at the beginning of the case,

1 when you get back in your deliberation room, you're
2 going to look at at them. And interestingly enough,
3 there are no two of them that are the same.

4 And the other thing that you'll notice is on
5 Plaintiff's Exhibit 1, this was the record that was
6 printed on October 1, 2010 at 1346. This is the first
7 one of all the anesthesia records that we have printed
8 in this case, this is the first one, missing page 1.
9 No. page 1.

10 The same thing that we see with the record
11 that's been marked as Plaintiff's Exhibit 4. And this
12 one was printed on October 12th of 2010. And it's
13 missing page 1.

14 Now, it's an interesting twist that Mr. Cooke
15 uses that he would have you believe that I'm somehow or
16 another trying to misdirect you and mislead you about
17 these records. Okay. These are not my records. All
18 that we can do is have Mr. Turner submit a request to
19 the Medical University, which has been marked in
20 evidence, for them to please produce a complete copy of
21 his chart. And all we can do is take the information
22 that they provide to us, and look through it, and do
23 the best that we can. And so when they've got records
24 that they turn over to us that are missing pages,
25 that's not me making something up.

1 And isn't it interesting that to this day, they
2 continue to try to tell you that the April, 2013,
3 record has not been changed. Well, obviously it's been
4 changed.

5 Now, they want to tell you that's some function
6 of how the printer works. I don't know if that's true
7 or not. And they want to tell you, well, it doesn't
8 really make any difference.

9 Well, but look, folks, it shows us one thing
10 with absolutely certainty, and that is that between the
11 time of this record and the time of this record,
12 somebody has gotten into the system and done something.
13 Whether it was effective in hoodwinking us, whether it
14 was effective in generating some defense for them that
15 previously existed, obviously not. There's not a
16 trail. We can compare the records and we can see. But
17 just because it was an unsuccessful effort doesn't mean
18 that something didn't happen to make those entries
19 re-arrange in that chart.

20 And we asked -- and, in fact, at one point in
21 time, we had to get the court involved. You know, we
22 asked for the audit trails in this case. And what we
23 were provided was marked as Exhibits 10 and 11. Okay.

24 And Exhibit 11 is the audit trail. You'll see
25 the parts that are highlighted that indicate when it is

1 that somebody is getting into this chart and printing
2 it. All right. That's how we knew, for example, that
3 there was a copy of this chart that Donna Embrey had
4 printed that she then shredded. Do you think that she
5 was going to step forward and admit that? No. She
6 couldn't deny it, because we have the audit trail.

7 Well, it's interesting because the audit trail
8 that they produced, at our insistence, doesn't say
9 anything about who accessed this record, this audit
10 trail only goes through October 2nd. It doesn't tell
11 us anything about who printed Exhibit 3, which is the
12 other one with the page missing. Okay.

13 So, again, this is, I think, it's a little bit
14 of a slight of hand for the Medical University, and its
15 defense team, to try to suggest that somehow or another
16 I am playing fast and loose with the records in this
17 case, and trying to mislead you because I'm not putting
18 the one second -- the one second record into evidence
19 even though it's marked as Plaintiff's Exhibit 5.

20 Now, they want to mark this Defendant's Exhibit
21 2, this blank Mayday card. And, boy, isn't this sort
22 of the million dollar record in this case, so they mark
23 this blank form. And now the argument is, well, if
24 look at the blank form, you can actually tell that
25 there isn't any important information in the one that

1 Donna Embrey used. And the last time that anybody saw
2 it, it was in her hands, tacked down in Mr. Mikell's
3 chart. Okay.

4 But I believe Mr. Cooke when he tells you that
5 there wouldn't have been anything useful in there, --
6 well, what did Donna Embrey tell us. I mean, I had
7 this on the overhead just earlier today. She said the
8 Mayday record was the document that I used to go back
9 through and reorganize the narrative. Okay.

10 And when you look at the first narrative, and
11 this is MUSC page 611, you'll see -- I mean, there's
12 virtually nothing in that first narrative. Virtually
13 everything was reversed engineered. And her
14 testimony -- this is not Mr. Ransom making this up or
15 accusing somebody -- her testimony is that the way that
16 she was able to piece all of that together and do it
17 accurately, was with this Mayday record.

18 And I tell you, if you don't think that she was
19 being untruthful about the Mayday record, I mean, come
20 on ladies and gentlemen, you know, Mr. Cooke suggests
21 that maybe what had happened was that she had forgotten
22 in August of 2014, when I took her deposition that her
23 memory had failed, and that she didn't remember that
24 she had used the Mayday record. And that she didn't
25 remember that this was the only time in her entire

1 career that she's ever changed a doctor's entries in a
2 chart. Maybe she just forget that in August of 2014,
3 because I had ambushed her somehow.

4 Keep in mind Exhibit 51 is the affidavit that
5 she signed, that's notarized October 19, 2015, so she's
6 got 13 months where she can inform everybody that my
7 memory has now been restored, and I now remember this
8 Mayday record, and I now remember making these changes,
9 and I now remember the phone calls and the text
10 messages. She didn't do any of that. So, again, this
11 isn't Mr. Ransom conjuring some nonexistent conspiracy
12 and just trying to make stuff up. Okay. Here it is.
13 Here's the evidence of deception right here. Signing
14 an affidavit, making no changes to her sworn testimony.

15 Now, I want to talk real quickly about some of
16 these values because what Mr. Cooke has done is a nice
17 job of trying to piece together some explanation for
18 what went wrong that doesn't indicate negligence on the
19 part of his clients. So he's coming and he's talking
20 about these PIP numbers. All right.

21 And here they are, as they run across the
22 bottom. Okay. And you see that they start showing up
23 with what appears to be legitimate real data right
24 around 7:56, 7:57. Now, keep in mind, it's true,
25 there's no way to -- there's no way to stand here and

1 say that those values don't mean that somebody doesn't
2 have that mask on Mr. Mikell's face, and they aren't
3 trying to squeeze air into his lungs. Who is doing
4 that? Who is there in the room? It doesn't tell us
5 that.

6 But what we do know is that Ms. Embrey is making
7 that up when she goes back, after the fact, and changes
8 Dr. Nelson's entry. Okay.

9 And listen, you'll remember, I asked him there
10 on the witness stand, I said, Dr. Nelson when was it
11 that you made this entry? It was before I even left
12 the room that morning. The audit trail shows that
13 those entries were made at about 8:34. Do you think
14 maybe that your recollection was better then than it
15 has been at some later time? Yeah. Were you intending
16 your entries to be accurate when you made them? I sure
17 was. Were you somehow or another confused, misled,
18 forgetting, not remembering when it was that you came
19 into the room? Nope, I can't tell you that. Okay.

20 So my point is, whatever is going on with this
21 bag ventilating in here -- all right -- the values
22 themselves, they don't tell you who's actually
23 squeezing the bag. But what we do know, and I
24 appreciate Mr. Cooke pointing this out from the other
25 part of the record, we do know that the Propofol gets

1 turned off at 7:53. Okay. And what that tells us is,
2 in Donna's own mind, by that point in time, it's all
3 over. I'm shutting it down. We are in big trouble.
4 Okay. So the procedure has gone so far south, that I'm
5 turning off the Propofol. Now, we're in a bad
6 scramble. Okay. So we do know that.

7 The other thing that we know, and it's
8 interesting Mr. Cooke didn't mention any of these
9 numbers, do you remember there was some brief
10 discussion about the end tidal CO2 numbers, and that's
11 these numbers right here. Right here, ETCO2, that's
12 end tidal CO2, that's a measurement of the carbon
13 dioxide that's in Mr. Mikell's exhaled breath. Okay.

14 And if he's -- his heart is working and he's
15 breathing, he's going to be breathing out carbon
16 dioxide, just like all of us are right now. Well, when
17 you look at those numbers, the first numbers are zero
18 and 0.754. That's at 7:48 and 7:49. And what that
19 means is, either he's not breathing at all -- that's
20 what the zero means -- or there's very, very little
21 carbon dioxide in his expired breath, which means the
22 exchange of gas going on between his lungs and his
23 blood is not taking place. So those are two very bad
24 looking numbers right there.

25 So they want to talk about the fact that what

1 five, six, seven, eight minutes later, somebody starts,
2 you know, hitting him with the mask ventilation, well
3 that looks like it starts at 7:56. And like I say,
4 that's eight minutes after these numbers show he's not
5 breathing at all.

6 So the point is, it's true that we have the
7 burden of proof. And we get stuck in this case dealing
8 with a record here that as Dr. Kofke himself described,
9 it's pretty goofy. It's hard to understand what these
10 numbers mean.

11 And part of the reason why the record is so
12 screwed up is because important parts of it have been
13 lost, altered, and destroyed. And so they want to come
14 in and say, well, they haven't proven their case
15 because they can't tell you what really happened.
16 Well, then they win, right. They've lost, altered, and
17 destroyed all the information that we need to prove our
18 case, so they win. Is that the way it works?

19 Now, you'll remember Dr. Kofke, he testified to
20 a reasonable degree of medical certainty, that if both
21 Dr. Nelson and Nurse Embrey had been attendant to their
22 patient, there would have been no cardiac arrest. And
23 that the cardiac arrest in the hospitalization caused
24 his death. Do you remember, I was asking the
25 questions, and he was answering. And at one point, he

1 was asked, and what do you think the relationship was
2 between the cardiac arrest and his death. And he says,
3 look, it's obvious to me that the cardiac arrest ended
4 up causing his death. It's obvious to me.

5 Maybe the most telling part of the whole case,
6 folks, relates to a question that Mr. Cooke asked Donna
7 Embrey while she was on the stand. And this was toward
8 the end of his examination. He said, you know, Donna,
9 I want you to look at the family and look at the jury,
10 and tell them if you had to do it all over again, would
11 you change anything? Remember that? You all remember
12 that? Do you remember her response? It was almost as
13 though she was called out because it took her 10, 15
14 seconds to kind of try to think of what she wanted to
15 say. And what did she say? She said, we had a good
16 plan.

17 Folks, the plan has to be put into execution.
18 And part of the execution of the plan means making sure
19 that everything is working, so that you don't get
20 distracted, so that you don't get stuck with text
21 messages and phone calls.

22 And let me just mention, too, do you really
23 think that the text messages and the phone calls was
24 all there was to it? Do you not think that she's
25 looking at that system, trying to figure out why it

1 isn't working? Do you not think that it took more than
2 just a text message and a phone call? I mean, she's
3 obviously got to sit there and try to get it to work,
4 right.

5 Have you ever had a computer lock up on you?
6 You just send a text message and it's fixed. So the
7 plan had to go into execution. The execution obviously
8 was marred by a series of blunders. All right. And
9 that's what resulted in Mr. Mikell going into cardiac
10 arrest and losing his life.

11 THE COURT: Madam Forelady, members of the jury, I
12 will give you a copy of these instructions in written
13 form. During your deliberations, you may refer to the
14 instructions to guide your decision making. You must
15 consider the instructions as a whole, and not follow
16 some, and ignore others.

17 Madam Forelady, please return the instructions
18 to the Court after you've reached a verdict please,
19 ma'am.

20 Now, under our constitution and code of laws
21 only you, the jury, can make the findings of facts in
22 this case. I'm not permitted to indicate to you how I
23 may feel about the testimony and evidence which has
24 been presented. Throughout this trial, it's been my
25 intention to be fair and impartial towards each of the

1 parties involved.

2 To determine the facts in this case, you will
3 have to evaluate the credibility and believability of
4 each witness. Some of the things you may consider as
5 you decide whether or not to believe a witness'
6 testimony about a particular matter include, the manner
7 and appearance of the witness who testified, was she
8 or -- or she hesitant or straight forward in answering;
9 was the testimony of a witness consistent or
10 inconsistent; how the witness came to know the facts
11 that he or she testified to; is there some reason a
12 witness would want to give testimony which would help
13 or hurt one side or the other? In other words, was the
14 witness biased or prejudiced? Does the testimony of a
15 witness strengthen or weakens by other testimony of
16 evidence?

17 You can believe as much or as little of each
18 witness' testimony as you think proper. Of course, you
19 do not determine the truth by merely counting the
20 number of witnesses presented by each side. Throughout
21 this process, you have but one objective, to seek the
22 truth regardless of its source.

23 Now, I have allowed you to take notes during the
24 trial of this case. However, please remember, that
25 some people are better note takers than others.

1 Juror's notes should not be given any greater weight
2 than the recollection of other jurors. The
3 recollection of individual jurors should be considered
4 as reliable as notes taken by any other jurors.

5 I also warned you, that when you are taking
6 notes, you may not notice the body language of a
7 witness in deciding the witness's credibility.

8 The same constitution and laws that designate
9 and make you the finders of fact, also make me the sole
10 instructor of the law. The attorneys are not the
11 instructors of the law. Do not make your decision
12 based from what you think the law should be, but what
13 you've heard it is, and only base your decision on what
14 the law is as I instruct it to you. You have heard me
15 refer to the parties in this action as plaintiff and
16 the defendant. The plaintiff is the person who brought
17 the action by the filing and serving a Summons and
18 Complaint. The defendant is the person against whom
19 the action was brought.

20 Since the plaintiff had brought the action, the
21 plaintiff has the burden of proof as I will explain to
22 you in just a moment. Both the plaintiff and the
23 defendant are entitled to a fair and impartial trial.

24 It shall be improper for you to decide this case
25 based upon sympathy, passion, prejudice, emotion, or

1 any other consideration not in evidence in this case.
2 Your job is to fairly and impartially decide this case
3 based on the evidence presented and the law as I have
4 explained it to you.

5 The evidence from which you are to decide the
6 facts consists of the following: The sworn testimony
7 of witnesses, both on direct and cross-examination,
8 regardless of who called a witness. The exhibits that
9 have been received into evidence, and any facts which
10 the lawyers read or stipulated.

11 Certain things are not evidence. You may not
12 consider them in deciding what the facts are. I will
13 list them for you: Arguments and statements by lawyers
14 are not evidence. The lawyers are not witnesses. What
15 they have said in their opening statement, closing
16 arguments, and other times is intended to help you
17 interpret the evidence, but it's not evidence. If the
18 facts, as you remember them, differ from the way the
19 lawyers have stated them, your memory controls.

20 Questions and objection by lawyers are not
21 evidence. The lawyers have a duty to their clients to
22 object when they believe the question is improper under
23 the rules of evidence. You should not be influenced by
24 the objection, by the court's ruling on the objection.

25 Testimony that has been excluded or stricken,

1 which you've been instructed to disregard as evidence,
2 must not be considered.

3 Anything you may have seen or heard when the
4 court was not in session is not evidence. You decide
5 the case solely on the evidence received at trial.

6 Direct and circumstantial evidence. There are
7 two types of evidence offered during a trial, direct
8 evidence and circumstantial evidence. Direct evidence
9 is testimony of a person who claims to have actual
10 knowledge of a fact, such as an eyewitness.

11 Circumstantial evidence is proof of a chain of
12 facts or circumstances indicating the existence of a
13 fact. The existence of a fact cannot be based on
14 speculation, surmise or conjecture. The law makes
15 absolutely no distinction with the weight or value to
16 be given to either direct or circumstantial evidence
17 and of direct evidence. You should weigh all the
18 evidence in this case to determine the facts in this
19 case. You have to evaluate the credibility, which
20 means the believability of witnesses on a contested
21 issue. You may have some direct and some
22 circumstantial evidence.

23 The plaintiff has the burden of proving his --
24 their claims in this case. The burden of proof in this
25 case is by the preponderance of the evidence. A

1 preponderance of the evidence simply means the greater
2 weight of the evidence. It is evidence which, as a
3 whole, shows that the facts sought to be proven, is
4 more likely true than not true.

5 This can be illustrated by imagining a set of
6 scales. When the case begins, the scales are even.
7 After all of the evidence has been presented, if the
8 scales remain even, or if they even tip in the
9 slightest in favor of the defendant, then the plaintiff
10 has failed to meet the burden of proof, you will be --
11 they will be entitled to a verdict.

12 If, on the other hand, the scales tip even
13 slightly in favor of the plaintiff, then the plaintiff
14 will have met his burden, and you should return a
15 verdict for the plaintiffs.

16 A preponderance of the evidence is not
17 determined by the number of witnesses, it must be
18 determined by the greater weight of all the evidence.

19 Testimony that has been presented to you by
20 deposition. A deposition is a written document or
21 video containing sworn testimony given by witnesses
22 outside of the court, in the presence of lawyers, so
23 each party may ask questions of the witness. This
24 testimony is entitled to the same consideration, and is
25 to be judged as to credibility and weight by you in the

1 same way as if the witness were present and gave
2 testimony. It's then, for you, the jury to determine
3 the effective value or weight and truth of the
4 testimony given in the deposition.

5 You've heard the testimony of several witnesses
6 who have special knowledge, skill, experience,
7 training, or education in a particular profession, and
8 who have given their opinions as experts as to matters
9 in which they are skilled.

10 In determining the weight to be given to each
11 opinion, you should consider the qualifications, the
12 credibility of experts, and the reason given for each
13 of their opinions. You are not bound by these
14 opinions. Give each of the opinion the weight, if any,
15 to which you think entitled.

16 Payment of witness' fee -- expert witness' fee
17 is an element of the cost of proving the claim and
18 proximate cause, but not proving -- proving damages.
19 The jury does not award expert fees in any judgment as
20 the element of damages.

21 You may consider payment of the expert witness
22 in calculating -- excuse me -- you may not consider
23 payment of an expert witness in calculating damages.
24 However, you may consider payment of an expert witness
25 if you believe the testimony shall -- has any bias or

1 prejudice in his or her testimony.

2 Spoliation of evidence: I charge you that when
3 a party fails to preserve material evidence for a
4 trial, it is for you to determine whether the party has
5 offered a satisfactory explanation for the failure. If
6 you find the explanation is unsatisfactory, you are
7 permitted, but not required, to draw the inference that
8 the evidence would have been unfavorable to the party's
9 claim.

10 To maintain a negligent cause of action against
11 the defendant, the law requires the plaintiff to prove
12 four essential elements. The plaintiff must prove each
13 of the following elements by a preponderance of the
14 evidence: One, the defendant owed a duty of due care
15 to the plaintiff. Two, that the defendant breached his
16 duty. Three, the plaintiff was injured. And, four,
17 that the defendant's breach of her duty of due care
18 proximately caused the plaintiff's injury. Later I
19 will explain to you proximate cause.

20 Negligent means that a person did not use the
21 same amount of care a person of ordinary reason and
22 prudence would exercise in the same circumstances.

23 Finally, the plaintiff must prove that the
24 defendant's negligence proximately caused the
25 plaintiff's injuries. Proximate cause is something

1 that produces a natural chain of events, which in the
2 end, brings about the injury. It is the direct cause
3 of the injury.

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

9 The plaintiff must also prove legal cause.
10 Legal cause is proven by showing that the injury was
11 foreseeable. This means that the injury occurred as a
12 natural and probable consequence of the defendant's
13 negligence. The plaintiff must prove that some injury
14 from the defendant's negligence was foreseeable, but
15 does not have to prove that the particular injury that
16 occurred was foreseeable -- was -- that occurred was
17 foreseeable. However, the defendant cannot be held
18 responsible for something which could not be expected
19 to happen.

20 Proximate cause does not mean the only cause.
21 The defendant's act can be the proximate cause of
22 plaintiff's injury if it was at least one of the direct
23 incurred causes of the injury.

24 The general rule is that one who does a
25 wrongful act is answerable for all consequences that

1 may ensue in the normal course of events. Any number
2 of causes and effects may interfere -- intervene
3 between the original wrongful act and the final injury
4 consequence, if the intervening act was set in motion
5 by the original wrongful act, and the normal aforesaid
6 would result in the original act, the final result as
7 well as -- every intermediate cause is considered in
8 law to be the proximate cause of the first wrongful
9 case.

10 Medical malpractice means doing that which the
11 reasonable health care provider or health care
12 institution would not do, or not doing that which a
13 reasonable, prudent health care provider or health care
14 institution would do in the same or similar
15 circumstances.

16 The plaintiff claims that the defendant
17 committed malpractice or professional negligence.
18 Malpractice is a failure to provide services with the
19 amount of skill, care, knowledge and judgment usually
20 used by members of the defendant's profession,
21 following good and acceptable practices in good faith
22 without fraud or collusion, resulting in harm to the
23 plaintiff as a form of carelessness or negligence.

24 In order to recover for malpractice, the
25 plaintiff must prove by the preponderance of evidence,

1 or greater weight of the evidence, what the standard of
2 the care the defendant owed to the plaintiff.

3 The law does not require absolute accuracy
4 either in practice or decision making. The law does
5 not hold a defendant to the standard of perfection, it
6 is how -- require the highest degree of care and skill
7 of which the human mind is capable.

8 The law does not require that the defendant use
9 that degree of knowledge, care, and skill ordinarily
10 used by professionals in good standing under the same
11 or similar circumstances, in that the defendant follow
12 the nationally accepted practice and procedures in the
13 profession. The defendant must use reason care and
14 diligence in using his or her skill in applying this
15 knowledge. You are not permitted to set up a standard
16 of your own in deciding whether the defendant's
17 learning, skill, and conduct fulfilled the duties
18 imposed on the defendant. You must use the standard of
19 care required, as I explained to you.

20 Next, the plaintiff must prove that the
21 defendant negligently parted from this standard of
22 care. Negligence is a failure to do what an ordinary,
23 careful professional would do under the same or similar
24 circumstances, or doing something that an ordinary,
25 careful professional would not have done under the same

1 or similar circumstances.

2 The defendant's duty is to be measured by both
3 the defendant's skill and diligence. If, by the lack
4 of this required skill, you find that the defendant
5 performed in any way which damaged the plaintiff, then
6 the defendant would be responsible for any injury
7 proximately caused to the plaintiff.

8 The defendant will also be responsible, if
9 having the required skill, the defendant negligently
10 fails to use it, or is not as careful and diligent in
11 using it as she should be.

12 Similarly, the defendant's mistake or error in
13 making a judgment alone does not constitute negligence.
14 However, the defendant failed to gather information
15 reasonably available, which a reasonable professional
16 would have gathered before making the decision, the
17 defendant failed to comply with the recognized standard
18 which would be followed by a similar professional under
19 similar circumstances.

20 In considering whether the defendant made a
21 reasonable decision, you must consider the decision
22 relative to the facts that existed at the time, and not
23 in light of what hindsight may reveal.

24 Finally, the plaintiff must prove that the
25 defendant's negligence proximately caused plaintiff's

1 damages. Proximate cause is something that produces a
2 natural chain of events, which in the end brings about
3 the injuries, to the direct cause of the injury.

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

9 Proximate cause does not mean the only cause,
10 the defendant's act can be a proximate cause of the
11 plaintiff's injury if it was at least one of the direct
12 concurring causes of the injury.

13 The plaintiff must also prove legal cause.
14 Legal cause is proven by showing the injury was
15 foreseeable. This means that the injury occurred as a
16 natural and probable consequence of the defendant's
17 negligence. The plaintiff must prove that some injury
18 from the defendant's negligence was foreseeable, but
19 does not have to prove a particular injury that
20 occurred was foreseeable. However, the defendant
21 cannot be held responsible for something which would
22 not be expected to happen.

23 The occurrence of a complication of a medical
24 procedure or a bad outcome, is not itself evidence of
25 negligence on the part of the health care provider. In

1 order to establish negligence, the plaintiff must prove
2 by the preponderance of the evidence that the defendant
3 committed one or more acts or omissions, or fell below
4 the current accepted standard of care.

5 The plaintiff must show more than increased risk
6 of harm. In order to carry his burden of proof on
7 causation, the plaintiff must prove more than an
8 alleged negligence merely increased the risk of harm.
9 It is not sufficient for the plaintiff to prove merely
10 that the harm or death might or could have resulted
11 from the defendant's negligence. Rather in order to
12 recover, the plaintiffs must prove by the preponderance
13 of the evidence that the harm or damage most probably
14 would have not occurred without the defendant's
15 negligence.

16 A defendant takes the plaintiff as he is found,
17 and the plaintiff is entitled to recover damages
18 resulting from the aggravation of a pre-existing
19 condition. Under the survival statute, the cause of
20 action which the deceased's person could have brought
21 in his lifetime against a wrong doer, an interest to
22 him survives the deceased's death to his
23 representative.

24 Generally, any cause of action which would have
25 been brought by the deceased in his lifetime survives

1 through his representatives of the estate under the
2 South Carolina General Survival Statute.

3 The Survival Statute recognizes, and is for the
4 conscious pain and suffering of the deceased.
5 Therefore, there can be no recovery unless the deceased
6 experienced conscious pain and suffering prior to and
7 related to the death.

8 Unlike a wrongful death action, which is solely
9 for the benefit of the deceased's family, damages in a
10 survival action are for the benefit of the deceased's
11 estate. In essence, a personal representative stands
12 in the shoes of the deceased, to bring any lawsuit the
13 deceased could have brought in his lifetime.

14 In considering damages, if any, you should only
15 consider the entitlement the es-- of the estate, not
16 the identity of the estate's beneficiary.

17 Actual damages in a survival action are awarded
18 for the benefit of the deceased's estate relevant for
19 the family. Damage in a survival action includes
20 recovery for the deceased's medical, surgical, hospital
21 bills and for the deceased conscious pain and suffering
22 known for stress.

23 In this wrongful death action, the plaintiff,
24 the personal representative of the deceased's estate
25 claims that the deceased wrongfully died as a result of

1 negligent acts or omissions of the defendant. The
2 personal representative of the estate of the deceased
3 has decided to bring an action for wrongful death. The
4 personal representative has a right to recover
5 compensation for the wrongful death. It's not
6 necessary to show the money value of the decedent's
7 life, since direct proof of the value of human life is
8 not possible.

9 What is reasonable compensation is left to your
10 sound discretion and judgment. Damages in the action
11 for wrongful death include pecuniary loss, that is the
12 loss of the deceased's ability to earn money, which the
13 plaintiff might logically and reasonably had been
14 expected to share such money for the care and
15 protection of the deceased's family, and for education
16 and training of the deceased's family.

17 Whether the relationship of husband or wife or
18 parent and child exists, pecuniary loss may be
19 presumed. Mental shock and suffering, wounded
20 feelings, grief and sorrow, loss of companionship, loss
21 of the use of the deceased's society, include the loss
22 of deceased's experience, knowledge, and judgment in
23 managing the affairs to the deceased and his
24 beneficiaries.

25 Medical and funeral expenses are not necessary

1 to show the exact amount of damages suffered by the
2 beneficiary, or the beneficiary suffers a monetary
3 loss. In addition to the person for whose benefit the
4 action is brought, does not have to be dependent on the
5 deceased for support.

6 Actual damages are sometimes called compensatory
7 damages, meaning to compensate the plaintiff for an
8 injury to put the plaintiff in the same position she or
9 he was in prior to the injury, insofar as monetary
10 compensation can do that.

11 In other words, actual damages include all
12 losses and expenses that the plaintiff has suffered
13 because of the defendant's carelessness. In wrongful
14 death action, the deceased's reasonable living expenses
15 must be deducted to establish pecuniary loss. Income
16 tax which the prospective earnings would have been
17 subject, must be deducted. Those prospective earnings,
18 as well as pension, income, must be discounted present
19 day value, and the plaintiff is never entitled to
20 recover conjecture or speculative damages. Any future
21 damage must be reasonable, certain to occur in the
22 future as a result of the defendant's acts. The
23 evidence must allow you to determine what amount of
24 damages is fair, just, and reasonable.

25 A person's life expectancy is determined by a

1 life expectancy table, which is part of the laws of the
2 this state. The life expectancy table is only an
3 estimate of the probable average remaining length of
4 the life of all persons in our state based on age.

5 Mr. Mikell was a 50 year old male, with a life
6 expectancy according to the life expectancy table of
7 27.40 years, or until age 79.40. This factor is to be
8 considered by you along with other evidence and
9 circumstances, and evidence bearing on Mr. Mikell's
10 life expectancy, including occupational habits and
11 health at the time of death, in deciding the amount of
12 damage to be awarded to the plaintiff.

13 In this case, the doctor and nurses were agents
14 of the principle MUSC. An agency is a consensual
15 relationship when one person or entity, the agents acts
16 on behalf of another, the principle, and is the subject
17 to the control of the principle. What the principle
18 does, through its agent, the law considers the act of a
19 principle. There is an agency relationship between
20 MUSC and its employees. If you find that Nurse Embrey
21 breached the standard of care, MUSC would be liable for
22 her actions.

23 In reaching your verdict, you should not
24 consider whether any party in this case was or was not
25 covered by insurance. As you may know, some plaintiffs

1 are covered and some are not. Some have various forms
2 of partial coverage. The same is true for the
3 defendants. The law does not allow the parties to
4 present any evidence about insurance, or lack of
5 insurance, or amount of insurance. And there is no way
6 that you, as a juror, can accurately determine whether
7 any party in this case has insurance coverage; Or if
8 they have it, how much insurance they do have.

9 An insurance policy generally has a subrogation
10 clauses. Subrogation means when an insured receives
11 money from a third party, the insured must reimburse
12 the insurance company who previously paid. More
13 importantly, insurance or lack of insurance has no
14 bearing on whether the defendant was or was not
15 negligent, or how much damage, if any, the plaintiff
16 has suffered.

17 Now, you've been chosen as fair and impartial
18 jurors, sworn to impartiality, to try and determine the
19 facts of this case. And when you comply with your oath
20 to do so, no one will have the right to criticize your
21 verdict, and you will have fully discharged your duty
22 as jurors to decide this case according to the
23 testimony you've heard from the sworn witnesses, along
24 with the other evidence.

25 I charge you, as jurors, you must decide the

1 issues in this proceeding without bias, without
2 prejudice to any party. You cannot allow yourself to
3 be governed by sympathy, by prejudice, by passion, by
4 public opinion, or any other arbitrary factor.

5 Both the plaintiff and the defendant have the
6 right to expect each of you to carefully impartially
7 consider all of the evidence in the case. You are to
8 follow the laws as I've explained it to you.

9 Madam Forelady, ladies and gentlemen of the
10 jury, I have prepared a verdict form. At the top, it
11 has Shon Turner as Personal Representative of the
12 estate of Charles Mikell, Deceased, the plaintiff, vs.
13 the Medical University of South Carolina, defendant,
14 with the case number.

15 "Do you unanimously find by the preponderance of
16 the evidence that the defendant was negligent in this
17 case in the care of Mr. Mikell? Yes or no." If you
18 answer -- the one is "no", stop here, and have the
19 foreperson sign the verdict form.

20 If your answer is "yes", you'll proceed to the
21 next question. The next question: "The amount of
22 damage that Mr. Mikell suffered as proximately caused
23 by the defendant's negligence is" blank.

24 This is your verdict as to the survival action:
25 "Do you unanimously find that the preponderance of the

1 evidence that the defendant's negligence proximately
2 caused Mr. Mikell's death? Yes or no." If your answer
3 is "yes", then state the amount of damages suffered by
4 Mr. Mikell's statutory beneficiary as a result of the
5 death. That's the answer to the wrongful death. A
6 place for you to date and sign.

7 You can find for the survival action and the
8 wrongful death, or you can find for one or the other,
9 or none. You don't have to find for both. You don't
10 have to find for any of it. It's your decision based
11 upon how you view the facts.

12 I would ask you to -- as the verdict form says,
13 your verdict has to be unanimous, all 12 of you have to
14 agree. I will tell you that it's a collective
15 reasoning process on your part.

16 I would ask you to respect each other's
17 opinions, review the evidence, discuss the evidence,
18 and reach a fair and just verdict.

19 Now, I'm going to ask you to go to the jury
20 room, Madam Forelady. Please don't begin your
21 deliberations. You may take your notepads with you,
22 but don't begin your deliberations until the bailiff
23 brings you all the exhibits and the charge book and the
24 verdict form, and then you may begin your
25 deliberations.

1 I may have to bring you back and charge
2 something that I missed, or something that I did wrong,
3 and correct it. So don't begin until the bailiff
4 brings everything to you.

5 The alternates, let me see, Laura Long, Mr. Alan
6 Utsey, and Robert Brown, if y'all would just keep your
7 seats while the rest of the jury of 12 goes to the jury
8 room, if you'll follow the bailiff, please.

9 The three alternates just keep your seat. The
10 rest of you go to the jury room.

11 (WHEREUPON, the jury leaves the courtroom at
12 3:41 p.m.)

13 THE COURT: All right. Would the plaintiff and
14 defense counsel come up and make sure all the exhibits
15 are present, the Plaintiff's Exhibits and the Defense's
16 Exhibits, and confer with the court reporter. Make
17 sure that they are all here. And once you have done
18 that -- but before we get there, let me ask, is there
19 any exceptions to the charge from the plaintiff?

20 MR. RANSOM: Judge, the only comment that I would
21 make was that you told them that they could find -- I
22 don't think that they could find for the plaintiff on
23 the wrongful death action without also finding for the
24 plaintiff on the survival action. They can find
25 survival, but not wrongful death. But I don't think

1 they could find wrongful death, but not survival. And
2 I think your charge may have been a bit confusing on
3 that one point.

4 THE COURT: Okay. All right. I think you're
5 right. I'll bring them back and tell them that.

6 MR. RANSOM: And the only thing I would say is
7 that I was listening, you charged them on negligence,
8 medical negligence, and professional negligence. And
9 that sort of -- I'm not quite sure that they'll
10 understand how all that fits together.

11 THE COURT: Okay. As far as that is concerned,
12 I'm not going to address that. Any exceptions from the
13 defendant?

14 MR. COOKE: Yes, Your Honor. We object to the
15 spoliation charge.

16 THE COURT: The what?

17 MR. COOKE: We object to --

18 THE COURT: Spoliation. Okay.

19 MR. COOKE: -- to spoliation on the basis that
20 that is an -- unless it's a sanction, and there's no
21 facts warning -- that is a sanction in this case, and
22 it's a charge on the facts. And also we believe that
23 the Spartanburg Hospital case, notwithstanding that the
24 rule is, it should be that -- that -- it's only
25 appropriate if there is evidence of the intentional

1 destruction of evidence.

2 We would also -- we object to the insurance
3 charge to the extent that it referenced subrogation
4 rights, because that would be a charge on the facts and
5 there's no evidence of subrogation in this case.

6 We also had requested -- defendant's requested
7 charge number one, which is unavoidable accident and
8 also number two --

9 THE COURT: You can mark those two. I don't have
10 a copy, so if you want to mark them as a Court's
11 exhibit.

12 MR. COOKE: I'll mark them. And finally, Your
13 Honor, we would just ask the court to direct the -- the
14 jury that they are to consider only Donna Embrey's
15 alleged negligence, and not the negligence of anybody
16 else consistent with the court's granting of a partial
17 directed verdict.

18 THE COURT: No, I'm not going to do that. Okay.
19 Okay.

20 MR. COOKE: Okay.

21 THE COURT: As far as those two charge requests,
22 that's denied. Okay. As far as the spoliation is
23 concerned, that's also denied.

24 And as far as sanctions, I think I have made it
25 very clear, I'm going to issue sanctions. I haven't

1 done it, but I think I made that very clear. I haven't
2 made it to the jury, I have made it clear to the
3 parties. Okay.

4 MR. COOKE: I understand.

5 THE COURT: For discovery abuse. Okay. I didn't
6 think it was relevant for the jury.

7 MR. COOKE: Understood.

8 THE COURT: Okay. If you'll come mark those
9 exhibits, please -- court's exhibit on those two
10 requested charges.

11 (Pause.)

12 (WHEREUPON, Court's Exhibit No. 7 was marked.)

13 (Pause. Exhibit verification by attorneys.)

14 THE COURT: All the forms there?

15 MS. FLEMING: Yes.

16 THE COURT: All right. For the record, I think
17 it's Defendant's Exhibit 8 that the defendant -- the
18 Plaintiff had asked to redact. I'm not going to redact
19 anything after reviewing those records on Defendant's
20 Exhibit No. 8.

21 Can the bailiff come get the exhibits and the
22 charge, and tell them to please begin their
23 deliberations.

24 Are y'all going to be staying in the courtroom
25 or are y'all going to be in and out? If you leave, can

1 you give the clerk or my clerk the phone number where I
2 can get a hold of you?

3 MR. COOKE: Yes.

4 MR. RANSOM: Yes.

5 (The exhibits and verdict form taken to the jury
6 at approximately 3:52 p.m.)

7 THE COURT: Now, what I'd like to do is go on the
8 record for a few minutes, and I will talk to the
9 alternates on the sanctions, okay.

10 I've got an order partially prepared, and
11 haven't reviewed his attorney -- Mr. Ransom attorney's
12 fees. Mr. Apostolou, are you going to offer any
13 attorney's fees, or do those include your time?

14 MR. APOSTOLOU: Briefly, yes, I would.

15 THE COURT: Pardon?

16 MR. APOSTOLOU: Yes, I would like.

17 THE COURT: All right. Mr. Ransom's attorney's
18 fees are up through 1/4/16. And since that time, he's
19 taken several depositions. When can you update your --
20 your attorney's fees affidavit?

21 MR. RANSOM: I feel confident in telling you I
22 could have that to you a week from today without any
23 trouble.

24 THE COURT: Okay. All right. When are you going
25 to give me yours?

1 MR. APOSTOLOU: I can have it within the same
2 timeframe, Judge.

3 THE COURT: All right. Now, my -- my
4 understanding, under the rules, that you are entitled
5 to -- if you disagree with these affidavits, you are
6 entitled to cross-examine them. Once you get them, if
7 you disagree with that position, please tell me.

8 MR. COOKE: I -- I agree with that.

9 THE COURT: Now, at some point in time, I need to
10 know from you when you are going to want to
11 cross-examine either one of them on the attorney's fee
12 affidavit before I rule.

13 MR. COOKE: Could we just have --

14 THE COURT: The only thing I can put on the
15 record, I am going to award attorney's fees and
16 costs -- okay -- for -- for discovery abuse.

17 MR. COOKE: Could we have, say a week after they
18 submit them to either object or maybe -- we may just
19 want to put in writing our objections, or we may want
20 to --

21 THE COURT: Well, it doesn't matter. I just want
22 to put some timeframe on when you're going to let me
23 know. Because if you want to proceed, I'll schedule a
24 hearing. And we'll call him as a witness, put them
25 under oath, and let you cross-examine them.

1 MR. COOKE: How about within a week after they
2 submit it?

3 THE COURT: Is that satisfactory?

4 MR. RANSOM: Yes, sir.

5 THE COURT: And once I've done all that, I will
6 issue my final order. But at this point in time, the
7 only thing I anticipate is attorney's fees and costs.
8 I don't anticipate any sanctions other than that.
9 Okay.

10 All right. We'll -- we'll adjourn, waiting on
11 the jury verdict. If y'all are going to be around,
12 there may be some questions.

13 MR. COOKE: We're going to stay around.

14 THE COURT: All right, thank you. Would the
15 alternates step out in the hall, please?

16 MR. COOKE: Just, could I -- we step up just a
17 second off the record --

18 THE COURT: Pardon?

19 MR. COOKE: Could I step up --

20 THE COURT: Yeah.

21 MR. COOKE: And ask you a question off the record.

22 THE COURT: Yeah.

23 (WHEREUPON, the court was adjourned while
24 awaiting a verdict from the jury.)

25 (WHEREUPON, the jury was sent home at 6:05 p.m.

1 and told to report at 9:30 in the morning to resume
2 deliberations.)

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1 * * * Tuesday, April 26, 2016 * * *

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3 (WHEREUPON, 9:30 a.m. the jury arrived. At
4 approximately 9:40 a.m, the jury resumed deliberations
5 and listened to a portion of Nurse Embrey's testimony
6 and Dr. Payne's testimony.)

7 THE COURT: Please go on the record. All right.
8 We were discussing at the bench the partial summary
9 judgment that the court granted to the defendant as to
10 Dr. Nelson's liability. In the court's opinion, that
11 would only affect the monetary terms if they get a
12 verdict based on the Tort Claims Act. You have a
13 motion on behalf of the plaintiff; is that correct?

14 MR. RANSOM: Yes. Judge, the plaintiff's position
15 is that the motion that was actually made was for
16 partial summary judgment on behalf of Dr. Nelson. The
17 dilemma that we face is the granting of a motion of
18 that nature, in favor of the Medical University
19 employee, who is not actually named as a defendant in
20 the case, and the jury not having been informed that
21 they shouldn't consider any of Dr. Nelson's conduct
22 during its deliberations, the plaintiff's position is
23 that the manner in which that dilemma is best resolved
24 is by awaiting the jury's determination. And if
25 necessary, sending them back to indicate on their

1 verdict form whether or not they found any malpractice
2 by -- by Dr. Nelson or by a physician, in that this
3 would be one way that the dilemma could be resolved in
4 a way that the plaintiff would ask that it be handled.

5 THE COURT: Okay.

6 MR. COOKE: Your Honor, that's not -- that's not
7 what the motion was. The motion was a motion for
8 partial directed verdict as to the Medical University's
9 liability for the actions of Dr. Nelson, and that's
10 what the court appropriately granted.

11 We believe that if there's a problem, that it
12 should be resolved simply by the jury being instructed
13 that they are only to consider the negligence -- the
14 alleged negligence of Donna Embrey, and not of any
15 other MUSC personnel, which would be consistent with
16 the court directing the verdict as it determined to do.

17 In terms of trying to change the verdict form
18 now that we've already had our closing arguments,
19 consistent with the court's ruling, and I think it
20 would be prejudicial to allow the jury to consider
21 returning a verdict on something that was not submitted
22 to them.

23 THE COURT: All right. I'll take your motion
24 under advisement. And, I mean, if it becomes a problem
25 at the time of the verdict, and I'll just have to take

1 whatever appropriate action the court deems appropriate
2 under the circumstances.

3 I -- I -- I had initially proposed bringing the
4 jury back and telling them as a matter of law, that the
5 only person -- the only agent that they should consider
6 committing medical malpractice would be the nurse, not
7 the doctor. But I understand the plaintiff does not
8 want that, is that correct?

9 MR. RANSOM: That's correct.

10 THE COURT: All right. And the defense has no
11 objection to that. But since both parties do not
12 agree, I'm not going to do it at this stage of the
13 proceedings.

14 MR. COOKE: All right. And just for the record,
15 we not only don't object to it, but we would
16 affirmatively ask the court to do that.

17 THE COURT: All right. I'm not going to do that.
18 Okay. I'll just have to deal with it -- you can go to
19 the Court of Appeals and take appropriate action
20 accordingly. Okay.

21 MR. COOKE: Thank you.

22 THE COURT: Thank y'all so very much. I
23 appreciate it.

24 (WHEREUPON, Court was in recess while awaiting a
25 verdict.)

1 THE COURT: All right. Please keep your seats.
2 Are you ready?

3 MR. RANSOM: Yes, sir.

4 THE COURT: Okay. Bring us the jury, please.

5 (WHEREUPON, the jury enters the courtroom at
6 approximately 11:53 a.m.)

7 THE BAILIFF: All jurors are present, Your Honor.

8 THE COURT: Madam Forelady, would you give the
9 verdict form to the bailiff, please, ma'am?

10 Thank you, sir.

11 THE CLERK: In case number 2012-CP-10-7275, Shon
12 Turner, as Personal Representative of the Estate of
13 Charles Mikell, deceased, Plaintiff, vs. Medical
14 University of South Carolina, Defendant: "As to the
15 professional negligence cause of action, do you
16 unanimously find by the preponderance of the evidence
17 that the defendant was negligent in his care of Mr.
18 Mikell?" Answer "No."

19 Signed by the foreperson, dated August -- April
20 26, 2016.

21 THE COURT: Thank you, sir.

22 THE CLERK: Yes, sir.

23 THE COURT: Anything from the plaintiff with the
24 jury?

25 MR. RANSOM: Nothing, Your Honor.

1 THE COURT: Anything from the defendant?

2 MR. COOKE: Nothing, thank you.

3 THE COURT: All right. Madam Forelady, and ladies
4 and gentlemen of the jury, I want to thank you very
5 much for your services. If anybody left anything in
6 the jury room or -- is the lunch here -- if you want to
7 take your lunch with you, if you want to sit in the
8 jury room and eat it, you are welcome to do that. But
9 it should be in the room waiting for you.

10 Does the bailiff know if it's here yet or not?

11 THE BAILIFF: I don't know, sir.

12 THE COURT: Okay. All right. If y'all follow the
13 bailiff to the jury room, they'll find the lunch, and
14 give you your boxed lunch. And if you want, you can
15 stay here and eat it, or you're welcome to leave.
16 Whatever you want to do.

17 (WHEREUPON, the jury leaves the courtroom at
18 11:56 a.m.)

19 THE COURT: Does the plaintiff want 10 days? I'll
20 be happy to give you 10 days?

21 MR. RANSOM: Yes, Your Honor, please. Thank you.

22 THE COURT: All right. I'll give the plaintiff 10
23 days to file any posttrial motions if you decide to
24 file them. Okay?

25 MR. RANSOM: Yes, sir.

1 MR. COOKE: Thank you.

2 THE COURT: All right. Thank y'all so very much.
3 I enjoyed working with you.

4 MR. COOKE: Thank you. The same here.

5 (WHEREUPON, the hearing was concluded.)
6

7 *** END OF TRANSCRIPT ***
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CERTIFICATE OF REPORTER

I, SHARON D. JONES, CERTIFIED COURT REPORTER, DO
HEREBY CERTIFY THAT THE FOREGOING IS A TRUE, ACCURATE
AND COMPLETE TRANSCRIPT OF RECORD OF THE PROCEEDINGS
HAD AND EVIDENCE INTRODUCED IN THE TRIAL OF THE
CAPTIONED CASE, RELATIVE TO APPEAL, IN THE COURT OF
COMMON PLEAS FOR CHARLESTON COUNTY ON THE 18TH, 19TH,
20TH, 21ST, 22ND, 25TH and 26TH OF APRIL, 2016.

I DO FURTHER CERTIFY THAT I AM NEITHER OF KIN,
COUNSEL NOR INTEREST TO ANY PARTY HERETO.

1/30/17

Sharon D. Jones

SHARON D. JONES
MY COMMISSION EXPIRES:
9/22/2024

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

SHON TURNER, as Personal
Representative of the Estate
of Charles Mikell, deceased

Plaintiff

vs.

MEDICAL UNIVERSITY OF
SOUTH CAROLINA,

Defendant

THE COURT OF COMMON PLEAS

DOCKET NO. 2012-CP-10-7275

TRANSCRIPT OF RECORD

July 18, 2016

Charleston, South Carolina

B E F O R E:

THE HONORABLE J. C. NICHOLSON, JR., JUDGE

A P P E A R A N C E S:

ROBERT B. RANSOM, ESQ.
GEORGE KAFALIS, ESQ.
Attorneys for the Plaintiff

M. DAWES COOKE, ESQ.
Attorney for the Defendant

JOYCE C. RUEGER, CVR-M
Circuit Court Reporter

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No exhibits were introduced

PROCEEDINGS

THE COURT: All right, Turner versus Medical University, MUSC. All right, we're here because I believe the defense counsel wanted to depose or cross examine the Mr. Ransom concerning the affidavit for attorney privileges, is that correct?

MR. COOKE: Correct. And there's also plaintiff's motion for a new trial, too.

THE COURT: All right. Okay.

MR. COOKE: Judge, I notice that we're infringing on the court's lunch break and we don't mind coming back if you want to take a break ---

THE COURT: --- well, whatever y'all want to do. Mr. Ransom? How long do think the cross examination is going to take on the...

MR. COOKE: I'm thinking it could take 45 minutes, maybe something like that?

THE COURT: On the attorney's fees?

MR. COOKE: Yes, Your Honor.

THE COURT: How long do you think the motion is going to take for a new trial?

MR. RANSOM: Fifteen minutes, Your Honor.

THE COURT: Why don't we hear the motion for a new trial, take a short -- take a break and if you don't mind we'll come back in for the attorney's fees because I

Shon Turner v Medical University of South Carolina
Proceedings
July 18, 2016

1 really don't want to rush you.

2 MR. COOKE: I know.

3 THE COURT: And I'm ready to get out of here for a
4 little while, okay?

5 MR. COOKE: That's why I brought it up.

6 THE COURT: Okay.

7 MR. COOKE: You've had a long morning already.

8 THE COURT: All right, I'm sorry y'all had to wait
9 but I sort of got tangled up in a couple of things that I
10 got to try to untangle somehow. Yes, sir, on the new
11 trial.

12 MR. RANSOM: May it please the court, Your Honor?
13 You sat through the trial, entertained arguments on the
14 issues at various points during the trial. The motion
15 has been filed and I'm grateful to you for giving me the
16 ten days after the verdict to do that. They filed a
17 responsive memorandum to which I have filed a reply.
18 Your Honor, I can highlight the arguments for you, if you
19 would like, or answer any questions that you may have,
20 but I don't want to belabor the issues because they have
21 been discussed at length at various times during the
22 proceedings.

23 THE COURT: Well, tell me why you think I should
24 grant a new trial ---

25 MR. RANSOM: --- sure ---

1 THE COURT: --- in a nutshell real quick, if you
2 don't mind.

3 MR. RANSOM: Sure. Judge, the primary ground is
4 that if you will recall you had granted the Medical
5 University's motion for partial summary judgment at the
6 close of all the evidence finding that there was no
7 reason to submit the claims against Dr. Nelson to the
8 jury for their consideration. You had originally denied
9 the Medical University's motion for a directed verdict at
10 the close of the plaintiff's case finding that there was
11 sufficient evidence on the claims against Dr. Nelson to
12 go to the jury. And then, at the close of the Medical
13 University's case on Friday afternoon Mr. Cooke made a
14 motion for partial summary judgment which you took under
15 advisement over the weekend.

16 And as you may recall, it was during the charge
17 conference Monday morning that the jury instructions and
18 the motion for partial summary judgment were being
19 discussed and you ultimately made the decision that you
20 were going to grant the motion for partial summary
21 judgment. But, you also made the determination that you
22 wouldn't inform the jury that you were removing the
23 claims against Dr. Nelson from their consideration. You
24 simply instructed me not to address those claims during
25 closing argument. The jury then got the case late

1 Monday afternoon, as you will recall one of the jurors
2 had childcare arrangements that we let them go around six
3 and then when we came back to court Tuesday morning, it
4 was at least my impression and I think Mr. Apostolou
5 shared this, that you had considered the matter again
6 over the course of the evening and believed, perhaps, it
7 had been a mistake to grant the motion for partial
8 summary judgment.

9 And as you may recall, we then had a discussion Mr.
10 Cooke and Mr. Apostolou and Ms. Fleming and I about how
11 that could be corrected. There was discussion about
12 informing the jury about certain things about submitting
13 a revised verdict form, but because Mr. Cooke and I were
14 not able to agree about how this could be resolved you
15 ultimately determined that you weren't going to intervene
16 in any fashion.

17 And my point that I'm trying to make here is that our
18 position, the plaintiff's position is, that it was a
19 mistake to take those claims against Dr. Nelson out of
20 the jury's consideration. It was my impression that you
21 yourself perceived that, but the verdict came in before
22 really anything could be done try to correct that in the
23 absence of an agreement between counsel. So, that's the
24 primary basis for the motion for a new trial is that
25 those claims were withdrawn from the jury's consideration

1 when they should have been submitted if there was issues
2 of fact for the jury to determine. There were a number
3 of other grounds that we cited in the written motion that
4 we filed. One related to the introduction of a blank
5 Mayday form into evidence. It's our position that this
6 was done in a backdoor attempt to defeat the best
7 evidence rule.

8 We also raised the issue of the opinion testimony
9 that was permitted to be introduced from Dr. Zile. You
10 will recall that he was one of the Medical University's
11 cardiologists who had treated Mr. Michael prior to the
12 colonoscopy and he gave opinion testimony about his life
13 expectancy. It had been your ruling that since we were
14 not advised, since the plaintiff's were not advised that
15 Dr. Zile was going to be called as an expert witness and
16 provide that type of opinion testimony, that it was not
17 appropriate for the jury to hear it.

18 But, Ms. Fleming repeatedly asked Dr. Zile questions
19 designed to illicit that opinion and it ultimately came
20 in. I asked to strike it, you declined to do that, we
21 think that that influenced the jury's determination.
22 There was also the issue, Judge, as you will recall a
23 very lively discussion at sidebar on Monday morning about
24 the jury instructions and what was to be instructed
25 relevant to the claim for medical malpractice. The form

1 had an instruction, that Your Honor had used defines
2 negligence, professional negligence, malpractice and puts
3 the matter in several different contexts which I had
4 objected in a very concise way after the jury
5 instructions that I believe was confusing to the jury.

6 And then lastly, was the issue of the manner in
7 which the discovery abuse that's the subject of the much
8 ballyhooed motion for sanctions affected the plaintiff's
9 ability to prepare for trial. And all of these issues,
10 again, are set forth in the memoranda that have been
11 submitted by the parties, but I think when you put all
12 those things together and most especially the taking of
13 the claims against Dr. Nelson from the jury's
14 consideration that the plaintiff would be entitled to a
15 new trial. Thank you, sir.

16 THE COURT: Thank you very much.

17 MR. COOKE: Thank you, Your Honor. We, too,
18 submitted a memorandum in opposition. As to Dr. Nelson,
19 first of all I believe it was a motion for partial
20 directed verdict. I -- maybe I misspoke at the time and
21 said summary judgment, but I think the court treated my
22 motion ---

23 THE COURT: --- I think you probably meant directed
24 verdict.

25 MR. COOKE: Well, either way, I mean it could have

1 been ---

2 THE COURT: --- maybe ---

3 MR. COOKE: --- it could have been ---

4 THE COURT: --- but obviously it had to be directed
5 verdict not summary judgment.

6 MR. COOKE: Right. Because you were in the course
7 of trial and of course the rule allows you to direct a
8 verdict as to specific issues within the case. But, what
9 I think had troubled you when you were thinking about it
10 afterwards was the fact that in retrospect, Dr. Nelson
11 wasn't actually a party and you were wondering how can
12 you grant a partial directed verdict.

13 But, you remember the issue was there physician
14 negligence or was there other personnel negligence. And
15 the difference would be the cap on liability. Then of
16 course, physician negligence the cap would be 1.2 million
17 and it would be 300,000 if it was a nurse or somebody
18 else. So that's why -- that's why it was important and
19 that's why you were concerned about it.

20 But in the end, first of all it didn't make -- first
21 of all you were correct in doing it. And second of all,
22 it didn't make any difference because the jury found that
23 there was no negligence on the part of Ms. Embry either.
24 And the negligence that was claimed against Dr. Nelson
25 was in failing to supervise her. And, as you recall the

1 licensing statute for nurses says that the nurse must act
2 under the supervision of a physician. And the
3 plaintiff's were arguing that essentially that -- I don't
4 want to put words in their mouth either -- caused by
5 careless liability or some sort of non-delegable duty or
6 strict liability on the part of the doctor. We argued
7 that the Hurst v Sandi [phonetic] case said that
8 licensing statutes don't create a duty of care the
9 violation of which gives rise to a cause of action. In
10 this particular case it's not even the physicians
11 licensing statute, it's the nursing statute. So, that
12 doesn't create a duty.

13 Plaintiff's expert Dr. Koffkey [phonetic] said that
14 it was appropriate for the anesthesiologist to supervise
15 up to four nurse anesthetists at a time and in this case
16 -- and that they should be rule of thumb he said as long
17 as you can get there within about two minutes or so after
18 you're called that's sufficient.

19 So, he didn't give any testimony from which a jury
20 could reasonably have inferred that Dr. Nelson deviated
21 from the accepted standard care because he was relying on
22 Donny Embry [phonetic] to call him if something went
23 wrong. We know absolutely for a fact that he was in the
24 room at 7:49. How do we know that, because the audit
25 trail, you remember that -- I know this is bringing back

1 fond memories but, the audit trail showed that he was
2 actually there, in the room, entering data in the
3 computer at 7:49. So, no matter what anybody testified
4 to that's one that you can't get away from.

5 We know that the note says that there was a decrease
6 in the saturation, at which time the nasal cannula was
7 inserted. He was present for that. The oxygen rate,
8 according to the note, came up to 94 percent. At 7:50 we
9 know it was at 90 percent. The nurse's note says he left
10 the room at 7:51 and we now know -- we know that he was
11 back in the room at least by 7:56 assisting in the
12 resuscitation.

13 Their experts said that well, I think the nurse must
14 not have known how to intubate or bag mask him correctly
15 because everybody else seemed to be able to bag mask him
16 but yet, in this case, he continued to desaturate when
17 the nurse was bag masking. Well, the testimony was that
18 Dr. Nelson was there with her assisting in the bag
19 masking. That they turned him in the lateral position,
20 they took the nasal airway out, and they bagged him --
21 bagged him during the resuscitation.

22 So, at most there was four to five minutes when Dr.
23 Nelson was not even -- was not in the room. But, the
24 expert's testimony and the testimony of our own experts
25 was that it was within the accepted standard of care for

1 the physician to rely on the nurse anesthetist to monitor
2 the patient and to call if he was needed. So, there was
3 no evidence of negligence on his part. But, second even
4 if there was it was harmless error because it could have
5 been a concern if the jury had found that she was
6 negligent and therefore the failure to supervise her
7 might have been an issue. But, in this case because the
8 jury found that she was not negligent the failure to
9 supervise her could not have been negligent.

10 And in Mr. Ransom's brief he says well maybe the
11 jury felt sorry for her because she was tearful and she
12 felt so bad about how things happened. And so maybe they
13 could have found that he was responsible and she wasn't.
14 Nobody tried to blame anything on Dr. Nelson. Even their
15 expert, our expert, Donna Nelson, she never said that I
16 was helpless because Dr. Nelson wasn't there to help me.
17 Their testimony was completely consistent with one
18 another and that is that she was doing what the nurse
19 practice act and his standard of care permitted her to do
20 which was to monitor the patient and be there.

21 So, we think the court was correct in granting a
22 partial directed verdict just to Dr. Nelson. It would be
23 a much more interesting argument had the jury found
24 against the Medical University then we'd be arguing about
25 whether the 1.2 million dollar cap should apply or the

1 lesser. As to the other grounds, the code sheet was
2 allowed and we had a big argument about it and you
3 wouldn't let him testify as to anything that was in the
4 missing code sheet. But, we were allowed to -- you
5 remember the testimony was that the code sheet didn't
6 even start until the code was called.

7 In other words, the arrest had already occurred and
8 so there wouldn't be anything -- the inference would be
9 that there wouldn't be anything on the code sheet that
10 reflected what happened before the code was called. We
11 were going to talk about that in a little while too
12 because you brought that up with regard to the sanctions
13 as well.

14 So, we put into evidence the blank code sheet to
15 simply corroborate that testimony and that is that if you
16 look at that form the blanks that are on the sheet,
17 there's nothing in there that caused for you to say what
18 caused the arrest or what was happening or what the
19 oxygen saturation numbers were prior to the arrest
20 occurring.

21 The -- over our objection, the court gave a
22 spoliation charge, but even under the -- even if the
23 Spartanburg hospital cases is the law and we argued a lot
24 in our brief why it shouldn't be just to preserve the
25 issue on appeal. But, even if it is, it's a rebuttable

1 presumption and various charges are rebuttable
2 presumption. So, we were allowed to put in evidence that
3 showed the jury that there wasn't anything damning in
4 that report that there wouldn't have been anything in
5 that report that was relevant to this case. And that's
6 exactly the kind of rebuttal that you're allowed to put
7 in in response to spoliation charge.

8 The issue of Dr. Zile, as you remember we moved at
9 the start of the trial to exclude the new testimony of
10 Dr. Koffkey[phonetic] because a week before trial we'd
11 gotten a letter from Mr. Ransom supplementing the
12 testimony that Dr. Zile was going to give to where he was
13 now going to say, instead of just saying that well I
14 think that -- I don't know the cause of death and I think
15 that certainly this insult, unless he returned to his
16 normal state before it had to have had some causative
17 effective. And you remember we filed -- we filed long
18 excerpts from his testimony where he said basically, I
19 don't know what caused him to die.

20 Well, now, a week before we get a supplementation
21 that says following his debilitating hospitalization, Mr.
22 Michael never returned to his pre-event baseline.
23 Several medications, which have been used to keep him
24 stable were changed while he was in the hospital. This
25 made him more susceptible to the type of heart

1 dysfunction described as being the likely cause of his
2 death. So, the cardiac arrest, physical injuries,
3 hospitalization, debilitation, medical management,
4 etcetera all contributed to his death. Now, that's brand
5 new. It wasn't based on any newly discovered evidence or
6 newly produced evidence. This goes back to the medical
7 records that when Dr. Koffkey [phonetic] was deposed he
8 said, I haven't really paid any attention to the records
9 of what happened after the arrest. My focus was on that.

10 And now, if you remember, at trial he was allowed to
11 testify that certain medications that Mr. Michael had
12 been on were changed during his recovery from the arrest.
13 And that he believed now that that made him more
14 susceptible to what was the most likely cause of his
15 death. Even though previously he said he didn't know
16 what that was.

17 So, the logical way that you would address that is
18 to call the treating physician and ask him about the
19 medications that were changed and would you have changed
20 those medications if you thought it would have made him
21 more susceptible to injury. And, you wouldn't let us
22 give -- you wouldn't let him give an opinion as to
23 whether, in fact, it contributed to the death or not.
24 But, you allowed him to testify as to the medications
25 that he was on and the reason for the change, and the

1 reasonable prognosis given his condition. So that was a
2 perfectly normal testimony that you would expect to come
3 from a treating physician. And it was the least the
4 court could do, with all due respect, to allow us to
5 respond to this last minute addition to Dr. Koffkey's
6 [phonetic] testimony. I think those were all of the
7 issues.

8 THE COURT: Okay. Thank you so very much. Is
9 there anything you want to add very briefly in rebuttal?

10 MR. RANSOM: Judge, the only -- as you will recall
11 there was a wealth of disputed evidence and testimony and
12 documents about what actually transpired during this ten
13 or fifteen minute period of time between when they first
14 administered the anesthetic to Mr. Michael and when he
15 was resuscitated from the cardiac arrest. And two things
16 that I want to make sure that you remember.

17 And the first was that Dr. Nelson himself testified
18 that he should not have left the room if his patient
19 wasn't stable. And when we look at the data that's in
20 the anesthesia record, questionable as it may be, it
21 shows these oxygen saturation levels -- forgive me, Dr.
22 Nelson's testimony was that if his oxygen saturations
23 were not consistently in the 90's then he shouldn't have
24 left the room. Dr. Koffkey's [phonetic] testimony was
25 that he shouldn't have left the room if the patient

1 wasn't stable. Well, the anesthesia records show that
2 Mr. Michael's oxygen saturations are up and down and up
3 and down. And it's interesting, Mr. Cooke, again
4 conflates did he leave the room at 7:48? Did he leave
5 the room at 7:49? Was he on the computer terminal at
6 7:48? Was he on the computer terminal at 7:49? That's
7 really important because his oxygen saturation level is
8 recorded as being about 90 at 7:48 and something like 60
9 at 7:49. And 60, of course, according to the nurse
10 anesthetist was real bad and required immediate
11 attention.

12 So, a bunch of disputed evidence about what's
13 actually taking place, when is he going in when is he
14 going out? As you'll recall when we got the audit trail,
15 the audit trail actually showed that Nurse Embry was
16 reconstructing all of these times when these things
17 supposedly happened and reverse engineering all of that
18 trying to fit it back together. And the question that
19 was asked of her was, how are you able to remember how
20 all of these things went down? And her testimony was
21 because I had the Mayday card.

22 And so, they continually took the position
23 throughout the case, and I don't fault them for trying
24 this because they're right, they had that Stokes case
25 adverse inference that was killing them. So, they had to

1 come up with some way to explain this Mayday record in a
2 benign fashion. And what they came up with was, well
3 let's just get a blank form and we'll put the blank form
4 in evidence and that will show that there wasn't anything
5 important in that Mayday record.

6 Well, that's exactly the effort that the best
7 evidence rule is designed to prohibit. And, taken in
8 addition to that was Nurse Embry's testimony that it was
9 the Mayday record that served as the guide for the
10 timeline of events that -- that she reconstructed in the
11 narrative.

12 The Medical University's position time and time
13 again has been that there was nothing in that Mayday
14 record that predated, or that came before the arrest
15 itself. Well that's their position. But when we look at
16 the narrative that Nurse Embry created by her own
17 testimony using that Mayday record it includes such
18 events as checking to make sure that the equipment is
19 working and functioning properly.

20 So, you know, it was completely within the jury's
21 domain, I think, to determine what pieces of evidence to
22 accept and reject. What testimony to accept and reject
23 and how they wanted to weave together the picture of what
24 actually happened, based on the totality of the
25 circumstances. It's true, I don't dispute Mr. Cooke put

1 up a good case and if the jury believed his version of
2 events that would explain why we lost the case. But,
3 they were certainly entitled to consider the evidence
4 that Dr. Nelson left when the patient's vital signs were
5 not stable, when they were not consistently in the 90's.
6 When he was actually headed down, you will remember the
7 slope into the valley of death as I called it.

8 And the jury could have accepted that evidence and
9 given a verdict against Dr. Nelson. And, again, in the
10 context, Judge of the statute that requires him to be
11 present, supervise, and directing the administration of
12 that anesthetic. Do you recall, that the evidence in the
13 anesthesia records show that the drug was given at 7:42.

14 THE COURT: You said a verdict against Dr. Nelson.
15 Dr. Nelson was never sued. The only issue with Dr.
16 Nelson was whether -- what cap was going to apply.

17 MR. RANSOM: Well, that's true and I agree to that
18 ---

19 THE COURT: --- he was never sued, so it could
20 never be a verdict against him. The issue was how were
21 we going to determine the cap. And he made a motion to
22 direct a verdict as to liability so he would -- so we
23 could predetermine the cap if I remember correctly. Is
24 that correct or incorrect?

25 MR. COOKE: That's correct.

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1 MR. RANSOM: That's correct.

2 THE COURT: Okay. When you said the jury could
3 return a verdict against Nelson ---

4 MR. RANSOM: --- well, finding that Dr. Nelson is a
5 physician ---

6 THE COURT: --- well ---

7 MR. RANSOM: --- that his conduct had been
8 substandard ---

9 THE COURT: --- if, in fact, we had put some
10 interrogatories to the jury yes they could have found
11 that Dr. Nelson had improperly supervised the nurse and
12 that would have affected the cap.

13 MR. RANSOM: That's right.

14 THE COURT: But, it wasn't directed verdict as to
15 liability.

16 MR. RANSOM: I believe it was, Your Honor. I
17 believe it was ---

18 THE COURT: --- I don't think so, but go ahead. Go
19 ahead with your argument.

20 MR. RANSOM: In any event ---

21 THE COURT: --- in any event, go ahead ---

22 MR. RANSOM: --- you're remembering this and you ---

23 THE COURT: --- I'm trying to bring it all back ---

24 MR. RANSOM: --- that's fine ---

25 THE COURT: --- while y'all talking but its ---

1 MR. RANSOM: --- again, my point is simply, Judge,
2 is there was a wealth of disputed evidence that I think
3 the jury was entitled to consider in order to determine
4 -- if you'll remember the verdict form initially proposed
5 by Mr. Cooke, it included a line do you find malpractice
6 by a physician or words to that effect. This is what he
7 had proposed to submit to the jury. And so, if you had
8 not granted this motion that form would have gone back
9 with the jury and they could have answered that question
10 ---

11 THE COURT: --- well, let me ask you -- well, I'll
12 just -- let me read your memorandums because I'm having
13 trouble bringing it all back ---

14 MR. RANSOM: --- yes, sir ---

15 THE COURT: --- to my mind. But, let me ask you
16 one question and I don't remember. I believe there was a
17 dispute as to when Nelson was in the room. The records
18 showed one thing and the records got changed and there
19 was a time frame before and nobody really knew. But, my
20 question, how did the Mayday card have anything to do
21 with that because the Mayday card wasn't even coming into
22 existence until they declared the Mayday. Until he was
23 going into the valley of death, as you recall it ---

24 MR. RANSOM: --- well, the way that I would answer
25 that, Judge, is to say that you can only reach that

1 conclusion by accepting the Medical University's
2 narrative about what's in this Mayday record. And I keep
3 coming back to; we don't know what's in the Mayday ---

4 THE COURT: --- well we don't know because it was
5 destroyed ---

6 MR. RANSOM: --- right. But what we do know is that
7 the anesthesia narrative, which existed in three
8 different forms in four different records, no two of
9 which were ever the same and which was highlighted by the
10 auditor ---

11 THE COURT: --- when did he start -- when did he --
12 at what time frame did he start falling off? Was it 46,
13 47 or do you remember?

14 MR. RANSOM: Well, as I say he came -- the testimony
15 evidence was that prior to 7:48 he had dipped and then
16 come back up. And there was a statement in the narrative
17 that his stats are back up to, I think, 94. We were
18 never able to actually identify that 94 on a record ---

19 THE COURT: --- but he had decreased prior to 48,
20 if I remember correctly somewhere about 45 or 46, is that
21 correct?

22 MR. RANSOM: The evidence would allow that
23 conclusion, yes, sir.

24 THE COURT: Right. Okay.

25 MR. RANSOM: All right. And then at 7:48 he's, the

1 data is reporting that at 7:48 his O2 sat is 90. And
2 also, Dr. Nelson was making the entry in the record that
3 he has to make in order for them to be able to bill
4 Medicare, all right. Has to show that he's present,
5 directing and supervising the provision of the
6 anesthetic. Which, anecdotally was absolutely false
7 because they gave that at 7:42, undisputed in the record
8 if he has ---

9 THE COURT: --- well after 7 ---

10 MR. RANSOM: --- but he doesn't make that entry
11 until 7:48 ---

12 THE COURT: --- after 7:42, when did he first show
13 signs of deterioration?

14 MR. RANSOM: The ---

15 THE COURT: --- time wise ---

16 MR. RANSOM: --- the slope started down at 7:48 and
17 went from 90 down to 40 and was fairly a consistent slope
18 downward ---

19 THE COURT: --- how about prior to 48, was there
20 anything prior to ---

21 MR. RANSOM: --- well, there was if you'll recall
22 Judge, prior to 48 the boxes were all empty because there
23 had been this software glitch.

24 THE COURT: Right.

25 MR. RANSOM: So we were having to accept everybody's

1 testimony from the Medical University that he was just
2 fine and dandy.

3 THE COURT: Okay. All right. Thank y'all very
4 much. I'll just have to read memorandums to refresh my
5 memory -- what time do y'all want to come back on the
6 other, it's now 1:25.

7 MR. COOKE: We're at your disposal, so ---

8 THE COURT: --- well, y'all got schedules too; I
9 don't want to impose too much on you. Is an hour okay?

10 MR. COOKE: An hour is plenty, I'm going to go down
11 and get crackers out of the snack machine so I can be
12 back as soon as you want us to come back.

13 MR. RANSOM: Your Honor, I've got Mr. Kefalos here
14 on my behalf and his request and mine would be two
15 o'clock unless Your Honor has something else.

16 THE COURT: You've got to do what now?

17 MR. RANSOM: I said, we would like to come back at
18 2:00, we'll be ready at 2:00 if that ---

19 THE COURT: --- you want to come back at 2:00?

20 MR. RANSOM: --- yeah, that seems ---

21 THE COURT: --- All right, we'll come back at 2:00
22 then, okay?

23 MR. COOKE: Thank you.

24 [Whereupon, the court is in recess from 1:30 to 2:30
25 p.m.]

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

CERTIFICATE OF COUNSEL

The undersigned counsel hereby certifies, pursuant to SCACR 210(g), that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

Dated: August 16, 2017

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