

THE STATE OF SOUTH CAROLINA
In the Supreme Court

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APPEAL FROM YORK COUNTY
Court of Common Pleas

S.C. SUPREME COURT

R. Scott Sprouse, Circuit Court Judge

Case No. 2015-CP-46-00882
Appellate Case No. 2019-000838

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

V.

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

APPENDIX

Volume I of II

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**THIS OPINION HAS NO PRECEDENTIAL VALUE. IT SHOULD NOT BE
CITED OR RELIED ON AS PRECEDENT IN ANY PROCEEDING
EXCEPT AS PROVIDED BY RULE 268(d)(2), SCACR.**

**THE STATE OF SOUTH CAROLINA
In The Court of Appeals**

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

v.

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

Appellate Case No. 2016-002008

Appeal From York County
R. Scott Sprouse, Circuit Court Judge

Unpublished Opinion No. 2019-UP-067
Submitted January 1, 2019 – Filed February 13, 2019

AFFIRMED

Chad Alan McGowan, of McGowan Hood & Felder,
LLC, of Rock Hill, and Whitney Boykin Harrison, of
McGowan Hood & Felder, LLC, of Columbia, both for
Appellant.

George Cox Beighley and Carmen Vaughn Ganjehsani,
both of Richardson Plowden & Robinson, PA, of
Columbia, for Respondents.

PER CURIAM: Affirmed pursuant to Rule 220(b), SCACR, and the following authorities: *State v. Lemire*, 406 S.C. 558, 565, 753 S.E.2d 247, 251 (Ct. App. 2013) ("An appellate court will not reverse the trial court's decision regarding jury instructions unless the trial court abused its discretion." (quoting *Clark v. Cantrell*, 339 S.C. 369, 389, 529 S.E.2d 528, 539 (2000))); *id.* ("An abuse of discretion occurs when the trial court's ruling is based on an error of law or, when grounded in factual conclusions, is without evidentiary support." (quoting *Clark*, 339 S.C. at 389, 529 S.E.2d at 539)); *State v. Mattison*, 388 S.C. 469, 479, 697 S.E.2d 578, 583 (2010) ("The trial court is required to charge only the current and correct law of South Carolina."); *In re Estate of Pallister*, 363 S.C. 437, 451, 611 S.E.2d 250, 258 (2005) ("A jury charge is correct if, when read as a whole, it contains the correct definitions and adequately covers the law."); *Hoard ex rel. Hoard v. Roper Hosp., Inc.*, 387 S.C. 539, 546, 694 S.E.2d 1, 4-5 (2010) (stating the plaintiff in a medical malpractice action must present (1) evidence of the generally recognized standards, practices, and procedures that a competent practitioner in the defendant's field of medicine would exercise under the same or similar circumstances, (2) evidence the defendant departed from the recognized and generally accepted standards, practices, and procedures in the manner the plaintiff alleged, and (3) evidence the defendant's departure from the generally accepted standards, practices, and procedures was the proximate cause of the plaintiff's injuries and damages); *Bowie v. Hearn*, 292 S.C. 223, 227, 355 S.E.2d 550, 552 (Ct. App. 1987) ("A doctor is not an insurer of health and negligence may not be inferred."), *rev'd on other grounds*, 294 S.C. 344, 364 S.E.2d 469 (1988); *Snow v. City of Columbia*, 305 S.C. 544, 555 n.7, 409 S.E.2d 797, 803 n.7 (Ct. App. 1991) ("South Carolina does not recognize the rule of *res ipsa loquitur*"); *id.* at 555, 409 S.E.2d at 803 ("[The] burden of proof cannot be met by relying on the theory that the thing speaks for itself or that the very fact of injury indicates a failure to exercise reasonable care."); *Fletcher v. Med. Univ. of S.C.*, 390 S.C. 458, 463-64, 702 S.E.2d 372, 374 (Ct. App. 2010) (rejecting the application of *res ipsa loquitur* in a medical malpractice action, and stating South Carolina courts were "not permitted to speculate that misfortune was the result of negligence in the absence of any evidence as to how the physicians deviated from the standard of care").

AFFIRMED.¹

HUFF, WILLIAMS, and GEATHERS, JJ., concur.

¹ We decide this case without oral argument pursuant to Rule 215, SCACR.

The South Carolina Court of Appeals

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

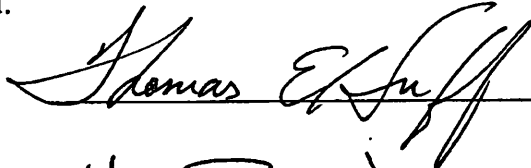
v.

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

Appellate Case No. 2016-002008

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.


_____ J.


_____ J.


_____ J.

Columbia, South Carolina

cc:
Chad Alan McGowan, Esquire
Whitney Boykin Harrison, Esquire

FILED

April 24, 2019

George Cox Beighley, Esquire
Carmen Vaughn Ganjehsani, Esquire
The Honorable R. Scott Sprouse

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

R. Scott Sprouse, Circuit Court Judge

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

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SC Court of Appeals

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

V.

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

Petition for Rehearing

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Lorrie Dibernardo, individually and as the Personal Representative of the Estate of Anthony Dibernardo, petitions the Court for rehearing with oral argument and reconsideration of Opinion No. 2019-UP-067 filed February 13, 2019, pursuant to Rule 221(a), SCACR. Appellant specifically asks this Court to reconsider (1) the import of *Childers v. Gas Lines, Inc.* 248 S.C. 316, 323–24, 149 S.E.2d 761, 764 (1966) and (2) the decision to summarily rely on the general proposition that *res ipsa loquitur* does not apply to medical malpractice cases—a fact undisputed by Appellant—in affirming the trial court. By summarily rejecting these arguments, the Court has failed to appreciate the distinction between the rejected doctrine of *res ipsa loquitur* and the allowed negative inference that may be drawn in medical malpractice cases, which includes the control of the instrumentality. Moreover, the Court is allowing inconsistency and uncertainty amongst the bench and bar by failing to squarely address the conflated cases upon which it relies. In support of the petition, Appellant respectfully submits the following:

I. Pertinent Facts

At trial, no one disputed the fact that Mr. Dibernardo’s heart was injured during the pericardiocentesis conducted by Respondent Mori.¹ (R.553-54). More importantly, it was undisputed that if the procedure had been performed correctly, this injury would not have occurred. (R. 191, 193-94, 197, 314-15, 321, 342, 343,400). While the parties disagree on whether the sheath or the needle caused the injury during the pericardiocentesis, Respondent Mori, and both experts testified in accord that when the procedure is done properly no injury occurs. (R. 191, 193-94,

¹ Specifically, Respondent Mori; Dr. Shah; Appellant’s expert, Dr. Alan Schob; and Respondents’ expert, Dr. Jim Story, all agreed an abrasion/injury to the heart occurred during the pericardiocentesis performed by Respondent Mori. (R.199, 205, 400). In fact, Dr. Shah testified that “but for the injury” to Mr. Dibernardo’s heart during the pericardiocentesis, Mr. Dibernardo “would not have died when he did.” (R. 132). The injury was further supported by the fluoroscopy recordings and echocardiogram images, along with the medical records. (R. 196-97; Fluro # 1, Fluro # 2, Fluro # 3).

197, 314-15, 321, 342, 343, 400). Further during cross examination of Respondent Mori and his experts, Appellant elicited there was no explanation for Mr. Dibernardo's injury, but for improper control of the procedure.

Based on the testimony and evidence presented, Appellant requested a jury charge regarding the control of an instrumentality pursuant to *Childers v. Gas Lines, Inc.*, 248 S.C. at 323-24, 149 S.E.2d at 764. The requested charge stated:

When a thing which causes injury is shown to be under the management of the defendant, and the accident is such as in the ordinary course of things does not happen if those who have management use proper care, it affords a reasonable evidence, in the absence of explanation by the defendant, that the accident arose from a want of care.

(R.602). The trial court declined to give the charge, finding it did not reflect the medical malpractice burden of proof. (R.541). Appellant's counsel noted his objection for the record and the requested charge was marked as a court's exhibit. (R.541-42, 602). The jury subsequently returned a verdict in favor of Respondents. (R.1).

II. The Court Confuses Res Ipsa Loquitur and Negative Inference of Negligence

Res ipsa loquitur speaks for itself. The doctrine arises in a context in which "there is *no evidence, circumstantial or otherwise*, at least none of sufficient probative value, to show negligence, apart from the postulate, which rests on common experience and not on specific circumstances of the instant case" *Id.* (emphasis added).

In contrast to res ipsa loquitur, our courts allow circumstantial evidence to support an inference as a means of satisfying the burden of proof requirements. *See e.g., Snow*, 305 S.C. at 553-55, 409 S.E.2d at 803-04. The distinction between res ipsa loquitur and circumstantial evidence that allows an inference of negligence is significant. The two theories are distinguished by whether the factual circumstances point merely to an occurrence "without any tendency to indicate the responsible human agency" or if there is some indication of "fault of omission or

commission upon the part of the defendant.” *Eickhoff*, 199 S.C. ____, 20 S.E.2d at 155. The first scenario cannot prove negligence without invoking *res ipsa loquitur* while, in the second circumstance, “a fact may be established *prima facie* by circumstantial evidence . . . without invoking the distinctive doctrine of *res ipsa loquitur*.” *Id.* Since *Eickhoff*, South Carolina courts have continually invoked a flexible case-by-case approach in the use of circumstantial evidence to warrant the inference of negligence. *Chaney v. Burgess*, 246 S.C. 261, 266, 143 S.E.2d 521, 523 (1965) (explaining when circumstantial evidence is relied upon to meet the burden of proof, “the plaintiff must show such circumstances as would justify the inference that his injuries were due to the negligent act of the defendant, and not leave the question to mere conjecture or speculation”).

Consistent with this approach, our courts have acknowledged an inference of negligence, as set forth in Appellant’s requested charge, is appropriate for control of an instrumentality. In *Childers v. Gas Lines, Inc.*, the Court explained a reasonable inference can be drawn when an injury occurs from an instrumentality under the known management of the defendant, and an accident of such nature does not occur if the instrument had been managed with proper care, in the absence of explanation. 248 S.C. 316, 323–24, 149 S.E.2d 761, 764 (1966) (“negligence may be inferred from all of the facts and attendant circumstances in the case, and where the circumstances are such as to take the case out of the realm of conjecture and into the realm of legitimate inferences from established facts, a *prima facie* case is made”). *Res ipsa loquitur* was not invoked in *Childers*, because there was a known “responsible human agency” to indicate fault and coupled with specific factual circumstances—established by testimony—warranted an inference of negligence. *Eickhoff*, 199 S.C. ____, 20 S.E.2d at 155; *See e.g., Childers, Sheperd v. United States Fidelity & Guaranty Company*, 233 S.C. 536, 106 S.E.2d 381 (1958) (explaining a *prima facie* inference of negligence is sufficient to satisfy the burden of proof for proximate cause); *see also Brumlette v.*

Charter-Med.-Columbia, 302 S.C. 68, 72, 393 S.E.2d 914, 916 (1990) (citing *Childers*) (relying on facts of instrumentality of control, the Court found in a medical malpractice action that a defendant “may be held liable for anything which appears to have been a natural and probable consequence of his negligence”). Additionally, South Carolina appellate courts have held an admission by the defendant doctor along with circumstantial evidence is sufficient to infer proximate cause in medical malpractice cases. *Green v. Lilliewood*, 272 S.C. 186, 191, 249 S.E.2d 910, 912 (1978). Thereby, demonstrating that an inference based on evidence, as well as an admission at times, is distinguishable from *res ipsa loquitur* because the evidence far exceeds *res ipsa loquitur*’s no evidence standard. Accordingly, choosing to affirm this case on the basis of *res ipsa loquitur* avoids the actual issue before this Court.

III. *Fletcher v. Medical University of South Carolina* Must be Clarified by this Court

Conclusory reliance on *Fletcher v. Medical University of South Carolina* only furthers the disparity in our jurisprudence on this issue and invites inconsistent application of the law throughout trial and appellate courts. As discussed herein, the *Fletcher* Court haphazardly relied on piecemeal case law to support its holding. In so doing, *Fletcher* characterizes *res ipsa loquitur* too broadly and suggests an impractical standard to warrant an inference in medical negligence cases. The holding in *Fletcher*, as now relied on by this Court, is at odds with *Bowie by Bowie v. Hearn* 294 S.C. 344, 364 S.E.2d 469 (1988) (*Bowie II*) and *Childers*. For these reasons, this Court must clarify *Fletcher* and recognize the use of circumstantial evidence to allow a negative inference in medical malpractice cases, including control of an instrumentality.

At the outset, Appellant does not take issue with the outcome in *Fletcher*.² The factual circumstances are different and is of no consequence to the matter before this Court. Rather,

² In *Fletcher*, the plaintiff underwent a bypass surgery and afterwards experienced bloating and shortening of breath. The plaintiff argued defendant doctors failed to inform her of such potential

Appellant takes issue with the reliance on *Fletcher*'s legal reasoning because it ignores the Supreme Court's holding in *Bowie II*. As such, Appellant turns to *Fletcher*'s interpretation of South Carolina case law to explain res ipsa loquitor and thereby illuminate the distinction with circumstantial evidence and the allowed negative inference.

The *Fletcher* Court began its analysis with citation to *Cox v. Lund*, 286 S.C. 410, 334 S.E.2d 116 (1985), which sets forth the well-known burden of proof for a plaintiff in a medical malpractice case. Specifically, the burden requires the plaintiff provide: (1) evidence of the generally recognized practices and procedures which would be exercised by a competent practitioner in similar circumstances and (2) evidence that the defendant doctor departed from the practices and procedures. The *Cox* Court found that the burden was established by plaintiff's expert who opined —based on a review of relevant medical charts and x-rays—that a doctor breached the standard of care for a colonoscopy when the evidence demonstrated the decedent's colon was unprepared for the procedure and offered the opinion that no colonoscopy should have been performed. 286 S.C. at 414–15, 334 S.E.2d at 119. Thus, the general proposition is derived from *Cox* that a plaintiff must satisfy the medical malpractice burden, which can be achieved through expert testimony that is formed through the review of relevant medical charts and x-rays.

The *Fletcher* Court then turned to *Bowie* by *Bowie v. Hearn*, 292 S.C. 223, 355 S.E.2d 550 (Ct. App. 1987) (*Bowie I*) for the following proposition that it deemed as “precisely on point”:

Under the plaintiff's reasoning in this case [*Bowie I*] the doctors in *Cox* could simply have testified that normally colons are not perforated during colonoscopies,

risks. 390 S.C. at 461–62, 702 S.E.2d at 373–74. The plaintiff's expert testified the defendant doctors breached the standard of care, and on cross-examination, the expert testified that the identified problem “could have occurred during this procedure even in the absence of any surgical negligence.” *Id.* at 463, 702 S.E.2d at 374. The Court of Appeals found no evidence established how defendant doctors deviated from the standard of care, and therefore plaintiff was improperly seeking recovery on a theory of res ipsa loquitor when the only basis was the expert saying a breach occurred. *Id.*

the standard of care. therefore is a doctor should not perforate the colon, and to do so violates the standard of care. Such reasoning would, in effect, make a doctor an insurer of perfect result in every surgical procedure. A doctor is not an insurer of health and negligence may not be inferred.

390 S.C. at 464, 702 S.E.2d at 374–75. The *Fletcher* Court explained because *Bowie I*'s reasoning was on point it ended all discussion. *Id.* The Supreme Court overturned *Bowie I* and allowed the plaintiff's position disparaged by *Bowie I* and *Fletcher*. Simply put, the reasoning isn't as conclusory as you can never assert such argument as *Fletcher* suggests. By making that assertion, the *Fletcher* Court incorrectly expanded the doctrine of res ipsa loquitur.

To appreciate that expansion, it's necessary to review both *Bowie* cases in their entirety. In *Bowie I*, plaintiff "sued the physician who delivered him via caesarean section because he was cut on the cheek during the procedure, resulting in a scar." *Fletcher*, 390 S.C. at 464, 702 S.E.2d at 374–75. Plaintiff's expert testified the proper standard of care would have been for defendant doctor not to cut the baby. *Bowie I*, 292 S.C. at 226, 355 S.E.2d at 552. The *Bowie I* Court found the expert's opinion to be "conclusory" and insufficient to satisfy the statutory requirements previously enunciated by the Supreme Court in *Cox*. 292 S.C. at 227, 355 S.E.2d at 552. Finding this reasoning legally unsound, the *Bowie I* Court found plaintiff failed to meet the burden of proof. 292 S.C. at 227, 355 S.E.2d at 552.

The Supreme Court reversed *Bowie I* in a per curium opinion. 294 S.C. 344, 364 S.E.2d 469 (1988) (*Bowie II*). The Supreme Court found the expert's testimony that "the use of [the] standard technique will not result in injury to the baby" was sufficient. 294 S.C. at 345, 364 S.E.2d at 469. The Court noted that defendant doctor testified that he made "swipes" with a scalpel, instead of the standard tiny incision, and this admission coupled with expert testimony was evidence that defendant doctor deviated from the standard of care. *Id.* at 346, 364 S.E.2d at 469. In sum, the Supreme Court found an expert stating the standard technique does not cause an injury,

coupled with evidence or admission by defendant doctor, is sufficient to meet the burden of proof, i.e. is not *res ipsa loquitur*.

Despite the reversal, the *Fletcher* Court relied on *Bowie I*'s misperception of *Cox* to find *res ipsa loquitur* and for the proposition that “negligence cannot be inferred.” 390 S.C. at 464–65, 702 S.E.2d at 375 (“[t]he analysis in *Bowie I* is precisely on point with this case, and we discern no factual basis that would cause the reasoning in that case to be inapplicable to the facts presented here.”) Appellant respectfully submits the reasoning of *Bowie I*, as interpreted by the *Fletcher* Court as *res ipsa loquitur*, was rejected by the Supreme Court in *Bowie II*—relying on the expert’s testimony to the effect that if the procedure had been done properly, the injury would not have occurred when coupled with other evidence. This is seemingly acknowledged by the *Fletcher* Court in footnote 3 in which it states, “No self-incriminating testimony from [the defendant doctors] in this case suggests a deviation in the standard of care,” however this is merely dicta and fails to set forth, and arguably ignores, the standard as outlined by *Cox* and *Bowie II*. 390 S.C. at 464 n. 3, 702 S.E.2d at 375 n. 3. Further, the suggestion that there is a requirement of self-incrimination to overcome an implication of *res ipsa loquitur* has never been the standard. Instead, South Carolina courts have readily relied on medical records and x-rays as the basis of circumstantial evidence in medical malpractice, as discussed *supra*. As it stands, *Fletcher* characterizes *res ipsa loquitur* too broadly and suggests an impractical standard to warrant an inference in medical negligence cases.

Moreover, reliance on the proposition that “negligence may not be inferred” is an incorrect statement of law. 292 S.C. at 227, 355 S.E.2d at 552. It is well settled in South Carolina that negligence can be inferred. *The Winthrop Univ. Trustees for the State v. Pickens Roofing & Sheet Metals, Inc.*, 418 S.C. 142, 162, 791 S.E.2d 152, 163 (Ct. App. 2016) (“where circumstantial

evidence is relied upon to establish liability. plaintiff must show such circumstances as would justify the inference that his injuries were due to the negligent act of the defendant, and not leave the question to mere conjecture or speculation”) (internal citation omitted).³ Both of these inconsistencies should be clarified by this Court.

In sum, the doctrine of *res ipsa loquitur* is inapplicable when expert testimony and other evidence, which can include admissions, demonstrate that if the procedure was done correctly the injury would not have occurred. Therefore, Appellant respectfully requests this Court reconsider its citation to *Fletcher*, and provide a rehearing as to the applicability of Appellant’s requested charge.

Conclusion

For the foregoing reasons, Appellant requests this Court grant this Petition for Rehearing with oral argument.

Signature Page to Follow

³ See e.g., *McQuillen v. Dobbs*, 262 S.C. 386, 392, 204 S.E.2d 732, 735 (1974) (affirming the denial of a directed verdict when plaintiff established a reasonable inference that defendant’s negligent inspection of furnace led to fire; based partially on testimony regarding recommended procedures for the proper inspection and maintenance of furnace that defendant’s failed to follow); *McCready v. Atl. Coast Line R. Co.*, 212 S.C. 449, 455, 48 S.E.2d 193, 196 (1948); *Graham v. Town of Latta*, S.C., 417 S.C. 164, 187, 789 S.E.2d 71, 83 (Ct. App. 2016); *Tucker v. Doe*, 413 S.C. 389, 401, 776 S.E.2d 121, 128 (Ct. App. 2015); *Gastineau v. Murphy*, 323 S.C. 168, 178–79, 473 S.E.2d 819, 826 (Ct.App.1996) (quoting 29 Am.Jur.2d *Evidence* § 313 (1994)), *rev’d on other grounds*, 331 S.C. 565, 503 S.E.2d 712 (1998).

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Whitney B. Harrison". The signature is fluid and cursive, with the first name being the most prominent.

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THE STATE OF SOUTH CAROLINA

In the Court of Appeals

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

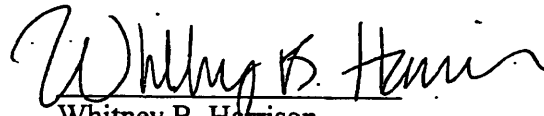
PROOF OF SERVICE

The undersigned hereby certifies that on March 13, 2019 she served counsel for
Respondent with the *Petition for Rehearing* in this matter by mailing a copy of the same by United
States Mail with first class postage prepaid to the following addresses:

George Beighley & Carmen Vaughn Ganjebsani
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Respectfully submitted,

March 13, 2019
Columbia, SC

A handwritten signature in black ink, appearing to read "Whitney B. Harrison". The signature is fluid and cursive, with the first name being the most prominent.

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March 13, 2019

Honorable Jenny Abbott Kitchings
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RE: *Lorrie Dibernardo v. Carolina Cardiology*
Appellate Case No. 2016-002008
Petition for Rehearing

Dear Ms. Kitchings,

Enclosed please find Appellant's Petition for Rehearing and one copy in the above captioned matter, along with the proof of service. Please return a stamped copy with my courier. Thank you for your assistance with this matter.

With kind regards,

Whitney B. Harrison
Whitney B. Harrison

RECEIVED
MAR 13 2019
SC Court of Appeals

Enclosures

cc: George Cox Beighley, Esquire
Carmen Vaughn Ganjehsani, Esquire

**THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS**

APPEAL FROM YORK COUNTY
COURT OF COMMON PLEAS
THE HONORABLE R. SCOTT SPROUSE
CIRCUIT COURT JUDGE

APPELLATE CASE NO. 2016-002008
CIVIL ACTION NO. 2015-CP-46-00882

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MAR 26 2019

SC Court of Appeals

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

APPELLANT,

versus

Carolina Cardiology Associates, PA and
Naresh Mori, MD,

RESPONDENTS.

Return to Petition for Rehearing

Respondents Carolina Cardiology Associates, PA and Naresh Mori, MD file this
Return to Appellant Lorrie Dibernardo's Petition for Rehearing of this Court's Opinion
No. 2019-UP-067 and state as follows:

Appellant brought this medical malpractice action individually and as the personal
representative of the estate of Anthony Dibernardo against Respondents alleging that Mr.
Dibernardo suffered a fatal injury during a pericardiocentesis, a procedure whereby fluid
is drained to remove a build-up of fluid around the heart through a tube or catheter. The

case proceeded to trial where for approximately three days a jury heard and considered the evidence which is more fully described in the Counterstatement of Facts of the Final Respondents' Brief.

In summary, the evidence showed that Mr. Dibernardo was born with Noonan's syndrome, a genetic disorder which caused him to have an extremely enlarged heart as well as other physical abnormalities such as a caved-in chest bone deformity. He had a longstanding history of heart problems and was eventually diagnosed with a massive pericardial effusion, a build-up of fluid in the sac surrounding the heart, which made it very difficult for Mr. Dibernardo to breathe.

Mr. Dibernardo was admitted to the hospital by Dr. Shah of Carolina Cardiology who believed Mr. Dibernardo needed a surgical evaluation for his worsening of fluid around the heart. Mr. Dibernardo refused to undergo any surgical procedure and thereafter met with Dr. Mori of Carolina Cardiology who recommended that Mr. Dibernardo undergo a pericardiocentesis to attempt to remove the fluid around his heart in light of Mr. Dibernardo's refusal to undergo surgery.

The evidence presented at trial was replete with testimony that known complications can occur during a properly performed pericardiocentesis. The most common and prominent complication from a pericardiocentesis is bleeding, particularly because a pericardiocentesis involves the insertion of a needle and catheter or other tube into the space surrounding the heart which contains a risk of striking veins, vessels, or the heart muscle itself. [R.pp. 131, l. 22 – 132, l. 7; 142, ll. 16-23; 261, l. 18 – 262, l. 5; 367, l. 19 – 368, l. 16; 431, l. 21 – 432, l. 15.] Dr. Mori and Respondents' experts explained that even if a physician properly performs a pericardiocentesis and all

precautions are taken, complications can still occur. A pericardiocentesis is never 100 percent fool proof and injury can occur to a patient despite a physician following all appropriate steps and procedures. A complication can occur even if a physician meets the standard of care, and injury is not indicative of a physician's departure from the standard of care. [R.pp. 315, ll. 12-18; 316, ll. 10-20; 344, ll. 7-17; 347, ll. 1-15; 369, ll. 2-15; 413, ll. 23-24; 417, l. 23 – 418, l. 4; 420, ll. 12-15; 431, l. 21 – 432, l. 25; 465, ll. 5-1.]

Appellant's expert agreed that a pericardiocentesis involves a number of risks and complications and that an occurrence of an injury during the procedure, whether from the use of needles or equipment, is not indicative of a physician's negligence or malpractice:

Q: Performing a pericardiocentesis on a patient has a number of risks associated it with it; is that true?

A: That's true.

Q: And bleeding is one of those risks; is that true?

A: Yes.

Q: And bleeding can occur even when the procedure is performed within the standard of care, can it not?

A: Yes, sir.

Q: And the fact that bleeding – a bleeding complication occurred by itself doesn't mean the physician did something wrong, does it?

A: In general, no.

...

Q: Needle injuries, equipment injuries, any kind of an injury will cause bleeding with this procedure; is that true?

A: In general, yes,

Q: And just because there's bleeding that doesn't mean somebody's committed a malpractice?

A: In general, that's correct.

[R.pp. 212, l. 21 – 213, l. 10; 224, ll. 4-10.]

In this case, Mr. Dibernardo's physical condition also raised the risk of complications during a properly performed pericardiocentesis. Mr. Dibernardo's massively enlarged, moving, and beating heart increased the difficulty of inserting a needle into a tight space with little room available for the insertion of the needle. [R.pp. 264, ll. 1-19; 266, ll. 19-23; 274, ll. 5-15; 315, l. 20 – 316, l. 4; 368, l. 10 – 369, l. 1.] The fluid into which the needle was to be inserted was not evenly distributed and most of the fluid was located behind the left ventricle, not around the right ventricle near where the needle was to be inserted. The narrow amount of fluid located at the needle insertion site left little room for the needle insertion with no risk of injury. [R.pp. 265, ll. 1-19; 273, l. 13 – 274, l. 5; 274, l. 16 – 275, l. 8; 315, ll. 20-25.] Mr. Dibernardo's abnormal anatomy and deformity in his chest area causing it to cave in also made access to his heart area difficult. [R.pp. 260, ll. 17-21; 264, ll. 20-23; 512, ll. 15-16.]

At the close of the evidence, the Trial Court instructed the jury on the applicable law, including that to recover in a medical malpractice action, the plaintiff must prove the standard of care owed by the defendant to the patient and must prove the defendant negligently departed from that standard of care in treating the patient. [R.pp. 471, l. 13 – 472, l. 14.] The Trial Court correctly charged the jury that a "doctor is not an insurer of a cure or even of a positive result; therefore, the mere fact that a treatment does not benefit the patient or that it even harms the patient does not in and of itself mean that the defendant was negligent. A bad result, injury, death or failure to cure is not by itself

enough to show that the defendant was negligent.” [R.p. 472, ll. 15-22.] Finally, the Trial Court instructed the jury on the use of circumstantial evidence. [R.pp. 468, l. 9 – 469, l. 2.]

After weighing and considering the evidence, the jury returned a verdict for the defense, finding that Dr. Mori did not violate the generally accepted standards of medical care in his treatment of Mr. Dibernardo. [R.pp. 1-3.]

At trial and on appeal, Appellant contended that the Trial Court erred by declining to give the following jury charge even though such a charge contradicts the longstanding principle that an adverse result does not equal medical malpractice:

When a thing which causes injury is shown to be under the management of the defendant, and the accident is such as in the ordinary course of things does not happen if those who have management use proper care, it affords a reasonable evidence, in the absence of explanation by the defendant, that the accident arose from a want of care.

[R.pp. 540, l. 8 – 541, l. 11; 602.]

After consideration of the briefs filed by the parties, this Court affirmed the defense verdict in an unpublished per curiam opinion. Appellant has now filed a petition for rehearing, challenging this Court’s reliance upon sound and well-established principles of law that a plaintiff must present evidence of a defendant’s breach of the generally accepted standards, practices, and procedures in a medical malpractice action and that an unfortunate result alone cannot establish a failure to meet the applicable standard of care.

As an initial matter, Appellant has not shown any points overlooked or misapprehended by this Court, largely repeating the arguments previously made to this Court in her Reply Brief.

Second, Appellant opens her Petition for Rehearing with the spurious claim that the evidence at trial was undisputed that if the procedure was performed correctly, the injury would not have occurred. In making this false claim, Appellant ignores the copious amount of evidence establishing the known complications of the procedure even when properly performed. As Appellant did in her previously filed briefs, she erringly takes the testimony of Dr. Mori and Respondents' expert out of context. While Dr. Mori testified that the goal of a pericardiocentesis is that injury should not occur if the procedure is done properly, this testimony should be construed against the backdrop of Dr. Mori's repeated explanation of the known complications which can occur during a properly performed pericardiocentesis. [R.pp. 314, l. 16 – 316, l. 20; 341, l. 15 – 345, l. 22.] Dr. Story explained that while the intent of a proper pericardiocentesis is not to cause an injury to the patient, including the patient's heart, complications and injuries can occur even with the best standard of care and techniques used,. [R.pp. 412, l. 4 – 413, l. 24.]

Appellant also contends that the trial testimony showed there was no explanation for Mr. Dibernardo's injury but for an improper control of the procedure. Once again, in making such an outlandish allegation, Appellant neglects to account for all of the evidence regarding the known complications of the procedure.

Relying upon her distorted view of the evidence, Appellant argues that her requested jury charge should have been given by the Trial Court. The requested charge, however, does not accurately state the law and the burden of proof for a medical malpractice case in South Carolina which requires a plaintiff to present evidence that the defendant departed from the recognized and generally accepted standard, practices, and

procedures in the defendant's field of medicine. Hoard ex rel. Hoard v. Roper Hosp., Inc., 387 S.C. 539, 546, 694 S.E.2d 1, 4-5 (2010). Appellant's requested charge is irreconcilable with the burden of proof in a medical malpractice case because the requested charge eliminates the requirement that the plaintiff prove a defendant's departure from the applicable standard of care and instead would permit an inference, based upon the occurrence of an injury or adverse result during a medical procedure, that the defendant must have failed to properly adhere to the standard of care. Rather than having to present evidence and prove the standard of care and departure therefrom, the requested charge would permit a plaintiff in a medical malpractice action to elude those elements of a medical malpractice claim when a plaintiff could not prove them with properly admitted direct or circumstantial evidence.

In her effort seeking to reverse this Court's decision affirming the defense verdict and the Trial Court's refusal to give the requested charge, Appellant argues that this Court has confused the doctrines of *res ipsa loquitur* and circumstantial evidence. While Appellant's argument is somewhat difficult to discern and contradictory (in that she claims to not be relying on the fact of injury to prove negligence but then argues that negligence should be inferred when an injury occurs during a medical procedure), Appellant seems to argue that she is not seeking to prove negligence by the fact of injury alone and rather only wants a charge that permits an inference of negligence based upon the admitted circumstantial evidence. The Trial Court gave such a charge to the jury:

Circumstantial evidence is proof of a chain of facts and circumstances indicating the existence of a fact. It is evidence which immediately establishes collateral facts from which the main fact may be inferred. Circumstantial evidence is based on inference and not on personal knowledge or observation. It is proof that does not actually establish the fact in question but that asserts or describes something else from which

you may either reasonably infer the truth about the fact or at least reasonably infer an increase in the probability that the fact is true.

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

...

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

[R.pp. 521, ll. 9-25; 522, ll. 3-7; 7.] Accordingly, Appellant's purported concerns about the use of circumstantial evidence are unfounded.

Appellant further challenges this Court's reliance on Fletcher v. Med. Univ. of South Carolina, 390 S.C. 458, 702 S.E.2d 372 (Ct. App. 2010) and attempts to create a conflict in the law where none exists. In Fletcher, the patient filed suit against a university hospital for medical malpractice after the patient suffered complications following subclavian bypass surgery. Id. at 461-62, 702 S.E.2d at 373-74. The plaintiff's expert, while testifying that he believed the hospital's physicians deviated from the standard of care, also conceded that he did not find any evidence in the medical records which indicated the hospital's physicians used any improper techniques during the operation. The plaintiff's expert further acknowledged that complications could occur during the procedure in the absence of any surgical negligence. Because the plaintiff presented no evidence of negligence in the performance of the procedure, the trial court directed a verdict in favor of the hospital on the medical malpractice claim. Id. at 462-63, 702 S.E.2d at 374.

In affirming the directed verdict on appeal, this Court observed that the patient was in essence asking the Court “to conclude that the occurrence of a complication [was] itself evidence of negligence.” Id. at 463-65, 702 S.E.2d at 374-75. Noting South Carolina’s rejection of *res ipsa loquitur*, this Court held it was “not permitted to speculate that misfortune was the result of negligence in the absence of any evidence as to how the physicians deviated from the standard of care.” Id. at 464, 702 S.E.2d at 374.

In stressing the requirement that a plaintiff cannot rely on the fact of injury to establish a physician’s negligence or departure from the standard of care in a medical malpractice case, the Fletcher court relied upon Bowie v. Hearn, 292 S.C. 223, 355 S.E.2d 550 (Ct. App. 1987) (Bowie I) which also addressed this very principle. In Bowie I, the plaintiff sued the physician who delivered him via cesarean section because he was cut on the cheek during the procedure, resulting in a scar. at 224–25, 355 S.E.2d at 551. The plaintiff’s expert testified the standard of care required the physician not to cut the baby. Id. at 226, 355 S.E.2d at 552. In analyzing the sufficiency of this testimony, the court referenced another oft-cited medical malpractice case and stated:

Under the plaintiff’s reasoning in this case [Bowie I] the doctors in [Cox v. Lund, 286 S.C. 410, 334 S.E.2d 116 (1985)¹] could simply have testified that normally colons are not perforated during colonoscopies, the standard of care, therefore, is a doctor should not perforate the colon, and to do so violates the standard of care. Such reasoning would, in effect,

¹ In Cox, the patient died because his colon was perforated during a colonoscopy, performed by the defendant-doctor. The decedent’s administratrix, who brought the action, produced expert testimony detailing the appropriate measures in preparing the colon for the procedure and in conducting the procedure. The expert witnesses also detailed exactly how the defendant-doctor deviated from the standard of care; namely in not properly preparing the colon and in persisting with the procedure when he knew or should have known to stop.

make a doctor an insurer of perfect result in every surgical procedure. *A doctor is not an insurer of health and negligence may not be inferred.*

Bowie I, 292 S.C. at 227, 355 S.E.2d at 552 (emphasis added).

Bowie I was reversed by the Supreme Court in Bowie v. Hearn, 294 S.C. 344, 364 S.E.2d 469 (1988) (Bowie II) on the particular facts presented in that case, namely that the plaintiff had in fact presented evidence at trial that the physician deviated from the standard of care for a caesarean procedure by making three or four swipes with a scalpel in order to incise the uterine wall. The Supreme Court in Bowie II made no commentary on the legal analysis of the Court of Appeals in Bowie I and only reversed the case on the basis of the particular facts presented by the plaintiff relating to the standard of care. In relying upon Bowie I for its reasoning in Fletcher, this Court specifically recognized the reversal of Bowie I but noted that the reasoning employed by the court in Bowie I remained instructive. Fletcher, 390 S.C. at 464, 702 S.E.2d at 374. The Supreme Court denied certiorari of Fletcher on May 25, 2012. Fletcher remains good law.

There is no conflict between Bowie II and Fletcher as Appellant insinuates. Fletcher is based upon the well-established burden of proof in medical malpractice cases that a plaintiff must present evidence of the standard of care and a departure from that standard of care by the defendant and that where a plaintiff does not do so, the plaintiff cannot rely upon the injury or adverse result as proof of any negligence. The Supreme Court in Bowie II merely found that in that case, the plaintiff had presented such evidence sufficient to go before a jury.

Appellant further contends that Fletcher somehow limits the use of inferences of negligence from circumstantial evidence in medical malpractice cases. Fletcher does no such thing. Inferences as to whether injuries are due to the negligence of a defendant can

still be made from properly admitted evidence on the issue of standard of care and breaches of that standard of care. What cannot be done is reliance upon the fact of injury occurring during a medical procedure to prove that a defendant did in fact depart from the standard of care. A plaintiff's burden to prove the standard of care and the departure therefrom cannot be met by simply relying on the fact that an injury or adverse result occurred during the procedure. This is what Appellant seeks to do with her requested jury charge, and it is contrary to the well-established principles set forth in the arena of medical malpractice law.

Even if the requested jury charge could ever be appropriate in a medical malpractice action, the charge would not have been proper in this case because it was repeatedly shown at trial that the procedure performed on Mr. Dibernardo carried with it a number of known potential complications. Appellant's requested charge required Appellant to show at trial (1) that the thing which caused injury was shown to be under the management of the defendant; (2) the accident was such as in the ordinary course of things does not happen if proper care is used; and (3) there was no other explanation by defendant of how the injury could have occurred. A failure of Appellant to meet even one of these elements defeats the charge.

Dr. Mori and all experts at trial, including Appellant's expert, agreed there were a number of known complications of a pericardiocentesis even when properly performed. Therefore, Appellant cannot show that Mr. Dibernardo's injury was one that would not have occurred in the ordinary course if proper care was used.

Further, the requested charge would only be applicable if the defendant could not explain why the injury or accident occurred. Dr. Mori and Respondents' experts

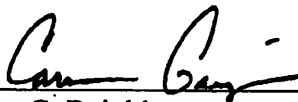
thoroughly explained how Mr. Dibernardo's injury could have occurred even with the use of proper care. At trial, they discussed the known complications of the procedure and how Mr. Dibernardo's physical condition increased the risk of injury from the procedure. See supra, pp. 2-4.

Finally, the requested jury charge requires "the thing" which causes injury to be under the management of the defendant. In any procedure involving a patient such as Mr. Dibernardo, who has numerous pre-existing conditions complicating a physician's performance of the procedure, a physician does not have full control and management over the conditions of the patient's physical anatomy which contributes to the injury.

The requested charge sought by Appellant would have permitted a jury to find negligence and medical malpractice by Respondents based upon the occurrence of Mr. Dibernardo's injury during the medical procedure alone. The requested charge not only would have invoked the inapplicable doctrine of *res ipsa loquitur* into a medical malpractice action and relieved the plaintiff from its burden of proof in such an action, but was also not supported by the evidence presented at trial. Dr. Mori and Respondents' experts testified that bleeding was a known complication during the performance of a pericardiocentesis and the risks from the procedure were heightened by Mr. Dibernardo's difficult anatomy, massively enlarged heart, and large pericardial effusion with uneven fluid distribution. While any injury to a patient during a medical procedure is unfortunate and undesired, the fact of an injury does not indicate malpractice by the physician. This Court correctly affirmed the Trial Court's rejection of Appellant's requested jury charge on the control of the instrumentality.

CONCLUSION

For the reasons set forth herein, Respondents respectfully request that this Court deny Appellant's Petition for Rehearing.



George C. Beighley
Carmen V. Ganjehsani
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(803) 771-4400
ATTORNEYS FOR RESPONDENTS
CAROLINA CARDIOLOGY ASSOCIATES,
PA AND NARESH MORI, MD

March 25, 2019.

CERTIFICATE OF SERVICE

I, the undersigned, attorney for Respondents, Carolina Cardiology Associates, PA and Naresh Mori, MD, do hereby certify that I have this date served the foregoing Return to Petition for Rehearing, dated March 25, 2019, by causing the same to be deposited in a United States Postal Service mailbox, postage prepaid, addressed to counsel of record as indicated below:

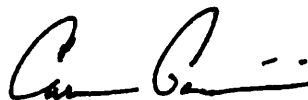
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MAR 26 2019

SC Court of Appeals



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**ATTORNEYS FOR RESPONDENT
CAROLINA CARDIOLOGY ASSOCIATES,
PA AND NARESH MORI, MD**

Dated: March 25, 2019.

Reply to: Carmen V. Ganjehsani
Direct Dial: 803-253-8692
cganjehsani@richardsonplowden.com

March 25, 2019

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MAR 26 2019

SC Court of Appeals

The Honorable Jenny Abbott Kitchings
Clerk of Court, S.C. Court of Appeals
P.O. Box 11629
Columbia, SC 29211

**Re: *Lorrie Dibernardo, individually and as the Personal Representative of the
Estate of Anthony Dibernardo, Deceased v. Carolina Cardiology Associates, PA
and Naresh Mori, MD***
Appellate Case No. 2016-002008
RPR File No.: 4180-162

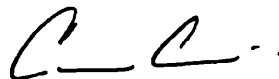
Dear Ms. Kitchings:

I am enclosing for filing the original and six copies of the Respondents' Return to the Appellant's Petition for Rehearing in the above referenced matter, along with our Certificate of Service.

By copy of this letter, I am serving a copy of this Return on opposing counsel of record.

Should you have any questions regarding this matter, please do not hesitate to call.

Sincerely,



Carmen V. Ganjehsani

Encs.

cc: Chad A. McGowan, Esq. (w/enc.)
Whitney B. Harrison, Esq. (w/enc.)
George C. Beighley, Esq. (FYI)

STATE OF SOUTH CAROLINA

IN THE COURT OF COMMON PLEAS

COUNTY OF YORK

Civil Action No: 2015-CP-46-882

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

vs.

Carolina Cardiology Associates, PA, and
Naresh Mori, MD

Defendant(s)

Verdict Form

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DAVID H. HILTON
CLERK OF COURT
YORK COUNTY, SC

As to Allegations of Wrongful Death:

1. Did Dr. Mori violate generally accepted standards of medical care in his treatment of Mr. Dibernardo?

X No
_____ Yes

If No, proceed no further. The Foreman will sign at the end of the verdict form.

If Yes, go to question 2.

2. Was Dr. Mori's violation of generally accepted standards of care a proximate cause of Mr. Dibernardo's death?

_____ No
_____ Yes

If No, proceed no further. The Foreman will sign at the end of the verdict form.

If Yes, go to question 3.

3. What amount of actual damages were incurred by the statutory beneficiaries as result of the death?

_____ Dollars (\$ _____).

Proceed to question 4.

4. Was Dr. Mori's violation of generally accepted standards of care the result of reckless, willful, wanton, or grossly negligent conduct, proven to a level of *clear and convincing evidence*?

_____ No
_____ Yes

If No, proceed no further. The Foreman will sign at the end of the verdict form.

If Yes, go to questions 5.

5. Did Dr. Mori engage in a misrepresentation related to the claim of plaintiff?

_____ No
_____ Yes

Proceed to question 6.

6. Did Carolina Cardiology associates engage in misrepresentation related to the claim of the plaintiff?

_____ No
_____ Yes

Proceed to question 7.

7. What amount of punitive damages should be awarded for reckless, willful, wanton, or grossly negligent proven to a level of *clear and convincing evidence*?

_____ Dollars (\$ _____).


Foreman

York, South Carolina

September 15, 2016

As to Survival Action:

1. Did Dr. Mori violate generally accepted standards of medical care in his treatment of Mr. Dibernardo?

X No
_____ Yes

If No, proceed no further. The Foreman will sign at the end of the verdict form.

If Yes, go to question 2.

2. Was Dr. Mori's departure from generally accepted standards of care a proximate cause of pain and suffering to Mr. Dibernardo before death?

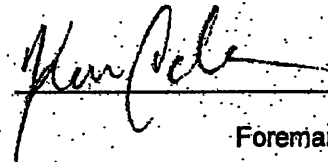
_____ No
_____ Yes

If No, proceed no further. The Foreman will sign at the end of the verdict form.

If Yes, go to question 3.

3. What amount of damages should be awarded to Mr. Dibernardo's estate for his conscious pain and suffering incurred before death?

_____ Dollars (\$ _____).


Foreman

York, South Carolina

September 15, 2016

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

R. Scott Sprouse, Circuit Court Judge

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

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SC Court of Appeals

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

V.

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

RECORD ON APPEAL

Volume I of II

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ATTORNEYS FOR APPELLANT

STATE OF SOUTH CAROLINA

COUNTY OF YORK

Lorrie Dibernardo, individually and as
the Personal Representative of the Estate
of Anthony Dibernardo, Deceased,

Plaintiff,

v.

Carolina Cardiology Associates, PA and
Naresh Mori, M.D.

Defendants.

IN THE COURT OF COMMON PLEAS

SIXTEENTH JUDICIAL CIRCUIT

Civil Action No: 14-NI-46-00004

**AMENDED NOTICE OF INTENT TO
FILE SUIT**

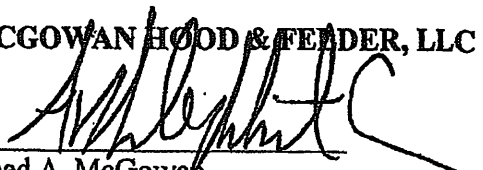
Pursuant to S.C. Code Ann. 15-79-125, Plaintiff files this Notice of Intent to File Suit. Attached as Exhibit A is Plaintiff's short and plain statement of the facts. Attached as Exhibit B is an affidavit from an expert witness delineating at least one negligent act or omission that would allow the Plaintiff to recover damages from Defendants in this case. Attached as Exhibit C are answers to Standard Interrogatories as set forth in Rule 33 (b) of the South Carolina Rules of Civil Procedure.

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2015 JAN 26 PM 12:34

DAVID HAMILTON
C.C. P. 16.1
YORK COUNTY, SC

MCGOWAN HOOD & FELDER, LLC



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(803) 328-5656 Facsimile

January _____, 2015
Rock Hill, South Carolina.

EXHIBIT

A

STATE OF SOUTH CAROLINA

COUNTY OF YORK

**Lorrie Dibernardo individually and as
the Personal Representative of the Estate
of Anthony Dibernardo, Deceased**

Plaintiff,

v.

**Carolina Cardiology Associates, PA and
Naresh Mori, M.D.**

IN THE COURT OF COMMON PLEAS

SIXTEENTH JUDICIAL CIRCUIT

Civil Action No:

**COMPLAINT FOR DAMAGES
Jury Trial Demanded**

The Plaintiff, by and through her undersigned counsel, for a Complaint against the Defendants, alleges as follows:

PARTIES

Plaintiff

1. The Plaintiff Lorrie Dibernardo is the duly appointed Personal Representative of the estate of her husband Anthony Dibernardo. Ms. Dibernardo brings this action both individually and as Personal Representative of the estate for the Survival and Wrongful Death actions. At all times relevant to this Complaint both Mr. and Ms. Dibernardo were citizens and residents of York County, SC.

Defendants

2. Defendant Carolina Cardiology Associates, PA is a corporation organized and existing under the laws of South Carolina, with its principal place of business in York County, South Carolina. At all times relevant to this Complaint Defendant Carolina Cardiology was the entity employing or in an agency relationship with Naresh Mori, M.D., who at all times relevant to this Complaint was acting within the scope of his agency and/or employment with Carolina Cardiology Associates, P.A.

3. Defendant Naresh Mori, M.D is a physician licensed by the state of South Carolina, who practices in York County, South Carolina. At all times relevant to this Complaint, Defendant Mori was acting within the scope of his employment and/or agency relationship with Defendant Carolina Cardiology.

FACTUAL ALLEGATIONS

4. On January 19, 2013, Mr. Dibernardo was admitted to Piedmont Medical Center in Rock Hill, SC due to swelling in his legs.

5. A pericardiocentesis was ordered as was a right and left heart catheterization with simultaneous measures of left and right ventricular pressures.

6. However, during the pericardiocentesis Dr. Mori inappropriately repositioned a pigtail catheter and sheath, which resulted in trauma to Mr. Dibernardo's right ventricle.

7. The trauma to the right ventricle led to bleeding into the pericardial space, cardiac tamponade, and shock.

8. Mr. Dibernardo underwent emergency surgery to create a subxiphoid pericardial window.

9. Mr. Dibernardo then was admitted to PMC's intensive care unit, where he was placed on a ventilator.

10. On January 24, 2014 Mr. Dibernardo extubated himself after a breathing trial and was placed on BiPAP.

11. However, later that evening his oxygen levels desaturated.

12. After discussion, the family made a difficult decision not to reintubate Mr. Dibernardo.

13. Mr. Dibernardo died later that evening.

14. Upon information and belief, Mr. Dibernardo's death is a direct result of the Defendants' failure to perform an appropriate pericardiocentesis.

15. Upon information and belief, had Defendants performed an appropriate pericardiocentesis, Mr. Dibernardo's death would have been prevented.

16. The injuries to and death of Mr. Dibernardo were the direct and proximate result of and were caused and occasioned by the negligence, carelessness, recklessness, willfulness, and wantonness on the part of Defendants, in failing to possess and exercise that degree of medical training, competency, and skill ordinarily and customarily possessed and exercised by physicians and hospital staff under similar circumstances and thereby rendered inappropriate medical care to Mr. Dibernardo by deviating from and falling below the prevailing and acceptable standards of care in one or more of the following particulars:

- Removing and replacing the pigtail catheter with a sheath;
- Failing to document appropriately the repositioning of the pigtail catheter and replacement with a sheath;
- Failing to use direct fluoroscopic visualization over a guide wire when manipulating a catheter in the pericardial space;
- Improperly manipulating and repositioning the catheter resulting in trauma to the right ventricle; and
- In such other ways that may be revealed during discovery and proven at the trial of this matter.

Attached as **Exhibit 1** is an affidavit of a qualified expert who will testify to one or more deviations from the standard of care.

**FOR A FIRST CAUSE OF ACTION
(Survival Action)**

17. Plaintiff reiterates paragraphs 1-16 above as if set forth verbatim herein.

18. As a direct and proximate result of the negligence, carelessness, gross negligence, recklessness and departure from the professional standards of care by Defendants, Mr. DiBernardo suffered from severe debilitating injuries which resulted in his permanent injury and disability, and conscious pain and suffering, as a result of which Mr. DiBernardo is entitled to recover a sum to compensate his estate for his conscious pain and suffering, medical expenses, mental anguish, loss of earnings capacity, loss of enjoyment of life, and other damages pursuant to S.C. Code § 15-5-90. Plaintiff is also entitled to recover a sum of punitive damages to punish and deter these defendants and others like them from similar conduct in the future. All damages should be in an amount determined by a jury in this action.

**FOR A SECOND CAUSE OF ACTION
(Wrongful Death)**

19. Plaintiff reiterates paragraphs 1-18 as if set forth verbatim herein.

20. As a direct and proximate result of the negligence, carelessness, gross negligence, recklessness and departure from the professional standards of care by Defendants, Mr. DiBernardo suffered from severe debilitating injuries which resulted in his death, and thus the negligence was the cause of the loss of the support, aid, society, comfort, and companionship of his heirs at law. Pursuant to S.C. Code § 15-51-20, the estate is therefore entitled to recover from defendants a sum of money to compensate the

heirs at law for the medical expenses, funeral expenses, mental anguish, loss of earnings capacity, and loss for the aid, society, comfort, and companionship of the decedent. Plaintiff is also entitled to recover a sum of punitive damages to punish and deter these defendants and others like them from similar conduct in the future. All damages should be in an amount determined by a jury in this action.

**FOR A THIRD CAUSE OF ACTION
(Loss of Consortium)**

21. Plaintiff reiterates paragraphs 1-20 above as if set forth verbatim herein.

22. Plaintiff Lorrie Dibernardo as the wife of Mr. Dibernardo has suffered a loss of consortium as a result of the actions and inactions of Defendants. She is therefore entitled to an award of damages to compensate her for her loss of the society, comfort, companionship, support, and good offices of his wife. Further, the Defendants' actions in this case have been reckless and/or grossly negligent and thus Plaintiff Lorrie Dibernardo is additionally entitled to an award of punitive damages to punish and deter these defendants and others like them.

WHEREFORE, Plaintiff respectfully prays for judgment against the Defendants for actual damages, special damages, consequential damages, and punitive damages in an amount to be determined by the jury at the trial of this action, for the costs and disbursements of this action and for such other and further relief as this court deems just and proper. Plaintiff specifically avers that the damages at issue in this case are more than \$100,000, such averment made to allow all manner of discovery under South Carolina Law.

Signature on Following Page

MCGOWAN HOOD & FELDER, LLC

Chad A. McGowan
Ashley White Creech
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, South Carolina 29732
(803) 327-7800
(803) 328-5656 Facsimile
Rock Hill, South Carolina

_____, 2015

EXHIBIT

B

AFFIDAVIT of ALAN H. SCHOB, M.D.

PERSONALLY APPEARED BEFORE ME, THE UNDERSIGNED, BEING DULY SWORN, SAYS AS FOLLOWS:

1. I am board certified in internal medicine, cardiovascular disease and interventional cardiology by the American Board of Internal Medicine. My education, training, and experience are set forth in the attached CV (Exhibit A). It is my belief that my education, training, and experience qualify me to render expert opinions in regard to the care rendered to Anthony Dibernardo in this case.

2. My medical practice is primarily located in Miami, Florida. I have been practicing for more than 30 years.

3. I am familiar with the standard of care of what a reasonably prudent physician would do or not do in treating a patient such as Anthony Dibernardo. I am also familiar with the potential complications that derive from failing to properly perform pericardiocentesis.

4. I have reviewed the medical records of Anthony Dibernardo which consisted in part of records from Carolina Cardiology, Piedmont Medical Center Carolina including the echocardiograms, cath lab images and death certificate. The records I have reviewed are the type of documents, which I would consider in rendering an expert opinion in this case.

5. It is my opinion, within a reasonable degree of medical certainty that the Defendants and/or their employees, or agents committed negligent acts or omissions in their care and treatment of Anthony Dibernardo. Without intending to limit the scope of my opinions, some of the specific breaches of the standard of care I have identified as being perpetrated by the Defendants and/or their employees, or agents, are as follows:

- After obtaining access a pigtail catheter was placed into the intra-pericardial space. The first cine image demonstrates proper placement with free efflux of contrast into the pericardial space. The second image in the same view plane shows repositioning of the pigtail and the pigtail is now within a sheath. Contrast injection during the second cine now shows staining of the right ventricular myocardium. For an unknown reason the pigtail catheter was removed leaving the sheath in place. The third image shows myocardial staining directly through the sheath.
- Documentation as to why it was necessary to reposition the pigtail and to eventually replace it with a sheath is lacking.

- Proper technique for catheter manipulation and exchanges in the pericardial space requires use of direct fluoroscopic visualization over a guidewire. This is not recorded in the cath log or cine run.
- Multiple cine runs demonstrate that the pigtail catheter and sheath were inappropriately repositioned resulting in trauma to the right ventricle. This resulted in bleeding into the pericardial space with resultant tamponade and shock.
- There is no notation in the record as to why it was necessary to replace the pigtail catheter with a sheath which is more likely to cause injury.
- Thus, I hold the opinion that the operating physician fell below the standard of care in the performance of the pericardiocentesis as to cause right ventricular injury with resultant cardiac tamponade and shock.

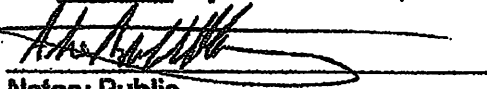
6. Further, it is my opinion to a reasonable degree of medical certainty, more likely than not, that the deviations from the standard of care by the Defendants contributed to Anthony Dibernardo's overall decline, injuries and subsequent death.

7. The factual basis for my opinion about the breaches of the standard of care by the Defendants at this time is the medical records of Anthony Dibernardo. The factual basis of my opinions may be supplemented at a later time. I hereby reserve the right to amend, supplement, or withdraw my opinion based on discovery and depositions of the relative parties.

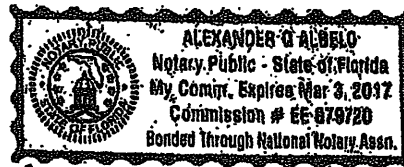
8. This affidavit is given in compliance with §§ 15-36-100 and 15-79-125 SCCA which does not require me to state all negligent acts or omissions by any defendant.


ALAN H. SCHOB, M.D.

Sworn to and signed before me
this 28th day of November, 2014.


Notary Public

My Commission expires: March 3rd 2017



Handwritten: P.D. 11/28/14 \$1000.00 30850
Exp: 03/05/2017

CURRICULUM VITAE

A. BIOGRAPHICAL INFORMATION

1. PERSONAL

Date: September 17, 2013

Name: ALAN H. SCHOB, M.D.

Telephone: Home: (305) 595-8803
Telephone: Office: (305) 585-6534
Telephone: Office: (305) 575-3182

Address: Home: 9001 S.W. 102 Street
Miami, Florida 33176

Address: Office: VA Medical Center
Medical Service (111A)
1201 N.W. 16th Street
Miami, Florida 33125

Status: Full-time

Current Rank: Associate Professor of
Clinical Medicine

Citizenship: U.S.A.

2. HIGHER EDUCATION

College: Queens College, C.U.N.Y., New
York, New York, 1971-1975,
B.A. - Biology.

Medical School: University of South Alabama,
College of Medicine, Mobile,
Alabama, 1978-1981, M.D.

3. POST DOCTORAL TRAINING:

Internship: Internal Medicine, University
of Miami School of
Medicine/Jackson Memorial
Hospital, Miami, Florida,

1981-1982.

Residency: Internal Medicine, University
of Miami School of
Medicine/Jackson Memorial
Hospital, Miami, Florida.

Fellowship: Cardiology, University of
Miami School of
Medicine/Jackson Memorial
Hospital, Miami, Florida,
1985-1987.

Invasive Interventional
Cardiology, University of
Miami School of Medicine,
Miami, Florida, 1987-1988.

4. BOARD CERTIFICATION AND LICENSURES

Certification: Internal Medicine, 1984
Cardiovascular Diseases, 1987
Interventional Cardiology,
2010

Licensures: Florida, 1982

5. PROFESSIONAL EXPERIENCES

Academic Appointments: Assistant Professor of
Clinical Medicine, University
of Miami School of Medicine,
Division of Cardiology,
Miami, Florida, 1988-1995.

Associate Professor of
Clinical Medicine, University
of Miami School of Medicine,
Division of Cardiology,
Miami, Florida, 1995-Present.

Co-Director Interventional
Cardiology Training Program -
University of Miami School of
Medicine

Hospital Appointments:

Chief, Cardiovascular
Laboratory VA Medical Center,
Miami, Florida 1990-Present.

Chief, Interventional
Laboratory, VA Medical
Center, Miami, Florida, 1990-
Present.

6. CURRENT AND PAST TEACHING RESPONSIBILITIES

Instructor Critical Care Cardiology Course, University of
Miami School of Medicine, Department of Cardiology, Miami,
Florida.

Mechanisms of Disease, University of Miami School of
Medicine, Department of Cardiology Miami, Florida.

Physical Diagnosis for Sophomore Students, University of
Miami School of Medicine, Department of Cardiology, Miami,
Florida.

Department of Medicine: Teaching of Medical Students,
Interns and Residents on Ward Medicine Rotation.

Division of Cardiology: Teaching of Cardiology Fellows in
CCU, Clinics, Consultations, Non-Invasive and Invasive
Laboratories. Training of 4th Year Fellows in
Interventional Cardiology, peripheral vascular disease and
Carotid stenting

Faculty Transcatheter Therapeutics Annual Scientific
meeting

Oct. 2004

Faculty Miami International Revascularization Summit
Feb.2004, 2005, 2006, 2007 and 2008.

Director of University of Miami Interventional journal club

Proctor Gore Viabhan endograft.

Proctor Boston Scientific Rotatablator

Director interdisciplinary weekly combined West Palm Beach

Miami VA Medical Centers conference

7. NATIONAL COMMITTEE RESPONSIBILITIES

- a) VA National CART-CL Oversight Committee
- b) VA National Interventional Cardiology Committee
- c) VA National Quality Management -Peer Review Committee
- d) VA National Stent Contracting Consignment Committee

8. DEPARTMENTAL ADMINISTRATIVE AND COMMITTEE RESPONSIBILITIES

- a) Invasive Procedures Committee VA Medical Center.
- b) Reviewer for Research & Development.
- c) Cardiovascular Subcommittee of PNT Committee.
- d) Cardiovascular Fellowship Review Committee
- e) Interventional Fellowship Selection Committee
- f) Departmental and Inter-Hospital VA Peer Review
- g) Root Cause Analysis Reviewer/Committee

9. HONORS AND AWARDS

Society and Membership:	Fellow American College of Cardiology, 1989 Diplomat - National Board of Medical Examiners, 1981.
Best Doctors in Florida:	Castle Connolly Medical LTD. 2000.
Best Doctors in America	Castle Connolly Medical LTD. 2011
Top Doctors in America	Castle Connolly Medical LTD. 2012

10. OTHER PROFESSIONAL ACTIVITIES

Non-invasive cardiology laboratory University of Miami Hospital and Clinics

Peer Reviewer South Florida Utilization and Review

11. COMMUNITY SERVICES

Volunteer American Red Cross Disaster Relief

B. BIBLIOGRAPHY

1. SCIENTIFIC ARTICLES IN REFERRED JOURNALS

Rothbart R, Harding L, Schob A, Russo C: An improved method for production of intravenous contrast during echocardiography. J CLIN ULTRASOUND, 12/2/87.

de Marchena E, Stang RB, Schob A, Topaz O, Chakko S, Kessler

KM: Percutaneous transluminal coronary angioplasty using a combined "balloon-on-a-wire" system and exchange guide wire technique. CATHETERIZATION AND CARDIOVASCULAR DIAGNOSIS 18:3; 11/89;183-86.

de Marchena E, Musial B, Wozniak P, Schob A, Chakko S, Kessler KM: Iatrogenic internal mammary artery to coronary vein fistula. CHEST 97:1; 1/90;251-53.

Musial B, Schob A, de Marchena E, Kenneth KM: Percutaneous Transluminal Coronary Angioplasty of Anomalous Right Coronary Artery. CATHETERIZATION AND CARDIOVASCULAR DIAGNOSIS 22:1; 1/91;39-41.

Kessler KM, Baurlein EJ, Schob A, de Marchena E, Myerburg RJ. ST Alternans. AM J CARDIOL 1992;70:1224-1225.

Youseff M, Schob A, Kessler KM. Iatrogenic Coronary Septal Artery to Right Ventricular Fistula Complicating Percutaneous Transluminal Coronary Angioplasty with Spontaneous Resolution. AM HEART J 1997;133:260-262.

Hsia SL, Duncan R, Schob AH, Chakko SC, Mulingtapang R, He JL, Perez GO. A comparative study of high-density lipoprotein phospholipids and cholesterol in patients with and without angiographically defined coronary artery disease. ATHEROSCLEROSIS 2000;152:469-73.

Fierro-Renoy C, Zambrano J, Schob A. Percutaneous stenting

of bilateral pulmonary artery stenosis caused by malignant extrinsic compression. Chest October 2002 122:1478-1480;

Chirinos J, Zambrano JP, Chakko S, Schob A, Virani A, Perez GO, Mendez AJ. Usefulness of C-reactive protein as an independent predictor of death in patients with ischemic cardiomyopathy. AMERICAN JOURNAL OF CARDIOLOGY 2005; 95: 88-90.

Chirinos JA, Zambrano JP, Chakko S, Veerani A, Schob A, Willens HJ, Perez HJ, Mendez AJ. Aortic pressure augmentation predicts adverse cardiovascular events in patients with established coronary artery disease. HYPERTENSION 2005; 45:980-985.

Chirinos J, Zambrano JP, Chakko S, Schob A, Virani A, Perez GO, Mendez AJ. Relation between ascending aortic pressures and outcomes in patients with angiographically demonstrated coronary artery disease. AMERICAN JOURNAL OF CARDIOLOGY 2005; 96:645-648.

Chirinos JA, Zambrano JP, Chakko S, Schob A, Goldberg RB, Mendez AJ. Ability of serum to decrease cellular AcylCoA: Cholesterol Acyl transferase activity predicts cardiovascular outcomes. CIRCULATION 2005; 112:2446-2453.

Tehrani H, Otero C, Arosemena M, Perez E, Zelnick K, Mendoza C, Yrizarry J, Stadtlander K, Rothenberg G, Cohen M, Zachow K, Schob A. Endovascular-First strategy in patients with critical limb ischemia. Vascular Disease Management 2006; 1556:380-383.

Willens HJ, Chirinos JA, Veerani A, Zambrano JP, Schob A, Mendez AJ, Chakko S. The Relation Between Mitral Annular Calcification and Mortality in Patients Undergoing Diagnostic Coronary Angiography. ECHOCARDIOGRAPHY. 2006 Oct;23(9):717-22.

Tanawuttiwat T, Brice T, Symes JF, Khramov I, Schob AH. Cardiac computed tomography in the evaluation of an intra-pericardial mediastinal mass. Eur Heart J Cardiovasc Imaging. 2012 Aug;13(8):712.

Tanawuttiwat T, O'Neill BP, Schob AH, Alfonso CE. Left Main Coronary Atresia. J Card Surg. 2012 Dec 12:1-10. doi: 10.1111/jocs.12044.

Schob AH, Bhatt M, Alfonso C, De Marchena E. Cryoplasty for the treatment of coronary bifurcation stenoses following main vessel stenting. J Interv Cardiol. 2013 Jun;26(3):239-44. doi: 10.1111/joic.12032. Epub 2013 Apr 30.

2. ABSTRACTS

Zambrano JP, Chirinos J, Chakko S, Tamariz L, Palacio A, Schob A, Perez GO, Mendez AJ. C-Reactive protein and the prediction of cardiovascular events in patients with documented coronary artery disease: effects of aspirin and statin therapy. JOURNAL OF INVESTIGATIVE MEDICINE 2004;52:S261.

Chirinos JA, Zambrano JP, Chakko SC, Schob A, Perez GO, Mendez AJ. High-density lipoprotein-mediated cholesterol efflux from cells is a strong independent predictor of cardiovascular risk. JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY 2004;43:463A.

Chirinos JA, Willens HJ, Veerani A, Zambrano JP, Schob A, Chakko S. Mitral annular calcification and its predictive value for mortality among patients with established coronary artery disease. JOURNAL OF THE AMERICAN SOCIETY OF ECHOCARDIOGRAPHY 2005 (in press).

J. Chirinos, JP. Zambrano, A. Veerani, G. Perez, A. Schob, AJ. Mendez, S. Chakko Evaluation of comorbidity scores to predict mortality in patients with coronary artery disease. EUROPEAN HEART JOURNAL 2005 (in press).

J. Chirinos, JP. Zambrano, S. Chakko, A. Veerani, A. Schob, GO. Perez, AJ Mendez. Correlation between ascending aortic pressures and outcomes in patients with coronary artery disease. AMERICAN JOURNAL OF HYPERTENSION 2005; A103.

J. Chirinos, JP. Zambrano, S. Chakko, A. Veerani, A. Schob, GO. Perez, AJ Mendez. Aortic pressure augmentation predicts adverse cardiovascular events in patients with established coronary artery disease. AMERICAN JOURNAL OF HYPERTENSION 2005; A11-12.

3. OTHER PROFESSIONAL ITEMS:

Other Works:

de Marchena E, Stang B, Schob A, Chakko S, Kessler KM. PTCA using a combined balloon-on-wire system and exchange guide wire technique. Cardiology Digest 1990.

Munoz O, Schob A, O'Rourke R; Percutaneous treatment of saphenous vein graft obstructions: an unresolved issue. Hurst's the Heart, McGraw-Hill Publishers; <http://cardiology.accessmedicine.com>

Schob A, Munoz O; Rotational Atherectomy. In De Marchena E and Ferreira A (eds): Interventional Cardiology Secrets, Hanley and Belfus Inc. Medical Publishers 2003; pp.106-111.

Schob A, Auerbach E; Total Chronic Occlusions. In De Marchena E and Ferreira A (eds): Interventional Cardiology Secrets, Hanley and Belfus Inc. Medical Publishers, 2003 pp.189-192.

Mendoza CE, Bhatt MR, Virani S, Schob AH, Levine S, Ferreira AC, de Marchena .Management of failed thrombolysis after acute myocardial infarction: an overview of current treatment options. Int J Cardiol. 2007 Jan 18;114(3):291-9. Epub 2006 Oct 31. Review.

Scientific Presentations at National and International Meetings:

Zambrano JP, Chirinos J, Chakko S, Tamariz L, Palacio A, Schob A, Perez GO, Mendez AJ. C-Reactive protein and the prediction of cardiovascular events in patients with documented coronary artery disease: effects of aspirin and statin therapy. Presented at the Annual Meeting of the American Federation for Medical Research - Southern Section, New Orleans, LA, February 2004.

Chirinos JA, Zambrano JP, Chakko SC, Schob A, Perez GO, Mendez AJ. High-density lipoprotein-mediated cholesterol efflux from cells is a strong independent predictor of cardiovascular risk. Presented at the 53rd Annual Scientific Sessions of the American College of Cardiology, New Orleans, LA, March 2004.

Chirinos JA, Zambrano JP, Chakko S, Schob A, Goldberg RB, Perez G, Mendez AJ. Serum-mediated intracellular cholesterol efflux activity predicts cardiovascular outcomes. Presented at the Florida Chapter of the American

College of Cardiology. Sheraton Bal Harbour Resort, Bal Harbour, FL September 2004.

J. Chirinos, JP. Zambrano, S.Chakko, A. Veerani, A. Schob, GO. Perez, AJ Mendez. Aortic pressure augmentation predicts adverse cardiovascular events in patients with established coronary artery disease. Presented at the Annual Scientific Sessions of the American Society of Hypertension San Francisco. May 2005.

Chirinos JA, Willens HJ, Veerani A, Zambrano JP, Schob A, Chakko S. Mitral annular calcification and its predictive value for mortality among patients with established coronary artery disease. Presented at the 16th Annual Scientific Sessions of the American Society of Echocardiography. Boston, MA. June 2005.

J. Chirinos, JP.Zambrano, A. Veerani, G. Perez, A. Schob A, AJ. Mendez, S. Chakko Evaluation of comorbidity scores to predict mortality in patients with coronary artery disease. Presented at the European Society of Cardiology Meeting, Stockholm Sweden. September 2005.

Schob, A. Clinical case presentations; Transcatheter Therapeutics annual meeting Oct. 2004, Washington, D.C.

Blank VA OA Presentation at VA National CART-CT/Cath Lab Meeting May 2011

Invited Lectures at National and International Meetings:

Spectrum of Peripheral Vascular Disease in the VA, New Cardiovascular Horizons, New Orleans, Louisiana September 2007

Sirolimus Eluting Stent Trials, Miami International Revascularization Summit, Miami, Florida, April 2008

Incidence and Impact of Peripheral Arterial Disease, Implications for Diagnosis and Management in the VA: The Michael E. DeBakey Session of the New Cardiovascular Horizons Meeting New Orleans, La. September 2008.

Mechanical Thrombectomy, Cardiovascular Congress 2009, Miami, Florida, February 2009.

Advanced Coronary Assessment VISN 8 Ambulatory Care Forum,
October 2009, Miami Florida

VISN 8 Primary Care Forum, April 2010, Miami Florida

Accomplishments at VAMC

Clinical Programs:

Developed the programs in;
Interventional Cardiology
Endovascular peripheral intervention
Carotid Stent program
Structural Heart Program

Previous research:

Role of phospholipids in cholesterol metabolism.

Role of endothelin in coronary artery disease and
restenosis.

Amlodipine in treatment of Angina.

Evaluation of Xemilofiban in Controlling Thrombotic
Events, #IG7-96-02-017.

Intracoronary ReoPro for the Prevention of Ischemic
Complications of Coronary Angioplasty.

OPUS-TIMI 16.

BRAVO Trial.

PRESTO Trial.

Grant in Aid, American Heart Ass. HDL function in
patients with coronary artery disease. (co-
investigator).

Ongoing research:

Triton-TIMI 38.

Cryoballoon coronary angioplasty for bifurcation
lesions

EXHIBIT

C

STATE OF SOUTH CAROLINA

COUNTY OF YORK

Lorrie Dibernardo individually and as
the Personal Representative of the Estate
of Anthony Dibernardo, Deceased,

Plaintiff,

v.

Carolina Cardiology Associates, PA and
Jugalkishor K. Shah, M.D.

Defendants.

IN THE COURT OF COMMON PLEAS

SIXTEENTH JUDICIAL CIRCUIT

Civil Action No: 14-NI- 00004

**RESPONSE TO STANDARD
INTERROGATORIES**

TO: ALL DEFENDANTS:

RESPONSES TO STANDARD INTERROGATORIES

1) Give the names and addresses of persons known to the parties or counsel to be witnesses concerning the facts of the case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.

RESPONSE:

**Lorrie Dibernardo
c/o Plaintiff's counsel**

**Medical Providers of Anthony Dibernardo
As revealed in the medical records**

All treating physicians and nurses

2) Set forth a list of photographs, plats, sketches or other prepared documents in possession of the party that relate to the claim or defense in the case.

RESPONSE: Medical Records from:

Carolina Cardiology Associates

Piedmont Medical Center

All docs in Plaintiff's possession are on the CD attached to the NOI served on Defendants.

3) In cases involving personal injury set forth the names and addresses of all physicians who have treated the party and all hospitals to which the party has been committed in connection with said injuries and also set forth a statement of all medical costs involved.

RESPONSE: Please see medical records.

4) Set forth the names and addresses of all insurance companies which have liability insurance coverage relating to the claim and set forth the number or numbers of the policies involved and the amount or amounts of liability coverage provided in each policy.

RESPONSE: None known

5) Set forth an itemized statement of all damages, exclusive of pain and suffering, claimed to have been sustained by the party.

RESPONSE: Medical bills from all medical providers
Funeral Expenses
Lost Income to Claimed Damages
Damages relating to Lorrie Dibernardo's Loss of Consortium

6) List the names and addresses of any expert witnesses whom the party proposes to use as a witness at the trial of the case.

RESPONSE: Alan Schob, MD
9001 SW 102 St.
Miami, FL 33176

See CV and Affidavit

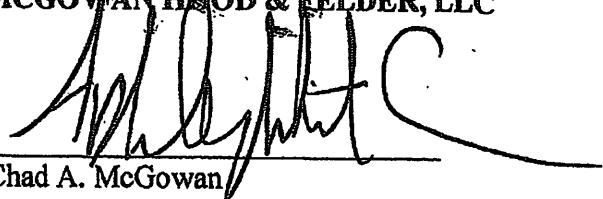
7) For each person known to the parties or counsel to be a witness concerning the facts of the case, set forth either a summary sufficient to inform the other party of the important facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witnesses.

RESPONSE:

The family members will testify to their knowledge of the facts, the injuries suffered by, and death of Anthony Dibernardo.

The medical providers are expected to testify in accord with their medical records.

MCGOWAN HOOD & FELDER, LLC



Chad A. McGowan
Ashley White Creech
McGowan, Hood, and Felder
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800
(803) 328-5656 Facsimile

January_____, 2015
Rock Hill, South Carolina.

STATE OF SOUTH CAROLINA

COUNTY OF YORK

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

Plaintiff(s)

vs.

Carolina Cardiology Associates, PA and Naresh
Mori, MD

Defendant(s)

Submitted By: Chad McGowan

Address: 1539 Health Care Drive, Rock Hill, SC 29732

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

15-CP - 46-

2015CP4600883

FILED-RECEIVED
MAR 23 PM 1:04
CLERK OF COURT
YORK COUNTY, SC

SC Bar #: 9943

Telephone #: 803-327-7831

Fax #: 803-324-1483

Other:

E-mail: cmcgowan@mcgowanhood.com

NOTE: The coversheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this coversheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (Check all that apply)

*If Action is Judgment/Settlement do not complete

- ☒ JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☒ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (Check One Box Below)

Contracts	Torts - Professional Malpractice	Torts - Personal Injury	Real Property
☐ Constructions (100)	☐ Dental Malpractice (200)	☐ Assault/Slander/Libel (300)	☐ Claim & Delivery (400)
☐ Debt Collection (110)	☐ Legal Malpractice (210)	☐ Conversion (310)	☐ Condemnation (410)
☐ Employment (120)	☒ Medical Malpractice (220)	☐ Motor Vehicle Accident (320)	☐ Foreclosure (420)
☐ General (130)	Previous Notice of Intent Case #	☐ Premises Liability (330)	☐ Mechanic's Lien (430)
☐ Breach of Contract (140)	20 14 -NI- 46 - 00004	☐ Products Liability (340)	☐ Partition (440)
☐ Other (199)	☐ Notice/File Med Mal (230)	☐ Personal Injury (350)	☐ Possession (450)
	☐ Other (299)	☐ Wrongful Death (360)	☐ Building Code Violation (460)
		☐ Other (399)	☐ Other (499)
Inmate Petitions	Administrative Law/Relief	Judgments/Settlements	Appeals
☐ PCR (500)	☐ Reinstate Drv. License (800)	☐ Death Settlement (700)	☐ Arbitration (900)
☐ Mandamus (520)	☐ Judicial Review (810)	☐ Foreign Judgment (710)	☐ Magistrate-Civil (910)
☐ Habeas Corpus (530)	☐ Relief (820)	☐ Magistrate's Judgment (720)	☐ Magistrate-Criminal (920)
☐ Other (599)	☐ Permanent Injunction (830)	☐ Minor Settlement (730)	☐ Municipal (930)
	☐ Forfeiture-Petition (840)	☐ Transcript Judgment (740)	☐ Probate Court (940)
	☐ Forfeiture-Consent Order (850)	☐ Lis Pendens (750)	☐ SCDOT (950)
	☐ Other (899)	☐ Transfer of Structured Settlement Payment Rights Application (760)	☐ Worker's Comp (960)
Special/Complex /Other		☐ Confession of Judgment (770)	☐ Zoning Board (970)
☐ Environmental (600)	☐ Pharmaceuticals (630)	☐ Petition for Workers Compensation Settlement Approval (780)	☐ Public Service Comm. (990)
☐ Automobile Arb. (610)	☐ Unfair Trade Practices (640)	☐ Other (799)	☐ Employment Security Comm (991)
☐ Medical (620)	☐ Out-of State Depositions (650)		☐ Other (999)
☐ Other (699)	☐ Motion to Quash Subpoena in an Out-of-County Action (660)		
	☐ Sexual Predator (510)		

Submitting Party Signature:

Date: 3/18/15

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCF, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

SCCA 7 234 (10/2014)

FOR MANDATED ADR COUNTIES ONLY

Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Clarendon, Colleton, Darlington, Dorchester, Florence, Georgetown, Greenville, Hampton, Horry, Jasper, Kershaw, Lee, Lexington, Marion, Oconee, Orangeburg, Pickens, Richland, Spartanburg, Sumter, Union, Williamsburg, and York

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

**Please Note: You must comply with the Supreme Court Rules regarding ADR.
Failure to do so may affect your case or may result in sanctions.**

STATE OF SOUTH CAROLINA

COUNTY OF YORK

Lorrie Dibernardo, individually and as
the Personal Representative of the Estate
of Anthony Dibernardo, Deceased
Plaintiff,

v.

Carolina Cardiology Associates, PA and
Naresh Mori, MD

Defendants.

IN THE COURT OF COMMON PLEAS

SIXTEENTH JUDICIAL CIRCUIT

Civil Action No: 15-CP-4600883

SUMMONS

DAVID HAMPTON
CLERK, S.C.
YORK COUNTY, SC

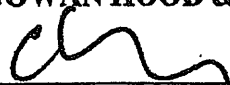
2015 MAR 23 PM 1:04

FILED-RECEIVED

TO: THE DEFENDANT(S) ABOVE NAMED:

YOU ARE HEREBY SUMMONED and required to Answer the Complaint in
this action, a copy of which is served upon you, and to serve a copy of your Answer to
the Complaint on the subscriber at his office at 1539 Health Care Drive, Rock Hill, South
Carolina, 29732, within thirty (30) days of service, exclusive of the date of service; and if
you fail to Answer the Complaint within that time, judgment by default will be rendered
against you for the relief demanded in the Complaint.

MCGOWAN HOOD & FELDER, LLC


Chad A. McGowan
Ashley White Creech
McGowan, Hood, & Felder, LLC
1539 Healthcare Drive
Rock Hill, South Carolina 29730
(803) 327-7800
(803) 328-5656 Facsimile
cmcgowan@mcgowanhood.com

March 19, 2015.

STATE OF SOUTH CAROLINA

COUNTY OF YORK

Lorrie Dibernardo individually and as
the Personal Representative of the Estate
of Anthony Dibernardo, Deceased

Plaintiff,

v.

Carolina Cardiology Associates, PA and
Naresh Mori, M.D.

IN THE COURT OF COMMON PLEAS

SIXTEENTH JUDICIAL CIRCUIT

Civil Action No:

2015CP4600882

COMPLAINT FOR DAMAGES
Jury Trial Demanded

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2015 MAR 23 PM 1:44
DAVID E. HAMILTON
CLERK, S.C.
YORK COUNTY, S.C.

The Plaintiff, by and through her undersigned counsel, for a Complaint against the
Defendants, alleges as follows:

PARTIES

Plaintiff

1. The Plaintiff Lorrie Dibernardo is the duly appointed Personal Representative of the estate of her husband Anthony Dibernardo. Ms. Dibernardo brings this action both individually and as Personal Representative of the estate for the Survival and Wrongful Death actions. At all times relevant to this Complaint both Mr. and Ms. Dibernardo were citizens and residents of York County, SC.

Defendants

2. Defendant Carolina Cardiology Associates, PA is a corporation organized and existing under the laws of South Carolina, with its principal place of business in York County, South Carolina. At all times relevant to this Complaint Defendant Carolina Cardiology was the entity employing or in an agency relationship with Jugalkishor K. Shah, M.D., who at all times relevant to this Complaint was acting within the scope of his agency and/or employment with Carolina Cardiology Associates, P.A.

3. Defendant Naresh Mori, M.D is a physician licensed by the state of South Carolina, who practices in York County, South Carolina. At all times relevant to this Complaint, Defendant Shah was acting within the scope of his employment and/or agency relationship with Defendant Carolina Cardiology.

FACTUAL ALLEGATIONS

4. On January 19, 2013, Mr. Dibernardo was admitted to Piedmont Medical Center in Rock Hill, SC due to swelling in his legs.

5. A pericardiocentesis was ordered as was a right and left heart catheterization with simultaneous measures of left and right ventricular pressures.

6. However, during the pericardiocentesis Dr. Shah inappropriately repositioned a pigtail catheter and sheath, which resulted in trauma to Mr. Dibernardo's right ventricle.

7. The trauma to the right ventricle led to bleeding into the pericardial space, cardiac tamponade, and shock.

8. Mr. Dibernardo underwent emergency surgery to create a subxiphoid pericardial window.

9. Mr. Dibernardo then was admitted to PMC's intensive care unit, where he was placed on a ventilator.

10. On January 24, 2014 Mr. Dibernardo extubated himself after a breathing trial and was placed on BiPAP.

11. However, later that evening his oxygen levels desaturated.

12. After discussion, the family made a difficult decision not to reintubate Mr. Dibernardo.

13. Mr. Dibernardo died later that evening.

14. Upon information and belief, Mr. Dibernardo's death is a direct result of the Defendants' failure to perform an appropriate pericardiocentesis.

15. Upon information and belief, had Defendants performed an appropriate pericardiocentesis, Mr. Dibernardo's death would have been prevented.

16. The injuries to and death of Mr. Dibernardo were the direct and proximate result of and were caused and occasioned by the negligence, carelessness, recklessness, willfulness, and wantonness on the part of Defendants, in failing to possess and exercise that degree of medical training, competency, and skill ordinarily and customarily possessed and exercised by physicians and hospital staff under similar circumstances and thereby rendered inappropriate medical care to Mr. Dibernardo by deviating from and falling below the prevailing and acceptable standards of care in one or more of the following particulars:

- Removing and replacing the pigtail catheter with a sheath;
- Failing to document appropriately the repositioning of the pigtail catheter and replacement with a sheath;
- Failing to use direct fluoroscopic visualization over a guide wire when manipulating a catheter in the pericardial space;
- Improperly manipulating and repositioning the catheter resulting in trauma to the right ventricle; and
- In such other ways that may be revealed during discovery and proven at the trial of this matter.

Attached as **Exhibit 1** is an affidavit of a qualified expert who will testify to one or more deviations from the standard of care.

**FOR A FIRST CAUSE OF ACTION
(Survival Action)**

17. Plaintiff reiterates paragraphs 1-16 above as if set forth verbatim herein.

18. As a direct and proximate result of the negligence, carelessness, gross negligence, recklessness and departure from the professional standards of care by Defendants, Mr. Dibernardo suffered from severe debilitating injuries which resulted in his permanent injury and disability, and conscious pain and suffering, as a result of which Mr. Dibernardo is entitled to recover a sum to compensate his estate for his conscious pain and suffering, medical expenses, mental anguish, loss of earnings capacity, loss of enjoyment of life, and other damages pursuant to S.C. Code § 15-5-90. Plaintiff is also entitled to recover a sum of punitive damages to punish and deter these defendants and others like them from similar conduct in the future. All damages should be in an amount determined by a jury in this action.

**FOR A SECOND CAUSE OF ACTION
(Wrongful Death)**

19. Plaintiff reiterates paragraphs 1-18 as if set forth verbatim herein.

20. As a direct and proximate result of the negligence, carelessness, gross negligence, recklessness and departure from the professional standards of care by Defendants, Mr. Dibernardo suffered from severe debilitating injuries which resulted in his death, and thus the negligence was the cause of the loss of the support, aid, society, comfort, and companionship of his heirs at law. Pursuant to S.C. Code § 15-51-20, the estate is therefore entitled to recover from defendants a sum of money to compensate the

heirs at law for the medical expenses, funeral expenses, mental anguish, loss of earnings capacity, and loss for the aid, society, comfort, and companionship of the decedent. Plaintiff is also entitled to recover a sum of punitive damages to punish and deter these defendants and others like them from similar conduct in the future. All damages should be in an amount determined by a jury in this action.

**FOR A THIRD CAUSE OF ACTION
(Loss of Consortium)**

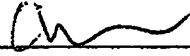
21. Plaintiff reiterates paragraphs 1-20 above as if set forth verbatim herein.

22. Plaintiff Lorrie Dibernardo as the wife of Mr. Dibernardo has suffered a loss of consortium as a result of the actions and inactions of Defendants. She is therefore entitled to an award of damages to compensate her for her loss of the society, comfort, companionship, support, and good offices of his wife. Further, the Defendants' actions in this case have been reckless and/or grossly negligent and thus Plaintiff Lorri Dibernardo is additionally entitled to an award of punitive damages to punish and deter these defendants and others like them.

WHEREFORE, Plaintiff respectfully prays for judgment against the Defendants for actual damages, special damages, consequential damages, and punitive damages in an amount to be determined by the jury at the trial of this action, for the costs and disbursements of this action and for such other and further relief as this court deems just and proper. Plaintiff specifically avers that the damages at issue in this case are more than \$100,000, such averment made to allow all manner of discovery under South Carolina Law.

Signature on Following Page

MCGOWAN HOOD & FELDER, LLC



Chad A. McGowan
Ashley White Creech
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, South Carolina 29732
(803) 327-7800
(803) 328-5656 Facsimile
Rock Hill, South Carolina

3-19, 2014

AFFIDAVIT of ALAN H. SCHOB, M.D.

PERSONALLY APPEARED BEFORE ME, THE UNDERSIGNED, BEING DULY SWORN, SAYS AS FOLLOWS:

1. I am board certified in internal medicine, cardiovascular disease and interventional cardiology by the American Board of Internal Medicine. My education, training, and experience are set forth in the attached CV (Exhibit A). It is my belief that my education, training, and experience qualify me to render expert opinions in regard to the care rendered to Anthony Dibernardo in this case.

2. My medical practice is primarily located in Miami, Florida. I have been practicing for more than 30 years.

3. I am familiar with the standard of care of what a reasonably prudent physician would do or not do in treating a patient such as Anthony Dibernardo. I am also familiar with the potential complications that derive from failing to properly perform pericardiocentesis.

4. I have reviewed the medical records of Anthony Dibernardo which consisted in part of records from Carolina Cardiology, Piedmont Medical Center Carolina including the echocardiograms, cath lab images and death certificate. The records I have reviewed are the type of documents, which I would consider in rendering an expert opinion in this case.

5. It is my opinion, within a reasonable degree of medical certainty that the Defendants and/or their employees, or agents committed negligent acts or omissions in their care and treatment of Anthony Dibernardo. Without intending to limit the scope of my opinions, some of the specific breaches of the standard of care I have identified as being perpetrated by the Defendants and/or their employees, or agents, are as follows:

- After obtaining access a pigtail catheter was placed into the intra-pericardial space. The first cine image demonstrates proper placement with free efflux of contrast into the pericardial space. The second image in the same view plane shows repositioning of the pigtail and the pigtail is now within a sheath. Contrast injection during the second cine now shows staining of the right ventricular myocardium. For an unknown reason the pigtail catheter was removed leaving the sheath in place. The third image shows myocardial staining directly through the sheath.
- Documentation as to why it was necessary to reposition the pigtail and to eventually replace it with a sheath is lacking.

- Proper technique for catheter manipulation and exchanges in the pericardial space requires use of direct fluoroscopic visualization over a guidewire. This is not recorded in the cath log or cine run.
- Multiple cine runs demonstrate that the pigtail catheter and sheath were inappropriately repositioned resulting in trauma to the right ventricle. This resulted in bleeding into the pericardial space with resultant tamponade and shock.
- There is no notation in the record as to why it was necessary to replace the pigtail catheter with a sheath which is more likely to cause injury.
- Thus, I hold the opinion that the operating physician fell below the standard of care in the performance of the pericardiocentesis as to cause right ventricular injury with resultant cardiac tamponade and shock.

6. Further, it is my opinion to a reasonable degree of medical certainty, more likely than not, that the deviations from the standard of care by the Defendants contributed to Anthony Dibernardo's overall decline, injuries and subsequent death.

7. The factual basis for my opinion about the breaches of the standard of care by the Defendants at this time is the medical records of Anthony Dibernardo. The factual basis of my opinions may be supplemented at a later time. I hereby reserve the right to amend, supplement, or withdraw my opinion based on discovery and depositions of the relative parties.

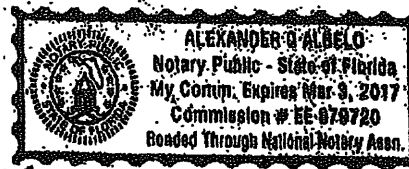
8. This affidavit is given in compliance with §§ 15-36-100 and 15-79-125 SCCA which does not require me to state all negligent acts or omissions by any defendant.

Alan H. Schob, M.D.
ALAN H. SCHOB, M.D.

Sworn to and signed before me
this 28th day of November, 2014.

[Signature]
Notary Public

My Commission expires: March 3rd 2017



*Notary Public License # 5102008530550
Exp: 03/03/2017*

CURRICULUM VITAE

A. BIOGRAPHICAL INFORMATION

1. PERSONAL

Date: September 17, 2013

Name: ALAN H. SCHOB, M.D.

Telephone: Home: (305) 595-8803
Telephone: Office: (305) 585-6534
Telephone: Office: (305) 575-3182

Address: Home: 9001 S.W. 102 Street
Miami, Florida 33176

Address: Office: VA Medical Center
Medical Service (111A)
1201 N.W. 16th Street
Miami, Florida 33125

Status: Full-time

Current Rank: Associate Professor of
Clinical Medicine

Citizenship: U.S.A.

2. HIGHER EDUCATION

College: Queens College, C.U.N.Y., New
York, New York, 1971-1975,
B.A. - Biology.

Medical School: University of South Alabama,
College of Medicine, Mobile,
Alabama, 1978-1981, M.D.

3. POST DOCTORAL TRAINING:

Internship: Internal Medicine, University
of Miami School of
Medicine/Jackson Memorial
Hospital, Miami, Florida,

1981-1982.

Residency:

Internal Medicine, University
of Miami School of
Medicine/Jackson Memorial
Hospital, Miami, Florida.

Fellowship:

Cardiology, University of
Miami School of
Medicine/Jackson Memorial
Hospital, Miami, Florida,
1985-1987.

Invasive Interventional
Cardiology, University of
Miami School of Medicine,
Miami, Florida, 1987-1988.

4. BOARD CERTIFICATION AND LICENSURES

Certification:

Internal Medicine, 1984
Cardiovascular Diseases, 1987
Interventional Cardiology,
2010

Licensures:

Florida, 1982

5. PROFESSIONAL EXPERIENCES

Academic Appointments:

Assistant Professor of
Clinical Medicine, University
of Miami School of Medicine,
Division of Cardiology,
Miami, Florida, 1988-1995.

Associate Professor of
Clinical Medicine, University
of Miami School of Medicine,
Division of Cardiology,
Miami, Florida, 1995-Present.

Co-Director Interventional
Cardiology Training Program -
University of Miami School of
Medicine

Hospital Appointments:

Chief, Cardiovascular
Laboratory VA Medical Center,
Miami, Florida 1990-Present.

Chief, Interventional
Laboratory, VA Medical
Center, Miami, Florida, 1990-
Present.

6. CURRENT AND PAST TEACHING RESPONSIBILITIES

Instructor Critical Care Cardiology Course, University of
Miami School of Medicine, Department of Cardiology, Miami,
Florida.

Mechanisms of Disease, University of Miami School of
Medicine, Department of Cardiology Miami, Florida.

Physical Diagnosis for Sophomore Students, University of
~~Miami School of Medicine, Department of Cardiology, Miami,~~
Florida.

Department of Medicine: Teaching of Medical Students,
Interns and Residents on Ward Medicine Rotation.

Division of Cardiology: Teaching of Cardiology Fellows in
CCU, Clinics, Consultations, Non-Invasive and Invasive
Laboratories. Training of 4th Year Fellows in
Interventional Cardiology, peripheral vascular disease and
Carotid stenting

Faculty Transcatheter Therapeutics Annual Scientific
meeting
Oct. 2004

Faculty Miami International Revascularization Summit
Feb.2004, 2005, 2006, 2007 and 2008.

Director of University of Miami Interventional journal club
Proctor Gore Viabhan endograft.

Proctor Boston Scientific Rotatablator

Director interdisciplinary weekly combined West Palm Beach
Miami VA Medical Centers conference

7. NATIONAL COMMITTEE RESPONSIBILITIES

- a) VA National CART-CL Oversight Committee
- b) VA National Interventional Cardiology Committee
- c) VA National Quality Management -Peer Review Committee
- d) VA National Stent Contracting Consignment Committee

8. DEPARTMENTAL ADMINISTRATIVE AND COMMITTEE RESPONSIBILITIES

- a) Invasive Procedures Committee VA Medical Center.
- b) Reviewer for Research & Development.
- c) Cardiovascular Subcommittee of PNT Committee.
- d) Cardiovascular Fellowship Review Committee
- e) Interventional Fellowship Selection Committee
- f) Departmental and Inter-Hospital VA Peer Review
- g) Root Cause Analysis/Reviewer/Committee

9. HONORS AND AWARDS

Society and Membership:	Fellow American College of Cardiology, 1989 Diplomat - National Board of Medical Examiners, 1981.
Best Doctors in Florida:	Castle Connolly Medical LTD. 2000.
Best Doctors in America	Castle Connolly Medical LTD. 2011
Top Doctors in America	Castle Connolly Medical LTD. 2012

10. OTHER PROFESSIONAL ACTIVITIES

Non-invasive cardiology laboratory University of Miami Hospital and Clinics

Peer Reviewer South Florida Utilization and Review

11. COMMUNITY SERVICES

Volunteer American Red Cross Disaster Relief

B. BIBLIOGRAPHY

1. SCIENTIFIC ARTICLES IN REFERRIED JOURNALS

Rothbart R, Harding L, Schob A, Russo C: An improved method for production of intravenous contrast during echocardiography. J CLIN ULTRASOUND, 12/2/87.

de Marchena E, Stang RB, Schob A, Topaz O, Chakko S, Kessler

KM: Percutaneous transluminal coronary angioplasty using a combined "balloon-on-a-wire" system and exchange guide wire technique. CATHETERIZATION AND CARDIOVASCULAR DIAGNOSIS 18:3; 11/89;183-86.

de Marchena E, Musial B, Wozniak P, Schob A, Chakko S, Kessler KM: Iatrogenic internal mammary artery to coronary vein fistula. CHEST 97:1; 1/90;251-53.

Musial B, Schob A, de Marchena E, Kenneth KM: Percutaneous Transluminal Coronary Angioplasty of Anomalous Right Coronary Artery. CATHETERIZATION AND CARDIOVASCULAR DIAGNOSIS 22:1; 1/91;39-41.

Kessler KM, Baurlein EJ, Schob A, de Marchena E, Myerburg RJ. ST Alternans. AM J CARDIOL 1992;70:1224-1225.

Youseff M, Schob A, Kessler KM. Iatrogenic Coronary Septal Artery to Right Ventricular Fistula Complicating Percutaneous Transluminal Coronary Angioplasty with Spontaneous Resolution. AM HEART J 1997;133:260-262.

Hsia SL, Duncan R, Schob AH, Chakko SC, Mulingtapang R, He JL, Perez GO. A comparative study of high-density lipoprotein phospholipids and cholesterol in patients with and without angiographically defined coronary artery disease. ATHEROSCLEROSIS 2000;152:469-73.

Fierro-Renoy C, Zambrano J, Schob A. Percutaneous stenting

of bilateral pulmonary artery stenosis caused by malignant extrinsic compression. Chest October 2002 122:1478-1480;

Chirinos J, Zambrano JP, Chakko S, Schob A, Virani A, Perez GO, Mendez AJ. Usefulness of C-reactive protein as an independent predictor of death in patients with ischemic cardiomyopathy. AMERICAN JOURNAL OF CARDIOLOGY 2005; 95: 88-90.

Chirinos JA, Zambrano JP, Chakko S, Veerani A, Schob A, Willens HJ, Perez HJ, Mendez AJ. Aortic pressure augmentation predicts adverse cardiovascular events in patients with established coronary artery disease. HYPERTENSION 2005; 45:980-985.

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Chirinos JA, Zambrano JP, Chakko S, Schob A, Goldberg RB, Mendez AJ. Ability of serum to decrease cellular AcylCoA: Cholesterol Acyl transferase activity predicts cardiovascular outcomes. CIRCULATION 2005; 112:2446-2453.

Tehrani H, Otero C, Arosemena M, Perez E, Zelnick K, Mendoza C, Yrizarry J, Stadtlander K, Rothenberg G, Cohen M, Zachow K, Schob A. Endovascular-First strategy in patients with critical limb ischemia. Vascular Disease Management 2006; 1556:380-383.

Willens HJ, Chirinos JA, Veerani A, Zambrano JP, Schob A, Mendez AJ, Chakko S. The Relation Between Mitral Annular Calcification and Mortality in Patients Undergoing Diagnostic Coronary Angiography. ECHOCARDIOGRAPHY. 2006 Oct;23(9):717-22.

Tanawuttiwat T, Brice T, Symes JF, Khramov I, Schob AH. Cardiac computed tomography in the evaluation of an intra-pericardial mediastinal mass. Eur Heart J Cardiovasc Imaging. 2012 Aug;13(8):712.

Tanawuttiwat T, O'Neill BP, Schob AH, Alfonso CE. Left Main Coronary Atresia. J Card Surg. 2012 Dec 12:1-10. doi: 10.1111/jocs.12044.

Schob AH, Bhatt M, Alfonso C, De Marchena E. Cryoplasty for the treatment of coronary bifurcation stenoses following main vessel stenting. J Interv Cardiol. 2013 Jun;26(3):239-44. doi: 10.1111/joic.12032. Epub 2013 Apr 30.

2. ABSTRACTS

Zambrano JP, Chirinos J, Chakko S, Tamariz L, Palacio A, Schob A, Perez GO, Mendez AJ. C-Reactive protein and the prediction of cardiovascular events in patients with documented coronary artery disease: effects of aspirin and statin therapy. JOURNAL OF INVESTIGATIVE MEDICINE 2004;52:S261.

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Chirinos JA, Willens HJ, Veerani A, Zambrano JP, Schob A, Chakko S. Mitral annular calcification and its predictive value for mortality among patients with established coronary artery disease. JOURNAL OF THE AMERICAN SOCIETY OF ECHOCARDIOGRAPHY 2005 (in press).

J. Chirinos, JP. Zambrano, A. Veerani, G. Perez, A. Schob, AJ. Mendez, S. Chakko Evaluation of comorbidity scores to predict mortality in patients with coronary artery disease. EUROPEAN HEART JOURNAL 2005 (in press).

J. Chirinos, JP. Zambrano, S. Chakko, A. Veerani, A. Schob, GO. Perez, AJ Mendez. Correlation between ascending aortic pressures and outcomes in patients with coronary artery disease. AMERICAN JOURNAL OF HYPERTENSION 2005; A103.

J. Chirinos, JP. Zambrano, S. Chakko, A. Veerani, A. Schob, GO. Perez, AJ Mendez. Aortic pressure augmentation predicts adverse cardiovascular events in patients with established coronary artery disease. AMERICAN JOURNAL OF HYPERTENSION 2005; A11-12.

3. OTHER PROFESSIONAL ITEMS:

Other Works:

de Marchena E, Stang B, Schob A, Chakko S, Kessler KM. PTCA using a combined balloon-on-wire system and exchange guide wire technique. Cardiology Digest 1990.

Munoz O, Schob A, O'Rourke R; Percutaneous treatment of saphenous vein graft obstructions: an unresolved issue. Hurst's the Heart, McGraw-Hill Publishers; <http://cardiology.accessmedicine.com>

Schob A, Munoz O; Rotational Atherectomy. In De Marchena E and Ferreira A (eds): Interventional Cardiology Secrets, Hanley and Belfus Inc. Medical Publishers 2003; pp.106-111.

Schob A, Auerbach E; Total Chronic Occlusions. In De Marchena E and Ferreira A (eds): Interventional Cardiology Secrets, Hanley and Belfus Inc. Medical Publishers, 2003 pp.189-192.

Mendoza CE, Bhatt MR, Virani S, Schob AH, Levine S, Ferreira AC, de Marchena .Management of failed thrombolysis after acute myocardial infarction: an overview of current treatment options. Int J Cardiol. 2007 Jan 18;114(3):291-9. Epub 2006 Oct 31. Review.

Scientific Presentations at National and International Meetings:

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Chirinos JA, Zambrano JP, Chakko SC, Schob A, Perez GO, Mendez AJ. High-density lipoprotein-mediated cholesterol efflux from cells is a strong independent predictor of cardiovascular risk. Presented at the 53rd Annual Scientific Sessions of the American College of Cardiology, New Orleans, LA, March 2004.

Chirinos JA, Zambrano JP, Chakko S, Schob A, Goldberg RB, Perez G, Mendez AJ. Serum-mediated intracellular cholesterol efflux activity predicts cardiovascular outcomes. Presented at the Florida Chapter of the American

College of Cardiology. Sheraton Bal Harbour Resort, Bal Harbour, FL September 2004.

J. Chirinos, JP. Zambrano, S.Chakko, A. Veerani, A. Schob, GO. Perez, AJ Mendez. Aortic pressure augmentation predicts adverse cardiovascular events in patients with established coronary artery disease. Presented at the Annual Scientific Sessions of the American Society of Hypertension San Francisco. May 2005.

Chirinos JA, Willens HJ, Veerani A, Zambrano JP, Schob A, Chakko S. Mitral annular calcification and its predictive value for mortality among patients with established coronary artery disease. Presented at the 16th Annual Scientific Sessions of the American Society of Echocardiography. Boston, MA. June 2005.

J. Chirinos, JP.Zambrano, A. Veerani, G. Perez, A. Schob A, AJ. Mendez, S. Chakko Evaluation of comorbidity scores to ~~predict mortality in patients with coronary artery disease.~~ Presented at the European Society of Cardiology Meeting, Stockholm Sweden. September 2005.

Schob, A. Clinical case presentations; Transcatheter Therapeutics annual meeting Oct. 2004, Washington, D.C.

~~Miami VA OA Presentation at VA National CATH/CL/CARDIAC Cath Lab Meeting May 2011~~

Invited Lectures at National and International Meetings:

Spectrum of Peripheral Vascular Disease in the VA, New Cardiovascular Horizons, New Orleans, Louisiana September 2007

Sirolimus Eluting Stent Trials, Miami International Revascularization Summit, Miami, Florida, April 2008

Incidence and Impact of Peripheral Arterial Disease, Implications for Diagnosis and Management in the VA: The Michael E. DeBakey Session of the New Cardiovascular Horizons Meeting New Orleans, La. September 2008.

Mechanical Thrombectomy, Cardiovascular Congress 2009, Miami, Florida, February 2009.

Advanced Coronary Assessment VISN 8 Ambulatory Care Forum,
October 2009. Miami Florida .

VISN 8 Primary Care Forum, April 2010, Miami Florida

Accomplishments at VAMC

Clinical Programs:

Developed the programs in;
Interventional Cardiology
Endovascular peripheral intervention
Carotid Stent program
Structural Heart Program

Previous research:

Role of phospholipids in cholesterol metabolism.

~~Role of endothelin in coronary artery disease and
restenosis.~~

Amlodipine in treatment of Angina.

Evaluation of Xemilofiban in Controlling Thrombotic
Events, #IG7-96-02-017.

Intracoronary ReoPro for the Prevention of Ischemic
Complications of Coronary Angioplasty.

OPUS-TIMI 16.

BRAVO Trial.

PRESTO Trial.

Grant in Aid, American Heart Ass. HDL function in
patients with coronary artery disease. (co-
investigator).

Ongoing research:

Triton-TIMI 38.

Cryoballoon coronary angioplasty for bifurcation
lesions

STATE OF SOUTH CAROLINA

COUNTY OF YORK

Lorrie Dibernardo, individually and as the
Personal Representative of the Estate of
Anthony Dibernardo, Deceased,

Plaintiff,

vs.

Carolina Cardiology Associates, PA and
Naresh Mori, MD,

Defendants.

COURT OF COMMON PLEAS
SIXTEENTH JUDICIAL CIRCUIT

Civil Action No: 2015-CP-46-882

ANSWER ON BEHALF OF
DEFENDANTS CAROLINA
CARDIOLOGY ASSOCIATES, PA, AND
NARESH MORI, M.D.

The Defendants, Carolina Cardiology Associates, PA and Naresh Mori, M.D., hereby
answer the Complaint herein, as follows:

FOR A FIRST DEFENSE

1. That each and every allegation of the Complaint which is not hereinafter specifically admitted is expressly denied.
2. These Defendants lack specific information upon which to form a belief concerning the allegations of Paragraph 1 and, therefore, unable to admit or deny said allegations.
3. That the allegations of Paragraph 2 of the Complaint are admitted.
4. That only so much of paragraphs 4, 5, 7, 8, 9, 10, 11, 12 and 13 are admitted as may be consistent with the deceased's medical records. Any allegations inconsistent therewith are expressly denied.
5. That the allegations of Paragraph 6 are denied.
6. That the allegations of Paragraphs 14, 15 and 16 are denied.

7. That the allegations of Paragraph 17 are answered as if the answers to Paragraphs 1 – 16, set forth hereinabove, were incorporated herein verbatim.
8. That the allegations of Paragraph 18 are denied.
9. That the allegations of Paragraph 19 are answered as if the answers to Paragraphs 1 – 18, set forth hereinabove, were incorporated herein verbatim.
10. That the allegations of Paragraph 20 are denied.
11. That the allegations of Paragraph 21 are answered as if the answers to Paragraphs 1 – 20, set forth hereinabove, were incorporated herein verbatim.
12. That the allegations of Paragraph 22 are denied.

FOR A SECOND DEFENSE

13. That any injuries or damages as alleged in the Complaint were due to and caused by Plaintiff's underlying medical condition, and complications arising therefrom, and was not due to or caused by any departure from generally accepted standards of care on the part of these Defendants, and as a result thereof these Defendants are in no way liable for the matters set forth in the Complaint.

FOR A THIRD DEFENSE

14. That at all times relevant to the matters set forth in the Complaint these Defendants rendered cardiac care in accord with generally accepted standards of care applicable to cardiologists rendering cardiology care under the same or similar circumstances, and as a result thereof, these Defendants are in no way liable to the Plaintiffs for the matters set forth in the Complaint.

FOR A FOURTH DEFENSE

15. Plaintiffs' claim for punitive or exemplary damages against these Defendants is barred by the Constitution of the State of South Carolina and the United States of

America. These Defendants specifically raise these constitutional bars to any claim against them for punitive or exemplary damages.

FOR A FIFTH DEFENSE

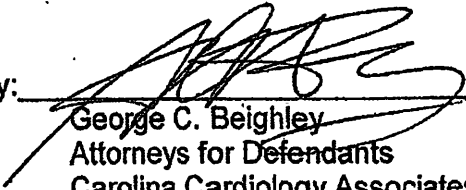
16. That any recovery sought in this action is limited to the terms and conditions of the South Carolina Tort Reform Act and these Defendants crave reference to said defenses as limitations on all claims for damages.

WHEREFORE, having answered the Complaint herein, these Defendants Carolina Cardiology Associates and Naresh Mori, MD., demand that the Complaint be dismissed as to them, that the Plaintiff be taxed with the costs of this action, and for such other and further relief as the Court deems just and proper.

This the 27th day of April, 2015 in Columbia, South Carolina.

RICHARDSON PLOWDEN & ROBINSON, P.A.
1900 Barnwell Street
Post Office Drawer 7788
Columbia, SC 29202
Phone: (803) 771-4400
Fax: (803) 779-0016

By: _____


George C. Beighley
Attorneys for Defendants
Carolina Cardiology Associates and
Naresh Mori, MD

CERTIFICATE OF SERVICE BY MAIL

I, the undersigned, an employee of RICHARDSON PLOWDEN & ROBINSON, P.A., attorneys for the Defendants, Carolina Cardiology Associates and Naresh Mori, MD, do hereby certify that I have this date served the foregoing Answer, on the below-listed individuals by depositing a copy of same into the United States Mail, first-class, postage pre-paid, addressed to:

Chad A. McGowan, Esquire
Ashley White Creech
McGowan, Hood and Felder
1539 Health Care Drive
Rock Hill, SC 29732



Lori C. Spooner
Legal Assistant to George C. Beighley

April 27, 2015

State of South Carolina

Court of Common Pleas

County of York

Lorrie Dibernardo,)
Individually and as)
Personal Representative)
of the Estate of Anthony)
Dibernardo, deceased)

Plaintiff,)

v.)

Carolina Cardiology)
Associates, PA and Naresh)
Mori, MD)

Defendants.)

Transcript of Record
2015-CP-46-00882

Week of September 12, 2016
York, South Carolina

B E F O R E:

The Honorable Scott Sprouse, Judge.

A P P E A R A N C E S:

Chad McGowan, Esquire
Attorney for the Plaintiff

George Beighley, Esquire
Attorney for the Defendant

Dana New
Official Court Reporter

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1 P R O C E E D I N G S

2 THE COURT: Are we ready to call our first
3 juror?

4 MR. MCGOWAN: Yes, sir, Your Honor.

5 THE COURT: All right. Ladies and gentlemen,
6 this next part of the process where we're calling
7 the jury for the first case. The first case on the
8 docket is that of Lorrie Dibernardo, Individually
9 and as the Personal Representative of the Estate of
10 Anthony Dibernardo, Plaintiff versus Carolina
11 Cardiology Associates, PA and Naresh Mori, MD. This
12 is a case where medical malpractice is alleged. The
13 plaintiff alleges that the defendant committed
14 medical malpractice and in so doing caused the death
15 of Mr. Dibernardo. The defendant denies the
16 allegations. First jury will be called to hear the
17 evidence in the case.

18 First order of business will be for the
19 attorneys involved in the case to introduce
20 themselves, their clients and any of their staff
21 that may be assisting them in the case.

22 MR. MCGOWAN: My name is Chad McGowan and I
23 represent Lorrie Dibernardo in this case. With us
24 here is Chance Farr, one of the lawyers in my
25 office, as well as Taylor Strain who is also part of

1 our staff.

2 MR. BEIGHLEY: I'm George Beighley. This is my
3 son George Beighley, Jr. We have the privilege of
4 representing Dr. Naresh Mori who is the commissioned
5 offender in this case.

6 THE COURT: Now, ladies and gentlemen, I know I
7 asked you a whole bunch of questions a while ago but
8 I'm going to ask you some more. These are questions
9 I'm asking you not to pry into your private lives
10 but just to ensure that each side receives a fair
11 and impartial jury.

12 First question: Is any member of the jury
13 panel related by blood or marriage or has a close
14 personal, business or social relationship with
15 either party or one of the attorneys involved in
16 this case? If so, please stand.

17 Has any member of the jury panel ever been
18 represented by one of the attorneys involved in this
19 case or their law firms or had them represent
20 someone against you in a litigation? If so, please
21 stand.

22 The following is a list of potential witnesses
23 in this case: Lorrie Dibernardo, Dr. Naresh Mori,
24 Dr. Alan Shove, Dr. Sally Wooten, Dr. Michael
25 Foster, Dr. James Story, Kelly Gregory, J. C.

1 Gregory, Dr. J. K. Shah.

2 Is any member of the jury panel related by
3 blood or marriage or has a close personal, business
4 or social relationship with any of these potential
5 witnesses? If so, please stand.

6 Yes, sir?

7 POTENTIAL JUROR NUMBER 164: Piedmont Medical
8 Center in Rock Hill.

9 THE COURT: Okay. This is Potential Juror
10 Number 164. With that knowledge do you feel that
11 you could be fair and impartial when called to serve
12 as a juror? .

13 POTENTIAL JUROR NUMBER 164: I do.

14 THE COURT: All right. Thank you. Any
15 further?

16 Is any member of the jury panel a patient of
17 any of the doctors listed or has ever been treated
18 by one of the doctors listed? If so, please stand.

19 Okay. Has any member of the jury panel ever
20 received medical care from the following
21 possibilities: Carolina Cardiology or Piedmont
22 Medical Center? If so, please stand.

23 (Potential jurors stand.)

24 THE COURT: Okay. Let's just go down the --
25 now I'm going to ask you to identify by number first

1 and then I'm going to ask you all a question in
2 unison. What's your number, ma'am?

3 POTENTIAL JUROR NUMBER 85: Eighty-five.

4 THE COURT: And on the end, your number?

5 POTENTIAL JUROR NUMBER 55: Fifty-five.

6 THE COURT: Number 55?

7 POTENTIAL JUROR NUMBER 16: Sixteen.

8 POTENTIAL JUROR NUMBER 133: 133.

9 POTENTIAL JUROR NUMBER 89: Eighty-nine.

10 THE COURT: We'll start with the next row.

11 POTENTIAL JUROR NUMBER 11: Eleven.

12 POTENTIAL JUROR NUMBER 74: Seventy-four.

13 THE COURT: Next row.

14 POTENTIAL JUROR NUMBER 132: 132.

15 POTENTIAL JUROR NUMBER 116: 116.

16 THE COURT: Hold on. What was your number
17 again, sir? What was your number?

18 POTENTIAL JUROR NUMBER 116: 116.

19 THE COURT: Thank you.

20 POTENTIAL JUROR NUMBER 132: 132.

21 THE COURT: 132?

22 POTENTIAL JUROR NUMBER 132: Yes.

23 POTENTIAL JUROR NUMBER 14: Fourteen.

24 POTENTIAL JUROR 53: Fifty-three.

25 POTENTIAL JUROR 152: 152.

1 POTENTIAL JUROR NUMBER 76: Seventy-six.
2 THE COURT: Let's start on the front row here.
3 Yes, ma'am?
4 POTENTIAL JUROR NUMBER 13: Thirteen.
5 POTENTIAL JUROR NUMBER 25: Twenty-five.
6 POTENTIAL JUROR NUMBER 15: Fifteen.
7 POTENTIAL JUROR NUMBER 47: Forty-seven.
8 POTENTIAL JUROR NUMBER 162: 162.
9 POTENTIAL JUROR NUMBER 167: 167.
10 POTENTIAL JUROR NUMBER 28: Twenty-eight.
11 POTENTIAL JUROR NUMBER 58: Fifty-eight.
12 POTENTIAL JUROR NUMBER 27: Twenty-seven.
13 POTENTIAL JUROR NUMBER 62: Sixty-two.
14 POTENTIAL JUROR NUMBER 99: Ninety-nine.
15 POTENTIAL JUROR NUMBER 2: Two.
16 POTENTIAL JUROR NUMBER 7: Seven.
17 POTENTIAL JUROR NUMBER 127: 127.
18 POTENTIAL JUROR NUMBER 38: Thirty-eight.
19 THE COURT: It's hard to see you in the back.
20 Yes?
21 POTENTIAL JUROR NUMBER 38: Thirty-eight.
22 THE COURT: All right. Is that -- did I miss
23 anyone?
24 All right. All of you who responded in the
25 affirmative, is there any member of this group who

1 feels that they could not be fair and impartial if
2 called to serve as a juror in this case?

3 Okay. Let the record reflect -- yes,
4 Mr. McGowan?

5 MR. MCGOWAN: Maybe ask the question a little
6 differently that just Carolina Cardiology and not
7 with Piedmont?

8 THE COURT: Okay. All right. Is there any --
9 of this group if you have not received treatment
10 from Carolina Cardiology you can say that.

11 Okay. And ma'am, what was your number again?

12 POTENTIAL JUROR NUMBER 133: 133.

13 THE COURT: All right. And ma'am, you feel
14 that you could be fair and impartial?

15 POTENTIAL JUROR NUMBER 133: Yes, sir.

16 THE COURT: All right. Thank you, ma'am. You
17 can be seated.

18 Yes, sir?

19 POTENTIAL JUROR NUMBER 116: Number 116.

20 THE COURT: And do you feel that you could be
21 fair and impartial?

22 POTENTIAL JUROR NUMBER 116: I believe so.

23 THE COURT: Thank you, sir. You may be seated.

24 Yes, ma'am.

25 POTENTIAL JUROR NUMBER 76: Seventy-six.

1 THE COURT: And do you feel that you could be
2 fair and impartial?

3 POTENTIAL JUROR NUMBER 76: Yes.

4 THE COURT: Thank you, ma'am.

5 Has any member of the jury panel or a member of
6 their immediate family ever been diagnosed with any
7 of the following medical conditions: One, Noonan
8 syndrome -- anyone been diagnosed with Noonan
9 syndrome?

10 -- Two, congestive heart failure?

11 Yes, sir? Your number?

12 POTENTIAL JUROR NUMBER 26: Twenty-six.

13 THE COURT: And you feel you could be fair and
14 impartial?

15 POTENTIAL JUROR NUMBER 26: Yes, Your Honor.

16 THE WITNESS: All right. Thank you. Yes,
17 ma'am?

18 POTENTIAL JUROR NUMBER 31: Thirty-one.

19 THE COURT: Do you feel that you could be fair
20 and impartial?

21 You need to speak up where the court reporter
22 can hear you.

23 POTENTIAL JUROR NUMBER 31: Yes.

24 THE COURT: Thank you, ma'am.

25 Yes, ma'am? What's your number?

1 POTENTIAL JUROR NUMBER 50: Fifty.

2 THE COURT: All right. Ma'am, do you feel that
3 you could be fair and impartial?

4 POTENTIAL JUROR NUMBER 50: Yes.

5 THE COURT: Okay. Thank you.

6 Number 50?

7 POTENTIAL JUROR NUMBER 50: Yes.

8 THE COURT: All right. Okay. Cardiomyopathy?
9 Edema or swelling in the legs?

10 Oh, yes, ma'am? Your number?

11 POTENTIAL JUROR NUMBER 55: Fifty-five.

12 THE COURT: And you feel you could be fair and
13 impartial?

14 POTENTIAL JUROR NUMBER 55: Yes, sir.

15 THE COURT: Yes, ma'am?

16 POTENTIAL JUROR NUMBER 75: Seventy-five.

17 THE COURT: And you feel that you could be fair
18 and impartial?

19 POTENTIAL JUROR NUMBER 75: Yes.

20 THE COURT: All right. Thank you, ma'am.

21 Edema or swelling in the leg?

22 Yes, ma'am?

23 POTENTIAL JUROR NUMBER 89: Eighty-nine and
24 yes.

25 THE COURT: You think you could be fair and

1 impartial?

2 POTENTIAL JUROR NUMBER 89: Yes, I do.

3 THE COURT: Thank you, ma'am.

4 Yes, ma'am?

5 POTENTIAL JUROR NUMBER 92: Ninety-two.

6 THE COURT: And do you feel you could be fair

7 and impartial?

8 POTENTIAL JUROR NUMBER 92: Yes.

9 THE COURT: Thank you, ma'am.

10 Yes, sir?

11 POTENTIAL JUROR NUMBER 28: Twenty-eight.

12 THE COURT: And do you feel you could be fair

13 and impartial?

14 POTENTIAL JUROR NUMBER 28: Yes.

15 THE COURT: All right. Thank you.

16 Okay. Has any member of the jury panel or

17 member of their immediate family ever received what

18 they thought was less than adequate medical care

19 from any doctor, nurse or other health-care

20 professional, medical clinic or hospital? If so,

21 please stand and -- or come forward if you don't

22 wish to give a public response.

23 Yes, sir?

24 POTENTIAL JUROR NUMBER 147: 147.

25 THE COURT: Okay. Why don't you come forward,

1 sir?

2 (Brief off-the-record discussion.)

3 THE COURT: All right. Has any member of the
4 jury panel or a member of their immediate family
5 been a party to a lawsuit? If so, state whether it
6 was on the plaintiff side or the defendant side. If
7 so, please stand.

8 Yes, ma'am? Your number?

9 POTENTIAL JUROR NUMBER 55: Fifty-five.

10 THE COURT: And were you the plaintiff or --
11 first, was it you or an immediate family member?

12 POTENTIAL JUROR NUMBER 55: Me. Defendant.

13 THE COURT: Okay. Do you feel that you could
14 be fair and impartial if called to serve as a juror?

15 POTENTIAL JUROR NUMBER 55: Yes, sir.

16 THE COURT: All right. Thank you, ma'am.

17 POTENTIAL JUROR NUMBER 11: Number eleven, and
18 I was the plaintiff.

19 THE COURT: And do you feel that you could be
20 fair and impartial if called to serve as a juror?

21 POTENTIAL JUROR NUMBER 11: Yes, sir.

22 THE COURT: All right. Thank you, ma'am.

23 POTENTIAL JUROR NUMBER 101: 101. Plaintiff
24 and defendant.

25 THE COURT: Okay. And do you feel that you

1 could be fair and impartial if called to serve as a
2 juror?

3 POTENTIAL JUROR NUMBER 101: Yes.

4 THE COURT: All right. Thank you, sir.

5 Yes, ma'am?

6 POTENTIAL JUROR NUMBER 47: Forty-seven. I was
7 a plaintiff.

8 THE COURT: And do you feel you could be fair
9 and impartial if called to serve?

10 POTENTIAL JUROR NUMBER 47: Yes.

11 THE COURT: All right. Thank you, ma'am.

12 Yes, sir?

13 POTENTIAL JUROR NUMBER 28: Twenty-eight. I
14 was a plaintiff.

15 THE COURT: And do you feel you could be fair
16 and impartial if called to serve?

17 POTENTIAL JUROR NUMBER 28: Yes.

18 THE COURT: All right. Thank you, sir.

19 POTENTIAL JUROR NUMBER 147: Your Honor, could
20 we go back to that last question? I didn't stand up
21 for that one but I do have a situation.

22 THE COURT: Okay.

23 (Brief off-the-record discussion.)

24 THE COURT: All right. Has any member of the
25 jury panel been diagnosed with any medical condition

1 which would impair their ability to fairly and
2 impartially decide the case based on the facts and
3 not emotion?

4 Okay. All right. Any further questions from
5 the plaintiff before I begin the defense?

6 MR. MCGOWAN: I thought those were the
7 defendant's.

8 THE COURT: Oh, I'm sorry.

9 Okay. I'm going to call out some names of
10 individuals who are not witnesses but are related to
11 the parties in the case: Michael Todd Pennington,
12 Dennis Dover, William Moss, Sue Moss, Connie Dover.

13 Does any member of the jury panel have a close
14 business, personal or social relationship with any
15 of those individuals? If so, please stand.

16 There's no responses. Okay. All right. Those
17 were the defense.

18 Mr. Beighley, any further questions?

19 MR. BEIGHLEY: We have a few more names on the
20 next page.

21 THE COURT: Oh, I see it. All right.
22 Sylvester Dover, Robbie Moss, Scott Moss?

23 All right. No responses.

24 MR. BEIGHLEY: Number 13 was a business
25 relationship.

1 THE COURT: Okay. Does any member of the jury
2 panel work at or have a relative work at Hamrick
3 Mills Musgrove Plant?

4 All right. No responses.

5 Okay. Does any member of the jury panel have
6 any moral, religious, personal or political belief
7 that would prevent you from awarding monetary
8 damages in a lawsuit? If so, please stand.

9 Okay. There are no responses. Oh, yes, ma'am?
10 Your number?

11 POTENTIAL JUROR NUMBER 50: Fifty.

12 THE COURT: And you don't think you could --
13 Number 50? Okay. Thank you, ma'am. I'm going to
14 have you be seated and remain with us.

15 Okay. Does any member of the jury panel belong
16 to any organization that takes a position on the
17 civil justice system or lawsuits?

18 Does any member of the jury panel have any
19 preconceived notions that people who employ the
20 courts to seek damages for personal injuries are
21 doing something immoral or wrong just by virtue of
22 doing so?

23 Does any member of the jury panel have a moral,
24 religious, personal or political belief opposed to
25 the American jury system?

1 Does any member of the jury panel have any life
2 experience that would make it difficult for you to
3 sit on a jury and be impartial towards someone who
4 claims to be injured and comes into court asking for
5 money damages?

6 Does any member of the jury panel have any
7 feelings a person should not be allowed to sue for
8 recovery of damages?

9 Does any member of the jury panel have any
10 feelings a person should not be allowed to recover
11 for pain, suffering and mental anguish?

12 Okay. Any further questions from the
13 plaintiff?

14 MR. MCGOWAN: No, sir, Your Honor.

15 THE COURT: Okay. Finally, ladies and
16 gentlemen, my standard -- two standard questions I
17 ask each pool: Does any member of the jury panel
18 have any knowledge from any source about the facts
19 of this case?

20 And finally, does any member of the jury panel
21 know of any other reason why he or she could not be
22 fair and impartial if called to serve as a juror in
23 this case?

24 Okay. Now, ladies and gentlemen, the way this
25 works is -- you used to have a big hopper and you

1 may have seen it on television where they drew names
2 out of a hat. We don't do that anymore. We have
3 advanced. The computer does all that for you. So
4 the clerk is going to generate a computer list and
5 then we will go from there. So we're going to take
6 a few minutes break.

7 Are y'all ready to -- attorneys come forward.
8 (Brief off-the-record discussion.)

9 MR. BEIGHLEY: Judge, can we be excused?

10 THE COURT: Yes, sir. Ladies and gentlemen,
11 the clerk has distributed the list to the attorneys
12 so I'm going to give the attorneys a break so they
13 can look over the list. So we're going to take
14 about a 15-minute break and then we'll be back and
15 select a jury, so do not leave the courthouse.

16 (Recess was taken.)

17 THE DEPUTY: All rise.

18 THE COURT: Thank you. Y'all be seated please.
19 All right.

20 All right. Are the parties ready to proceed?

21 MR. MCGOWAN: Yes, sir, Your Honor.

22 MR. BEIGHLEY: Yes, Your Honor.

23 THE COURT: All right. Madam Clerk?

24 THE CLERK: Plaintiff strikes -- we're
25 alternating strikes beginning with the plaintiff.

1 MR. MCGOWAN: Plaintiff strikes Number 8.
2 MR. BEIGHLEY: Defendant strikes Number 4.
3 MR. MCGOWAN: Plaintiff strikes Number 21.
4 MR. BEIGHLEY: Defendant strikes Number 6.
5 MR. MCGOWAN: The plaintiff strikes Number 5.
6 MR. BEIGHLEY: Defendant strikes Number 19.
7 MR. MCGOWAN: Plaintiff strikes Number 21. I'm
8 sorry. Number 20.
9 MR. BEIGHLEY: Defendant strikes Number 11.
10 MR. MCGOWAN: On alternate the plaintiff
11 strikes Number 25.
12 MR. BEIGHLEY: Defendant strikes Number 24.
13 I'm sorry. Yes, sir, 24.
14 THE CLERK: I will verify the strikes for both
15 sides. For the plaintiff I have the following
16 strikes: Number 8, 21, 5, 20 and as your alternate
17 Number 25. Is this correct?
18 MR. MCGOWAN: Yes, ma'am.
19 THE CLERK: For the defendant I have the
20 following strikes: Number 4, 6, 19, 11 and as your
21 alternate Number 24. Is this correct?
22 MR. BEIGHLEY: Yes, it is.
23 THE CLERK: Ladies and gentlemen, if I call
24 your number, if you'll please get your personal
25 belongings and come down and sit to my left in the

1 jury box at the direction of the bailiff: Juror
2 151, Gerard Jake Rine; Juror Number 147 Thomas E.
3 Pool; Juror Number 197, Robert S. Wilson; Juror
4 Number 6, Stevie B. Allen; Juror Number 15, Lavell
5 Barrett; Juror Number 26, Kevin M. Cabrera; Juror
6 Number 174, Barbara G. Stegall; Juror Number 44,
7 Delancey L. Currence; Juror Number 16, Glenda B.
8 Huffstetler; Juror Number 163, Julie M. Simpson;
9 Juror Number 45, Pamela G. Curry; Juror Number 17,
10 Ashleigh N. Burley; and serving as alternate is
11 Juror Number 42, Gregory W. Crump.

12 THE COURT: All right. Are there any motions
13 or exceptions to the jury panel from the plaintiff?

14 MR. MCGOWAN: No, sir, Your Honor.

15 THE COURT: Are there any motions or exceptions
16 to the jury panel from the defense?

17 MR. BEIGHLEY: No, Your Honor.

18 THE COURT: All right. Madam Clerk, would you
19 swear our jurors please?

20 THE CLERK: If you'll please stand and raise
21 your right hand.

22 (The jury was duly sworn.)

23 THE COURT: Ladies and gentlemen in the
24 remainder of the jury pool, you can't breath a sigh
25 of relief yet. We're not through with you. The

1 clerk's going to take you next door. Judge Hill --
2 we're having another term of common pleas court. I
3 don't know what kind of case it is but I'm sure it
4 will be something interesting. So Mr. Clerk, if
5 you'll take the remainder of our jury pool next
6 door.

7 Juror Number 50, ma'am, if you'll just have a
8 seat on the front row please. We'll have you stay
9 with us.

10 Okay. Ladies and gentlemen, before we start
11 let me explain our roles in this trial. I am the
12 judge of the law. You must apply the law as I give
13 it to you. You are the judge of the facts. As a
14 judge of the facts you have the duty to evaluate the
15 evidence that is presented. Evidence is the sworn
16 testimony from the witness stand or any exhibits
17 that have been entered into evidence. You and you
18 alone determine the credibility of witnesses and how
19 much weight to give their testimony.

20 Each attorney will have an opportunity to give
21 an opening statement to outline their positions and
22 the evidence that he intends to present to support
23 those claims. The attorneys will also have the
24 opportunity to make closing arguments after the
25 testimony has concluded. Keep in mind that the

1 statements of the attorneys are not evidence but
2 merely tools they use to help you understand their
3 respective positions. The plaintiff has the burden
4 of proof in this trial. The plaintiff must prove
5 her case by a preponderance of the evidence.

6 Now, a few more things that I'm going to give
7 you before we take our first break. This is not an
8 endurance contest. We will take breaks as we go
9 along. As I mentioned before, I don't think this is
10 going to be an overly long case but this will be a
11 significant case. If you need to take a break, if
12 you get in distress and you need immediate
13 assistance, let your bailiff know. Okay? The
14 bailiff and the clerk staff, as I told you before,
15 are here to help you, so if there are issues that
16 arise, let them know.

17 Now, I'm going to give you some instructions
18 here that are very important during the course of
19 this trial. The first is, there should be no
20 independent investigation. You are not allowed to
21 do research on the law or the facts of the case.
22 That's very easy in the age in which we live.
23 People have smart phones, WiFi Internet access.
24 You're not allowed to do that. You can't do any
25 independent research. The only thing you should

1 base your decision on at the end is the evidence
2 that is presented during this trial. You may not
3 take notes. The reason for this is that some folks
4 are good note takers and others are not. Your
5 deliberations at the end should not turn into a
6 contest between those who take good notes and those
7 who do not. I know I always was one that didn't
8 take very good notes so if you're in the same
9 situation I understand. But also, as the judges of
10 the facts you have the duty to evaluate witnesses
11 and sometimes what we call the demeanor of a witness
12 can be an important factor in a trial. If your
13 head's buried in a notepad you may miss something
14 that's important during the trial.

15 Second thing to keep in mind -- and I've
16 already mentioned this -- is when we are in breaks
17 or in recess you cannot discuss this case with
18 anyone, including amongst yourselves. If someone
19 comes up to you attempting to discuss this case, you
20 let the bailiff know. They will let me know and I
21 will tend to that. You cannot discuss the case with
22 anyone.

23 Final thing is, you may not deliberate amongst
24 yourselves until I instruct you to do so at the end.
25 When you're in the jury room or at lunch or

1 wherever, you can't talk to each other about the
2 case. You can talk to each other about anything you
3 want to but this case. As I mentioned before, if
4 you encounter one of these attorneys outside, and
5 sometimes that's unavoidable in a courthouse,
6 they're not going to talk to you. They're not going
7 to have any contact with you. Again, it's not that
8 they're trying to be rude but they know they can't
9 have contact with you.

10 During the course of the trial there may be
11 objections that are made, an objection an attorney
12 makes over a particular piece of evidence or a
13 particular question or something in the trial. The
14 fact that I rule one way or the other should not be
15 interpreted to mean that the Court favors one side
16 or the other. My duty as judge is to make sure each
17 side receives a fair trial and that -- accordingly,
18 there may be times where we send you to the jury
19 room when we have an issue of law to take up outside
20 your presence. Again, that's not to hide things
21 from you. It's just to ensure that each side
22 receives a fair trial.

23 Now, I'm going to have you go to the jury room
24 now. Your first order of business before we break
25 for lunch is, I want you to elect a foreperson.

1 This will be the presiding juror over your
2 deliberations at the end. This will also be the
3 juror that communicates with the Court if there are
4 any issues that arise during the course of the
5 trial. Communication with the Court should be by
6 written note.

7 So, Mr. Bailiff, if you'll take our jury to the
8 jury room.

9 (The jury panel exits the courtroom.)

10 THE COURT: Okay. Any exceptions to my
11 preliminary instructions from the plaintiff?

12 MR. MCGOWAN: No, sir.

13 THE COURT: Any exceptions from the defense?

14 MR. BEIGHLEY: No, Your Honor.

15 THE COURT: Okay. When they come back with the
16 foreperson I'm going to go ahead and send them to
17 lunch and then the attorneys can -- I believe you
18 indicated y'all were going to try to get your
19 exhibits marked?

20 MR. MCGOWAN: Yes, sir.

21 THE COURT: So go ahead and do that. I'm
22 thinking it's almost one o'clock. We can start at
23 2:30 and -- since jury selection took a little
24 longer than I thought it was going to. But that
25 will give you an hour and a half for lunch and time

1 to mark your exhibits and prepare for your opening
2 statements.

3 So we'll stand down until the jury comes back
4 with a foreperson.

5 (Recess was taken.)

6 THE COURT: Let's go back on the record. We
7 have received a note from the jury. They have
8 selected Juror Number 26, Mr. Cabrera, as the
9 foreman.

10 So Mr. Bailiff, would you get our jury back for
11 us please?

12 (The jury panel enters the courtroom.)

13 THE COURT: All right. Ladies and gentlemen, I
14 have received the note that Mr. Cabrera has been
15 elected foreman.

16 Mr. Cabrera, when you come back in the
17 courtroom each time you'll sit on the end where
18 you're seated now.

19 JURY FOREMAN: Yes, sir.

20 THE COURT: Let's make this note a Court
21 exhibit. Hand that to the court reporter.

22 (Court Exhibit No. 1 was marked and entered
23 into evidence.)

24 THE COURT: All right. We're going to go ahead
25 and break for lunch. I know you've been here all

1 morning. It's one o'clock. Be back in the jury
2 room shortly before 2:30. Trial will begin at 2:30.
3 I hope everyone has a good lunch. Remember my
4 instructions. You can't discuss the case, can't do
5 research and can't deliberate. So everyone have a
6 good lunch and we'll see you at 2:30.

7 (Lunch recess from 1:00 to 2:30 p.m.)

8 THE COURT: Thank you. Thank you. Y'all be
9 seated. All right. Anything from either party
10 before we bring our jury in?

11 MR. MCGOWAN: Not from the plaintiff, Your
12 Honor.

13 MR. BEIGHLEY: Nothing from the defendant, Your
14 Honor.

15 THE COURT: Okay. Mr. Bailiff, if you'll get
16 our jury for us please, sir.

17 (The jury panel enters the courtroom.)

18 THE COURT: Thank you. Ladies and gentlemen, I
19 hope everyone had a good lunch. We are ready to
20 begin the trial. We'll start with opening
21 statements.

22 Mr. McGowan?

23 MR. MCGOWAN: May it please the Court, Your
24 Honor. I am Chad McGowan. I'm a lawyer here in
25 Rock Hill. I am representing Ms. Lorrie Dibernardo.

1 This case is about her husband Anthony Dibernardo or
2 Ant as he was known. Lorrie and Ant were from York
3 County.

4 With me is Taylor Strain, an associate in my
5 office, and Farr is a relatively new South Carolina
6 lawyer and he's in my office as well. What we as
7 lawyers have to do is watch a number of trials.
8 They're called 403s. So he's here because he wants
9 to be but also because he has to be, if he wants to
10 try a case one day.

11 But let's talk about -- let's get to what this
12 case is about. Whether we want to admit it or not,
13 health-care is a big business. Hospitals and
14 doctors who perform procedures, they -- they're part
15 of that business. And whether we want to admit it
16 or not, hospitals have become more of a processing
17 plant really than a place of rest and recuperation.
18 If we're lucky, we get to go home out the front door
19 in our car, but if things go wrong, we go out the
20 back door to the funeral home.

21 And the safety of the patients relies upon the
22 doctors and the other medical professionals
23 following the rules of care called standards of
24 care. If you don't do procedures the way they're
25 supposed to be done, people get hurt and they can

1 die from that. The medical community knows this.

2 We're here about a cardiologist and there's a
3 whole specialty of cardiology. And there's a group
4 called the American College of Cardiology and that's
5 all -- pretty much all the cardiologists in the
6 country, and they get together and agree on what is
7 modern day good medicine. And of course, that
8 changes and evolves over time. You know, medicines
9 come into favor. They get to studying and it
10 doesn't work or procedures are done different ways
11 and all that. But at any given time they generally
12 agree on what's the best thing to do and how to do
13 things.

14 If the doctor doesn't do that and they hurt
15 somebody, they would have fallen below the standard
16 of care and the law says that they are responsible.
17 Those are the minimum standards they are supposed to
18 adhere to.

19 That's especially true when you have
20 specialists that are -- you know, they make their
21 money doing procedures and part of the deal is, I'll
22 let you do this to me if you do it the way you're
23 supposed to do it. If the doctor doesn't do it the
24 way they're supposed to do it and you get hurt, the
25 law provides a remedy for that and that's why we're

1 here.

2 This case involves a cardiologist, Dr. Mori,
3 causing a fatal injury to the heart of Anthony
4 Dibernardo. The injury was caused quite simply by
5 the doctor getting in a rush and not doing the
6 standard, everyday, normal procedure for this type
7 of case. You're going to hear a lot of
8 explanations, I guess we could call them at this
9 point, but fundamentally that's what happened.
10 We're going to prove it to you.

11 This heart injury caused a tear or an abrasion
12 or an injury, however you want to call it, to the
13 surface of Mr. Dibernardo's heart, and as a result
14 he started bleeding. He started bleeding so bad
15 that the blood had to be taken from around his heart
16 and put back in him while he awaited emergency
17 surgery. That emergency surgery led to him being on
18 a ventilator, which he was taken off of and then he
19 was put back on because he couldn't deal with it.
20 And then he was taken off again and the family was
21 faced ultimately with the decision of -- what they
22 were told was, if he goes back on that ventilator
23 he's going to never come off of it or he'll die very
24 shortly thereafter. So the family made a hard
25 decision and said, well, let's let him go.

1 This case is about a procedure called
2 pericardiocentesis. It's a heart procedure, and of
3 the procedures that cardiologists do this is a
4 pretty simple one. It involves draining fluid from
5 around one's heart. We're going to get into why
6 this occurred and all that sort of thing. But we
7 have a normal heart. It is surrounded by a sac.
8 Everybody's got one. So it's literally a bag that
9 your heart is in and that's called the pericardium.
10 Peri just means, I guess, around cardium. And it's
11 a fibrous membrane. It's -- normally there's not a
12 ton of fluid in it. There's just enough in there,
13 inside that sac to lubricate your heart so that it
14 can be -- it helps protect the heart from insults
15 and bruises and stuff like that. Normally there's a
16 very thin layer around the edge of the sac. You can
17 imagine if your heart's in a sac there's a very thin
18 layer to just lubricate the heart to do its
19 business..

20 Mr. Dibernardo had a condition called
21 pericardial effusion and that is where there's a
22 build-up of fluid between the heart and the
23 pericardium. Sometimes this can arise emergently.
24 This can arise on an emergency basis. Somebody gets
25 in a car wreck, for instance, and they can get

1 bruised on their heart. It starts bleeding in the
2 sac and then you've got to go in quick, fast and in
3 a hurry to get that stuff out of there; otherwise,
4 your heart gets a condition called tamponade which
5 just says there's too much fluid outside the heart
6 and the bag doesn't give so your heart can't beat
7 well.

8 Mr. Dibernardo's build-up of fluid was
9 different. It was chronic. He had a -- he was born
10 with a condition called Noonan's syndrome and that's
11 just a genetic condition. It made him -- his facial
12 features be a little bit different and it made him
13 have a pretty large heart. That's called
14 cardiomyopathy, which just means that he was born
15 with a big heart. What you'll find interesting is
16 that he was born with both a literal and a
17 figurative big heart in this case.

18 He had been seen by Carolina Cardiology for
19 about eight years before this happened continually.
20 He was treating normally from Carolina Cardiology
21 and his normal doctor was Dr. Jay K. Shah. Dr. Shah
22 had been monitoring him and adjusting his
23 medications and doing all the normal stuff that one
24 would do for a cardiac patient.

25 In July of 2013 Mr. Dibernardo started having

1 some swelling and it was getting a little bit worse.
2 He reported some shortness of breath, that he would
3 walk around -- his walking around more than normal.
4 So Dr. Shah knew that he had a pericardial effusion.
5 He knew that. This was dated back to at least 2009
6 through the medical records. So Dr. Shah said, you
7 know, you're getting a little short of breath.
8 Let's figure this out.

9 So he puts him in Piedmont. Puts him into
10 Piedmont on July 19th and part of the deal was they
11 were going to take a look at the heart chambers and
12 make sure there was -- you know, the arteries were
13 clear enough and he wasn't at 50 -- and then it came
14 that they recommended a procedure called a
15 pericardiocentesis.

16 Now, before this Dr. Shah had spoken with
17 Anthony Dibernardo and said, there's two ways really
18 to treat this. One, we could do a surgery where
19 they cut you open. It's called a pericardial
20 window. They cut a little hole in your chest and
21 let the fluid out. The other way is a
22 pericardiocentesis and that's done with a needle and
23 a catheter and they drain that fluid out. Mr.
24 Dibernardo chose the pericardiocentesis because he
25 was told it was the safest way to do it. He was

1 nervous about it but he agreed to do it.

2 So on July 22nd this procedure is done by Dr.
3 Mori. Now, Dr. Mori had not seen Mr. Dibernardo
4 before and that was the first introduction and I --
5 part of that relationship was not -- out of all the
6 times that he had seen Carolina Cardiology Mr.
7 Dibernardo only saw Dr. Shah. Dr. Mori was not his
8 doctor but he was the one that was going to be doing
9 the procedure.. So what is this procedure?

10 Basically -- and we're going to have experts
11 and doctors tell us how to do this but what you're
12 doing is you're inserting a needle into that sac and
13 then you feed a catheter -- a wire through it and
14 then you feed a catheter into that and let all that
15 stuff drain out. This is not done blindly. It
16 should never be done blindly. There's
17 echocardiography done. An echo is -- anybody that's
18 had a child that's had ultrasound, that's what that
19 is there. So echocardiography. There's fluoroscopy
20 which is x-ray video. And then there's another
21 method called EKG guidance.

22 So the way this is supposed to be done is --
23 we'll have all this stuff for y'all to look at but
24 it started with -- this is actually a
25 pericardiocentesis needle. It's not the smallest

1 thing you'll ever see. It's kind of big. And what
2 you'll do is you'll visualize where you're going
3 with the echo and the fluoro so you know where
4 you're at, and then because there's no real question
5 where the anatomy should be you should know exactly
6 where to stop it because you can see it.

7 Mr. Dibernardo had a big heart. He also had a
8 really large layer of fluid around his heart.
9 Dr. Mori measured it at around 4.3 centimeters,
10 which is about an inch and a half thick layer of
11 fluid, so this was not a small, slip it through the
12 window seal kind of area. This was a pretty
13 significant area.

14 So he had the patient on the table. And you
15 know where your anatomy is. You know where the
16 heart pieces are. You know where the fluid is
17 because you've seen it on fluoro and echo. And then
18 you take your needle and you attach an EKG clip to
19 it. It's a cardiac lab where this happens. And
20 your patient is on the table and he's got, you know,
21 EKG things -- I don't know if y'all have ever had
22 those but it's those electrodes that monitor your
23 heart. You take one off of -- it looks like it's
24 lead number five is what they're saying -- and you
25 clip it to here, so that means that your needle is

1 now connected to your EKG machine.

2 So you start advancing this needle into your
3 patient and that membrane gives a little pop when it
4 goes through. At the same time you're doing all
5 this you're pulling back on this syringe -- it's
6 called negative pressure -- so that when you hit
7 that fluid pocket you know because it starts filling
8 with fluid.

9 The EKG is on there. The clip is on there so
10 that you'll know if you touch the heart -- I don't
11 know if you remember the game of Operation but if
12 you touch the heart and you connect the circuit it
13 gives a signal and that's what that EKG clip will do
14 before you can do damage to the heart. You never
15 jab in. It's a slow insertion. Pretty basic rules
16 like look where you're going, go slow and be
17 patient. So you insert this needle into the
18 patient, pull back. It's called aspiration and pull
19 back the fluid. It should be pericardial fluid
20 coming. In this case it was pinkish, which is not
21 uncommon. If it's blood in your syringe that means
22 you hit an artery or a vein or you hit the heart.
23 If the EKG is indicating that it tells you to stop,
24 you should be going slow enough that you don't
25 injure the heart before the EKG can tell you to

1 stop.

2 You'll then take off your syringe. You can
3 verify placement. They call it agitated saline.
4 You just run bubbles in it and look at it on echo
5 and make sure you're in the right spot. You'll see
6 the little bubbles on your echo. You then run your
7 wire down this. The wire is called a J wire and
8 that needle is hollow. You'll feed this little
9 thing through it. It's very soft. It's actually a
10 big spring. It's not like a wire, wire. You feed
11 that down your needle, into your patient. Figure
12 out where you want to be with that. And you can
13 either take a look at this part on fluoro, the x-ray
14 part, or you can go ahead and feed in your catheter.

15 Now, your catheter goes on top of your wire and
16 so you'll slide your catheter down the wire like
17 this. Slide your catheter down the wire. This is
18 not the actual catheter that was used. This is
19 similar but not the same. We'll get into all that
20 down the road. So your wire is now in the patient
21 and you've had your needle stick. This is inside
22 the heart bag, the pericardium of the patient. You
23 feed your catheter down it and you can take a
24 picture of where everything is pretty much whenever
25 you want. Then you pull your wire out and you're

1 left with the catheter. You're then supposed to put
2 some dye in the catheter to make sure you're in the
3 right spot. You can see the dye comes up. It's
4 called radiopaque. It just says it shows up on
5 x-ray.

6 So this catheter will be in the pericardial
7 sac. You put in your dye to make sure you're in a
8 good spot and that it looks right, and then you
9 start draining fluid. You drain fluid until there's
10 no more fluid to be drained. The general rule of
11 thumb that cardiologists will tell you about,
12 generally speaking, if you get to the point where
13 you're an ounce -- 25 cc's per hour, which is about
14 an ounce per hour, it's a good idea to take a
15 bathroom break. That's the way it's supposed to
16 happen. Once you're in there, your catheter's in
17 there and it's draining properly you stop. You let
18 that fluid drain, and if there's some reason to
19 think there's a problem you then investigate the
20 source of the problem and you take the appropriate
21 measures. That's the way it's supposed to happen.
22 That's the way it did happen until we get a little
23 bit further into this procedure.

24 Now, medical records, there are lots of medical
25 records for every patient for every procedure. In

1 this case -- this is already actually in evidence.

2 This is a timeline, which is going to end up being
3 very important for our purposes in this case. .

4 This is called the cardiac cath lab report.

5 This is created by a lab tech who actually sits in a
6 separate area of the room. I want you to envision
7 that if this was the procedure table right here
8 you're going to have above this your C-arm which is
9 your fluoroscope, your x-ray camera; you're going to
10 have a bunch of screens up for EKGs and video and
11 everything where you can see. In this case there's
12 an echo tech there with one of those echo machines.
13 You know, the ultrasound that you can see. Then
14 probably about here there's glass, there's speakers
15 and there's microphones picking things up, and this
16 person's job is to record what happens and when it
17 happens. And that's what this cath lab report is.

18 For instance, it has the basic stuff like who's
19 here, Dr. Mori; who's the circulator; who order this
20 particular, some medicines, a cardiologist in the
21 same group. It has the people that are there
22 involved. Then it has some assessments and whatnot.
23 This is all very normal, standard. We have a list
24 of medications, a list of vital signs. We're going
25 to get into this very detailed, going line by line

1 in this trial.

2 But we then start with a timeline. So this
3 patient was logged in at 8:01 and they start taking
4 vital signs: 8:21 100 percent O2 stat. That's
5 where you want to be. BP here was 114/54. The mean
6 -- the third number is -- the third number, the 75,
7 that's the mean arterial pressure. That's just the
8 mean average between 114 and 54. That number's
9 going to become very important but right now 75 is
10 good.

11 So we go through our procedure and you'll
12 notice all these times, these are events that occur.
13 It's timed to the hour, the minute and the second.
14 Dr. Mori arrives -- this is where he shows up at
15 10:32 so the patient's been there about two and a
16 half hours and Dr. Mori then arrives. Patient's
17 been monitored and medicated. That's what this
18 stuff is. This is all vital signs. Versed is
19 medication. Fentanyl is a medication. Those are to
20 relax the patient. Those are conscious sedation.
21 All very normal until we get to here.

22 So what happens? What starts happening? At
23 10:42 -- excuse me. At 10:40 and 42 seconds is when
24 the echo tech arrives. When you're going to do this
25 procedure you need the echo tech there to help run

1 the machine. And then we have a puncture to the
2 chest wall. That's what you do. So it's all
3 looking good at this point. 10:42:52 percutaneous
4 puncture to the chest wall. No problem. Catheter
5 inserted over the guide wire. Absolutely normal.
6 They start drawing out fluid at 11:07:35 -- excuse
7 me -- yeah. They inject contrast into the
8 pericardium at 10:50.

9 This is the same record we just saw, just cut
10 up a little bit. So we have the first fluoró image
11 that we have -- I'll show you here -- was at 10:50.
12 All right. This is the first fluoro and what you
13 see here is, these are ribs. This is Mr.
14 Dibernardo's diaphragm and this is the catheter that
15 was put in. It comes up and over and back, and for
16 his situation that's not a problem at all. That's
17 what it should look like and that's normal and
18 that's appropriate. What you'll see is some
19 cloudiness coming out of the end of the catheter,
20 and that's where Dr. Mori injected contrast into the
21 catheter. And that's the verify the placement of
22 the catheter. Sounds good. It's what you do.

23 It's important to know and what Dr. Shog
24 tomorrow will go over with you is that -- to watch
25 the contrast flow from right to left nicely, gently

1 and evenly inside the pericardial space. I'm going
2 to play that one more time. So you're going to see
3 the contrast in sort of a fog almost go across.
4 That's perfect. That's what you do. If Dr. Mori
5 had stopped here and not done anything else, Mr.
6 Dibernardo would be here and we wouldn't because
7 that is a catheter that's placed the way it should.
8 There's no injury of any kind. He's stable, vital
9 signs are stable. That would have been fine but
10 that's not what happened.

11 Dr. Mori said in about the first -- we have
12 this data -- about the first 15 minutes a liter and
13 a quarter of fluid came out from his heart sac.
14 That's a lot. Dr. Mori said it wasn't coming out
15 fast enough so what he decided to do was to put in a
16 sheath.

17 Now, I took Dr. Mori's sworn testimony. It's
18 called a deposition. He gave us, I think, four
19 different versions of it when he answered the
20 question, why did you change out the equipment? The
21 tie that binds them all is fluid wasn't coming out
22 fast enough. Now, remember this was now at 10:30,
23 10:45 in the morning and he still had Mr.
24 Dibernardo. He was going to do three procedures
25 that day: the pericardiocentesis plus both a left

1 and a right heart catheterization. So this was
2 going to be the first of three procedures that Dr.
3 Mori was going to do on Mr. Dibernardo that
4 particular day.

5 So Dr. Mori decides that he doesn't like the
6 speed at which the fluid is coming out of the heart,
7 so he decides to change equipment and he does that,
8 swapped out for something called a sheath. This is
9 a sheath, and inside the sheath is a hard blue
10 plastic tube that's called an introducer or a
11 dilator. The way that you are supposed to -- you
12 have to learn to do this. The way you're supposed
13 to do it is you feed your wire back onto your
14 catheter. You've got your catheter in your patient.
15 That's the thing that's going round and round. You
16 shove your wire down the catheter and pull your
17 catheter out and leave your wire. So now you've got
18 your wire in the same spot the catheter was in. You
19 then feed the wire -- the sheath and the dilator on
20 top of the wire and push this in. You've got to
21 always protect the end of this with the wire until
22 you get your sheath where you want it to be. Then
23 you pull your wire out.

24 Now what have you got? You've got your sheath.
25 Then you can take out your introducer. That's the

1 hard part. Now you have a sheath. What Dr. Mori
2 did at that point is he put another catheter into
3 the sheath. So he fed another catheter and put it
4 into the sheath. You're going to see some video on
5 this in a little bit but he did this. Okay? Then
6 he shot some more dye in there and then he pulled
7 out the catheter and shot some more dye in there.
8 What the evidence will show you is that shortly
9 after he removed the catheter the second time Mr.
10 Dibernardo's blood pressure started to drop and
11 dropped significantly. He also started having frank
12 blood -- just blood come out.

13 Now, there's going to be some question about
14 time but this is just the timeline we put together.
15 This is blood pressure. This is the high number,
16 the low number and the dot is the mean arterial, the
17 MAP. Right? This line is 60, 60 millimeters or
18 MAP. If you're above 60, that's what you need to
19 have to make sure your brain gets enough blood.
20 Below 60 it's a problem. Dr. Mori will tell you
21 this. So as long as the dots are above the blue
22 line you're doing all right. What happened here --
23 and this is the timeline showing this is where the
24 original puncture occurred, inserted that first
25 pigtail cath which we saw right there. He then.

1 injects the contrast here, which this time on this
2 timeline -- this is on the hospital timeline -- is
3 that right there.

4 He then, forward nine minutes later, puts in a
5 sheath. It's going along. He injects contrast.
6 I'm going to show you that video next and this is
7 the first time we see [inaudible]. He then removes
8 the pigtail catheter and we see our dots start to
9 drop. He then calls the surgeon. And over here is
10 where he starts taking the blood out of the sac
11 around the heart and putting it back in the patient.

12 That's what happened. That's just -- this is
13 not a question of opinion or speculation. That's --
14 this is just true. It's just true. This is the
15 second fluoro. Right? So this is after the sheath
16 was inserted, after that catheter was put back in
17 and it's indicated on the chart contrast injected.
18 So what do we see now? We see sheath to here. We
19 then see catheter coming out of the sheath and it's
20 down -- and it's embedded down in the surface of the
21 heart. This is where contrast or dye is going into
22 the muscle of the heart and if it does that, that
23 means there's heart injury. That means that the
24 heart has been injured. And that's before this.

25 So let's look at the video and you'll see the

1 way this stuff -- the heartbeat. There's a couple
2 things to point out: One, you can see the dye
3 rushing in. That's initially. So we see it comes
4 in so we know what's going on there. This area is
5 what I want you to concentrate on. The catheter
6 goes inside the heart. This stays with the
7 heartbeat. You're going to see that movement with
8 the heartbeat. What does that tell us? Well, the
9 first video tells us that the first catheter was in
10 a prime spot. There was no sheath. There was no
11 injury, no staining. Nicely fog over right to left
12 just like it should. This tells us that there's now
13 an injury to the heart and the only way that can
14 happen is if you don't put in your sheath right.
15 I'll explain that to you in a second. This is
16 unequivocal -- this is heart injury. That's what it
17 is.

18 There was another fluoro done. This is number
19 three. This is after the catheter from the sheath
20 was removed and this is the end of the sheath.
21 Remember, it's in about the same spot that it was
22 when it had the catheter in it. See it's in the
23 same general neighborhood, the end of it is, but
24 this time there's no catheter.

25 This video is after the pigtail was removed --

1 the second pigtail was removed so what does this
2 show? Where I want you to concentrate on is this
3 area. Okay? I'm going to play that and we're going
4 to talk about it. You see dye going in and what do
5 we see up there? We see a rhythmic heartbeat and we
6 see that stain. This stuff is staining right here
7 and that's dye coming out staining the heart tissue.
8 What does that tell you? There's an injury there
9 too. That's not a question of opinion. It's just
10 -- it's just the way it is. So the second video
11 pigtail was removed; there's more contrast and
12 things start going downhill.

13 So how does that happen? It happens because,
14 number one, Dr. Mori decided to swap out what was in
15 a good spot because he wanted to get it done
16 quicker, decided to put a sheath in. The other way
17 it happens is what the testimony will show you is
18 that if you don't insert the sheath right. The
19 sheath itself is -- it's not -- I wouldn't say, soft
20 but it's not -- it may hurt you but it's not
21 relatively hard. The dilator, however, is a hard
22 plastic that the inserter goes inside of, which
23 gives this stiffness. This, we will show you, is
24 what caused the injury to Mr. Dibernardo. It should
25 have never been put in in the first place, and in

1 the second place it ought to have been put in
2 properly.

3 The only way to get an injury like this is if
4 you're not paying attention to what you're doing and
5 how you're putting this in and frankly if you do not
6 keep the wire fully out of the dilator. If the wire
7 is inside it, it's not going to be able to make a
8 gouge or an injury of any kind to anybody's heart.
9 It's just not. That's why the rule is what you've
10 got to do is you've got to keep the end of this
11 thing protected with your wire. You can watch it
12 the whole time or you can do it by feel or you can
13 do it -- you've just got to make sure it happens.
14 That's not what happened here.

15 The way this injury occurred, Dr. Schob will
16 tell you tomorrow, is that the wire was allowed to
17 come back revealing this, revealing this as a point
18 of injury, which then injured the heart which when
19 you remove this what do you have now? Well, you
20 have this tip in your injury of the heart. And then
21 what happens when you put your catheter -- put your
22 catheter in there and it's in the injury of the
23 heart. The first place the catheter tip goes is
24 where the tip of this thing was. And then you start
25 pushing it out and what do you get as a result?

1 Well, you get this.

2 Notice a couple of things here. Your sheath --
3 your catheter has a very tight angle on it and the
4 end of that catheter is now embedded into the heart.
5 He shoved dye in there. It stains it. You can see
6 it. The only way to get the end of the catheter
7 embedded in the heart to make that is if you don't
8 do this properly and if you don't protect the end of
9 this dilator, and if you do it when you didn't need
10 to do it to begin with.

11 That's what this case is about. That's what
12 happened. That's why we're here. Because what this
13 then caused was Mr. Dibernardo to start bleeding
14 inside that heart sac. That blood turned to just
15 more blood and Dr. Mori properly called the heart
16 surgeon, an open-chest surgeon to come in and said
17 if we don't get this dealt with you're going to --
18 this man's going to die.

19 So what he did is he started autotransfusing,
20 which is when you take the blood out of the sac and
21 you put it back in the patient so that hopefully it
22 will maintain the circulation, and you start giving
23 him drugs, Levophed. Those are called pressors, and
24 what they do is they clamp down your arteries and
25 your veins and they help to raise your blood

1 pressure. Because at this time when our MAPS are
2 this low, when the dots are below this line, we're
3 in a bad way, and we're in a bad way such that we
4 have to maintain and raise that blood pressure with
5 volume, with his own blood and with drugs.
6 Otherwise, even if your patient lives, he's going to
7 have pretty bad brain damage. This is not a
8 10-minute period when he was below this line.
9 That's just the drill.

10 Mr. Dibernardo then went to emergency surgery.
11 Dr. Savage did the procedure and he evacuated a
12 large clot -- it was three-by-two inches big. We
13 have reports on it -- and put some SurgiSeal -- he
14 found an area of the heart that was oozing at that
15 time. Put some material on it called SurgiSeal,
16 which is kind of like plumber's putty almost for
17 doctors. During this procedure in surgery he's on a
18 ventilator at this point. Anesthesia is maintained
19 and circulation and his heartbeat.

20 And he never comes off that ventilator but he
21 does two days later and the doctor, Dr. Wooten says
22 -- she's the critical care pulmonology specialist
23 and she's now taking care of him in the ICU --
24 Mr. Dibernardo is, seems to be doing okay so Dr.
25 Wooten says, I'm going to take you off the machine.

1 So she unplugs the vent, took the tube out from down
2 his throat and he breathes on his own for a little
3 while. For whatever reason, it doesn't work. Puts
4 him back on the ventilator. Breathes for him for
5 another day or so and said we're going to try this
6 again tomorrow. So tomorrow comes -- and it's
7 relatively early 9ish, 8ish. Dr. Wooten takes the
8 tubes out and Mr. Dibernardo is breathing at that
9 point. That's good. And towards about 4:30 --
10 4:00, 4:30 in the afternoon he starts having trouble
11 breathing.

12 Dr. Wooten meets with Lorrie Dibernardo, her
13 father-in-law and other family, her sister, were
14 then told at that point that if he goes back on it
15 he'll probably be on it for five to seven days and
16 then at that point he may live another day or two.
17 So they made the difficult decision to say, well, if
18 he's not going to make it anyway, he's not the kind
19 of guy that wants to live on a machine, so let him
20 go. That's what happened.

21 Why are we here? The law provides a remedy for
22 this sort of thing and it's important for all of us
23 that doctors be held accountable. And that's what
24 this case is about. It's about the loss to Ms.
25 Lorrie Dibernardo of her husband and her best friend

1 -Anthony -- Ant, like I said, as he was known. He
2 was -- this is a picture of Anthony Dibernardo. The
3 way his face looks is due to the Noonan's syndrome,
4 and along with that came a relatively short
5 stature -- he wasn't a huge fellow -- and a big
6 heart. And that was obviously well known to the
7 doctors who were treating him for eight years or so.

8 But he and Lorrie found each other. This would
9 have been in 2004 and they met online. And they
10 were together for a total of nine years. They were
11 married for four years. Ant was the kind of guy
12 that just wanted to make other people happy. He was
13 disabled from the Noonan's syndrome. He --
14 sometimes people would be a little standoffish
15 because he looked a little different. But he
16 thought it was his job to try and make other people
17 happy and make Lorrie happy he certainly did; to
18 make his sister-in-law and brother-in-law happy he
19 certainly did. You'll hear from JC who's out there
20 and JC says, the best wing man I ever had was
21 Anthony Dibernardo. They were thick as thieves.
22 They -- Lorrie told me a story that Anthony -- he
23 was from New Jersey so he never went, probably,
24 fishing before. The first time she took him fishing
25 he caught a fish in like five minutes and was hooked

1 from that point forward. That's one of the things
2 he loved to do more than anything in the world.

3 So what is it that we have to prove to you?

4 Well, we have to prove to you that Dr. Mori didn't
5 do the normal thing, didn't follow the standard of
6 care and caused an injury to Mr. Dibernardo. That's
7 it. We think -- our evidence is going to show that
8 the only way this injury happened was from this
9 dilator and this sheath. It wasn't put in right and
10 never should have been put in at all because there
11 was no rush. You can't rush through this thing.

12 If we prove that by a mere preponderance of the
13 evidence under the law, what's sort of the response
14 to all this? Well, it's -- they say that he
15 probably injured the heart when he stuck the needle
16 in the first time. Now, why that's a defense we
17 haven't quite figured out but what they're saying is
18 that the injury occurred with the initial insertion
19 of the needle. Now, what that is going to show you
20 is the EKG -- he says he was using it in every
21 signal -- when he drew back there was never any
22 frank blood in it, which there should have been.
23 The space was a good inch, inch and a half to get so
24 nobody should have done that and then the blood --
25 he's going to say that the blood came out earlier

1 and that's why the sheath was put in. Now, you're
2 going to have to get to the bottom of that.

3 And his medical record -- he actually dictated
4 a medical record within minutes of this happening
5 and didn't mention that. He said that blood
6 pressure was dropping and blood was coming out,
7 which would have put it over here. That's what he
8 said back then but now he says that he was bleeding
9 -- initially he says it wasn't coming out fast
10 enough and he was decompensating. His blood
11 pressure was dropping. That's what he said. He has
12 four different versions of his answer. We'll get to
13 them all.

14 So the first thing he says is, I put the sheath
15 in because the blood pressure was dropping. That's
16 just -- that's just not what the facts will show.
17 So then he changes his answer to, I put the sheath
18 in because it wasn't coming out fast enough and the
19 color started changing. And then he started to say,
20 well, I put the sheath in because it wasn't coming
21 out fast enough and because he was decompensating
22 and blood was coming out. And then he finally
23 settled on, it wasn't coming out fast enough and
24 there was blood coming out.

25 You're going to have to figure out the facts.

1 That's why y'all are here. But at the end of the
2 day it's going to -- a question, legit question
3 should be asked is, even if it was the needle why is
4 that admitting he's not responsible for it? Because
5 if you do it right -- and he'll testify to this.
6 He'll say if you do what you're supposed to do
7 right, you don't injure the heart, and you certainly
8 don't injure it in this way. If you're using echo,
9 you know where you're going. If you're using
10 fluoro, you know where you're going. You got your
11 EKG and you contact the heart, you know it. You
12 pull back, you see blood. You know you've got a
13 problem so what do you do? You inject contrast to
14 see if you're in the right spot.

15 So if it was, in fact, the needle, which we
16 don't think it was, that's still, we say, Dr. Mori's
17 responsibility. At the end of the day Dr. Mori
18 needs to take responsibility for the fact that he
19 caused the injury to this man's heart, caused the
20 death.

21 Now, this is not the best way to solve ,
22 problems. It's the best way America has come up
23 with: jury trial. Y'all are going to be asked to
24 decide if we've proven our case or not, and then
25 you're going to be asked to decide, if we have, what

1 damages are assessed. It's a crass, it's a rude
2 process. It's money and it's somebody's loss of
3 their husband and best friend but it's what we do.

4 At the end of this trial we're going to ask you
5 for a verdict, and we're going to ask you for a
6 verdict for \$2 million based upon the loss to
7 Ms. Lorrie Dibernardo. It's up to you what you do
8 but that's what we're going to be asking you for at
9 the end of this trial.

10 And we're going to be as efficient as we can.
11 We're going to have family members, doctors,
12 Dr. Alan Schob who teaches this in Atlanta and he's
13 coming in first thing tomorrow. And then we're
14 going to have Ms. Dibernardo testify last and
15 hopefully we'll have the evidence in this case done
16 by Wednesday. That's what we're here about and I
17 appreciate it very much. Thank you.

18 THE COURT: Mr. Beighley?

19 MR. BEIGHLEY: May it please the Court.

20 Mr. Foreman, members of the jury, I'm George
21 Beighley. We met a little while ago. My son George
22 and I represent Carolina Cardiology and Dr. Naresh
23 Mori.

24 After the last 45 minutes you probably
25 understood why His Honor told you, wait until the

1 end of the case. Don't decide anything until you've
2 heard all the facts. Don't decide anything until
3 you hear the law. Because there's two sides to this
4 case. I ask you to remember that neither myself nor
5 Mr. McGowan are physicians. We're lawyers. This is
6 a medical case. It's a very technical medical case.
7 So you're going to have to listen to experts in the
8 field of cardiology, including Dr. Mori. You're
9 going to have to keep an open mind. As much as you
10 might think at one point in time that a certain
11 thing is true, wait until you've heard everything.
12 See, I go last. I don't get to come up here first.
13 I have to wait.

14 I want to tell you a little bit about the legal
15 framework that's controlling our activities today.
16 It's called the law of medical malpractice. And the
17 judge will tell you the law so if I say something
18 that differs from what he tells you, you pay
19 attention to what he says, of course. But a doctor
20 is charged with following generally accepted
21 standards of medical care in the care he renders to
22 a patient, and the law realizes that medicine is an
23 inexact science, that procedures have risks as well
24 as benefits. The judge will tell you that just
25 because an adverse result occurred, just because the

1 treatment wasn't successful in no way indicates that
2 malpractice occurred. There must be a finding that
3 the defendant physician violated generally accepted
4 standards of care in the treatment that he rendered
5 the patient.

6 We submit to you at the end of the day when you
7 have heard all of the evidence, all of the
8 testimony, all the experts and the judge gives you
9 the law, you will realize, as we do, that this was a
10 complication of a procedure that occurred without a
11 departure from the standard of care on the part of
12 Dr. Mori.

13 Now, I want to go back and tell you what I
14 believe the facts will show, and at the end of the
15 day you'll compare those with what counsel said.
16 Make your own determination. Mr. Dibernardo had a
17 serious congenital condition, Noonan's syndrome. It
18 affected his heart. It affected his lungs. It had
19 numerous effects, including congestive heart
20 failure, heart wall failure, a massively enlarged
21 heart. He couldn't process fluid so he was
22 swelling. His lower extremities were swollen up.
23 His stomach was -- had fluid in it. It became
24 increasingly hard for him to breathe with any amount
25 of effort whatsoever. And his symptoms progressed

1 over the last several months.

2 Dr. Shah was his cardiologist. Dr. Shah sent
3 him to see a number of specialists, including a
4 surgeon, and Mr. Dibernardo decided he did not want
5 to have surgery to deal with his problem. That was
6 his right. You don't have to have surgery. But he
7 was offered a procedure known as pericardiocentesis
8 and a cardiac catheterization, and he elected, with
9 disclosure of the risks, to accept this procedure.

10 Bleeding was one of the known risks. It can
11 happen when you work on the human heart. Bleeding
12 can occur. It's not like a clear picture of some
13 immobile object. You've got an organ that's moving
14 in and out and side to side and you've got an
15 enlarged heart. You've got a massive pericardial
16 effusion and you're trying to do the very best you
17 can to get the needle in the right place.

18 And what happened in this case, as Dr. Mori
19 will tell you, is when that needle went in it came
20 in contact with an artery or a vein on the heart,
21 and when that happens it doesn't set off the EKG or
22 ECG alarm and say, oh, the needle's made contact
23 with the heart.

24 I've got here a model of the heart and we'll
25 talk about this with various witnesses as the trial

1 progresses. But you'll note that the background is
2 a dark brown, reddish muscular area which represents
3 the heart muscle because that's the strongest muscle
4 in the body. It's a muscle and that muscle has to
5 be nourished. These red and blue lines here are the
6 circulation system for the heart. That's how the
7 heart gets its nourishment. So if you've got a
8 bigger heart like Mr. Dibernardo had, you're going
9 to have to have a bigger basket of system to service
10 it.

11 And so when a sharp needle, like you saw, goes
12 in there, you don't get to look at it like this.
13 You're looking at it through a two-dimensional
14 image. You put that needle in and if it contacts an
15 artery or a vein, guess what happens? Blood comes
16 out. And that's what happened in this case.

17 On the initial attempt to get that needle in --
18 Dr. Mori will tell you he had to make two or three
19 approaches to do it. He started out drawing the
20 fluid off. It started turning red and it got redder
21 and redder. And he's got -- he'll tell you about
22 what a pigtail catheter is. It's a catheter that
23 was drawing the fluid out. Now there's blood coming
24 out, and there's a lot of blood. More than should
25 be there.

1 So he becomes concerned that two things can
2 happen: Number one, this man can lose enough blood
3 so that his circulating blood volume could be
4 dangerously low, and number two, it can fill up that
5 sac around his heart and create tamponade. We'll
6 have testimony about what that is, but basically if
7 you think of the heart in a bag and it's beating
8 within that bag, if that bag's filled up with fluid
9 and the heart can't beat because there's no room for
10 it, then you're going to be dead for sure.

11 So he's confronted with this situation and what
12 he decides is, I'm not getting enough blood out of
13 this pigtail catheter. I've got to put in a larger
14 instrument. So he puts in a sheath. He calls for
15 the cardiac surgeon. The cardiac surgeon is with
16 another patient. He can't just run across the hall
17 into the room. So now you've got a man who's
18 bleeding. You're worried about cardiac tamponade.
19 You're worried about blood volume. So Dr. Mori
20 autotransfuses. He puts a line in the groin and the
21 blood that's coming out of the heart now goes into
22 the groin. And that allows this patient to be
23 stabilized in the cath lab.

24 You saw this chart here and it's interesting.
25 This chart cuts off at 11:35. Won't it be

1 interesting to see what happens after that?
2 Wouldn't you want to know that? Well, I'll tell you
3 what happens. His blood pressure comes back up. He
4 comes back. He's stable. At no time did he lose
5 consciousness. He was talking to Dr. Mori. He was
6 talking to the people in the cath lab. They note
7 his pain description in the chart, and they have to
8 ask him and he has to tell them.

9 So yes, yes, there was a low blood pressure
10 episode and that's my whole point. That's what Dr.
11 Mori was concerned about. And that change takes a
12 little while. If you've got blood coming out over
13 here, it's going to take a little while before that
14 loss of blood translates into these low blood
15 pressures.

16 Now, the surgeon does come in. Dr. Mori has
17 stabilized. The surgeon takes him to the operating
18 room and he finds an area in the heart that has been
19 abraded by the sheath that was put in to get the
20 blood out to save the man's life. It did not go
21 through the heart. It did not penetrate the heart.
22 Blood was not coming out of the inside of the heart.
23 It did not even require a suture. He put some
24 SurgiSeal on that area, which is a type of substance
25 that is almost like an artificial -- some of those

1 -- you've seen those devices you put on a cut that
2 feels stiff like a fibrous bandage or whatever.
3 That's a similar thing to SurgiSeal. The doctors
4 will talk about that. But that was the nature of
5 the injury to the heart, and that injury occurred in
6 the efforts to save this man's life, to get the
7 blood out that occurred from the initial start of
8 the procedure.

9 Now, he goes down to the intensive care unit
10 and is under Dr. Wooten's care. We'll have her
11 testimony by video. She will tell you what his
12 course was. He was tried off the ventilator.
13 Initially it didn't work so they tried the next day.
14 Plan was to see if he could be off the ventilator
15 and he did for a while, and then he had to go back
16 on. Dr. Wooten told Mrs. Dibernardo what the plan
17 was. She was going to put him back on the
18 ventilator. And then shortly thereafter
19 Mrs. Dibernardo and the family wanted to talk to
20 Dr. Wooten about this and they said --

21 MR. MCGOWAN: Your Honor, I hate to interrupt
22 an opening but this is...

23 THE COURT: Counsel, approach.

24 (Sidebar discussion.)

25 MR. BEIGHLEY: Family said he doesn't want a

1 nursing home, doesn't want rehab, does not want to
2 be on a ventilator. We categorically deny that
3 anyone said that he could be on a ventilator a week
4 and then he'd live two days. There's no evidence of
5 that in the record and we dispute that happening.
6 But the family didn't want this on him, didn't want
7 him to suffer. And they said because of the
8 progressiveness of his illness they didn't want him
9 back on the ventilator. So a decision was made.
10 Nobody criticizes that decision. That was -- it was
11 a family decision. But bottom line is, we got to
12 that point because -- not because of this issue of
13 negligence but because a known, potential
14 complication occurred during the original procedure.

15 You'll have testimony before you about what
16 would have happened -- and nobody is in dispute --
17 even the plaintiff's expert will tell you if he had
18 not gotten the treatment -- supposed he had just
19 keep swelling and kept having shortness of breath.
20 He was looking at that downward, end stage course,
21 if he hadn't even come in the door. He wanted to
22 try to see if he could get some relief, try to look
23 at a procedure to improve his quality of life, and
24 we tried to provide that for him. A known potential
25 complication occurred. Dr. Mori managed it.

1 appropriately.

2 At the end of this case I think that you will
3 agree with me, that the evidence, the testimony and
4 the law has the judge gives it to you will support
5 your verdict in favor of Dr. Mori and Carolina
6 Cardiology. Thank you for your attention.

7 THE COURT: All right. Mr. McGowan, call your
8 first witness.

9 MR. MCGOWAN: Yes, sir. Plaintiff calls Kelly
10 Gregory.

11 THE CLERK: Ms. Gregory, step forward here to
12 be sworn. Place your left hand on the Bible and
13 raise your right.

14 (Witness was duly sworn.)

15 DIRECT EXAMINATION

16 BY MR. MCGOWAN:

17 Q. Ms. Gregory, tell the jury who you are. What's
18 your name and where do you live?

19 A. Kelly Gregory. I am Anthony Dibernardo's
20 sister in law. I'm Lorrie's sister.

21 Q. Okay. Lorrie is your sister?

22 A. She's my sister.

23 Q. Okay. Tell me about Anthony Dibernardo.

24 A. He's -- I have four brothers and he was closer
25 to me than any of them.

1 Q. Did he spend a lot of time with you and your
2 husband?

3 A. He was actually our children's -- four
4 children's godfather.

5 Q. Okay. Now, you were aware of what was
6 happening when he was in the hospital in July of
7 2013?

8 A. I was.

9 Q. Okay. Did you ever visit him in the hospital?

10 A. I did. I was there most of the time.

11 Q. Okay. Tell me about your observations of
12 Mr. Dibernardo before the procedure
13 pericardiocentesis.

14 A. We were there with him before the procedure in
15 the room with him. He was nervous, scared about
16 having the procedure done. He didn't want to have
17 it done, and you know, he talked to us -- he even
18 told us he was scared of not, you know, coming out
19 of it because, you know -- he said, I know when I
20 get in there they're going to see me for my big
21 heart, my condition. They're going to look at me as
22 a person that -- they're going to use me as an
23 experiment.

24 Q. Okay.

25 A. That's exactly what he said: They're going to

1 look at me and my condition and they're going to
2 experiment on me. I'm scared to go in there and
3 have anything done.

4 Q. Was he mentally there? Was he active? I mean,
5 was he --

6 A. Oh, yeah. He was up walking around. You know,
7 yeah, he had some swelling. You know, he had
8 swelling the whole time I've known him.

9 Q. Okay.

10 A. In all the nine years that we had known him so
11 that was nothing new. Yeah, the swelling was
12 getting worse. He took water pills and things like
13 that and he was -- he was concerned about the
14 swelling but it wasn't to the point where he was --
15 he was still driving. He wasn't disabled to the
16 point where he couldn't get out of bed or anything
17 like that. And you know, everybody keeps saying
18 about this other procedure. You know, as far as I
19 know, the only thing they were supposed to do was go
20 in and reduce the swelling around his heart.

21 Q. Okay. Now, before he went to the hospital in
22 July tell me what kind of activities Mr. Dibernardo
23 did. Was he bedbound? Was he laid up? Was he --
24 what was he doing?

25 A. No. A month before -- it was my daughter's

1 senior year. She's the only daughter and she was
2 extremely close to him. She was graduating high
3 school and we had a graduation party the month
4 before. We had a southern party down in Hickory
5 Grove. There's a place -- it's a bar but there was
6 no alcohol. We had a party down there and there was
7 a pole in the back, and all the guys got back there
8 and did the pole dancing. Ant joined in and had a
9 great time.

10 Q. Just --

11 A. Pole dancing.

12 Q. -- trying to make everybody laugh?

13 A. He was a great storyteller, joked, laughed. He
14 was just like a big kid.

15 Q. Okay. And he was originally from New Jersey?

16 A. New Jersey. But he turned southern very
17 quickly.

18 Q. Okay. How did he treat your sister?

19 A. He treated her like a queen. I was sort of
20 jealous but I had my -- my husband's a good guy but
21 he did -- he did. He waited on her hand and foot.
22 He just -- he treated her better than any man I've
23 ever seen treat anybody.

24 Q. Okay. Now --

25 A. He was just --

1 Q. -- he looked a little differently?

2 A. Yeah, but it didn't -- you know, when you look
3 at Ant, you would look at him -- you know, people --
4 my husband almost got in a fight one time because,
5 you know, some teenage boys picking on him about the
6 way he looked. But once you get to know Ant -- it
7 doesn't take long -- you don't pay attention to the
8 way he looked because his personality was so much
9 larger than the way he looked. He was just that
10 type of person.

11 Q. Yeah.

12 A. You know, he just -- he loved to tell stories.
13 And I have some video and I wish I thought to give
14 you some of those when you came by the house but
15 he's -- I -- he was very photogenic. You saw some
16 that I took of him. I loved to do photography with
17 him because he loved to pose, and he'd crack jokes,
18 tell stories. He was just that type of person. He
19 could have been a professional comedian. You know,
20 it just -- he was that type of person. He was a
21 lively individual.

22 Q. Okay.

23 A. Had a great life ahead of him --

24 Q. Tell me what --

25 A. -- no matter what anybody says.

1 Q. You were there at the hospital with Lorrie
2 throughout that whole time?

3 A. Yeah.

4 Q. Okay. Did there come a time when you had
5 learned that there had been a problem during the
6 pericardiocentesis and he had a surgery?

7 A. After the surgery the doctor that performed the
8 surgery came out. I was with her in the waiting
9 room when he came out and said they had him in the
10 ER.

11 MR. BEIGHLEY: Your Honor, we'd object to what
12 somebody said --

13 THE COURT: Sustained.

14 BY MR. MCGOWAN:

15 Q. Okay. Let's not say what other people said,
16 mostly your observations. But you were there when
17 the doctor came out after the surgery?

18 A. I was there when the doctor came out and said
19 to me --

20 Q. No, no. Don't say what he said.

21 A. Okay.

22 Q. All right.

23 A. I wasn't in there during the surgery.

24 Q. I know.

25 A. I just know about what was told to me.

1 Q. And then did you see Ant in the ICU when he was
2 on the ventilator?

3 A. Yeah, I did.

4 Q. Okay. And then were you in -- was Lorrie by
5 his side during these times?

6 A. Uh-huh.

7 Q. Did she stay with him the whole time?

8 A. She was there.

9 Q. Okay. Were you there for when he got taken off
10 the ventilator the first time, when they unplugged
11 the vent --

12 A. The first time I was there, yeah.

13 Q. Okay. And did there come a time he went back
14 on that ventilator?

15 A. Yeah. He had to go back on there because,
16 yeah, his blood pressure had dropped and he couldn't
17 breathe on his own. He was not doing well at all.

18 Q. Struggling?

19 A. Yeah.

20 Q. Okay. Now, the next day when the decision was
21 made not to put him back on there, from what I
22 understand, you had gone home to get cleaned up and
23 had got a call; is that right?

24 A. Right. I got a call -- we got a call while we
25 were at home. We were about to leave to come back,

1 we got the call that he didn't make it. They had
2 taken him off and we had went to go get cleaned up
3 and come back, and he didn't make it.

4 Q. Okay. Tell me what kind of loss this has been,
5 from your observation, to Lorrie.

6 A. Hard. It's been hard on her.

7 Q. Okay. What about the rest of y'all? Do you
8 miss him?

9 A. Yeah, a lot.

10 Q. Your husband miss his buddy?

11 A. Uh-huh.

12 MR. MCGOWAN: All right. Thank you very much.
13 Mr. Beighley is going to ask some questions. Sit
14 tight.

15 THE COURT: Mr. Beighley, your witness..

16 MR. BEIGHLEY: Thank you, Your Honor.

17 CROSS-EXAMINATION

18 BY MR. BEIGHLEY:

19 Q. Ms. Gregory, I believe, if I understood your
20 testimony correctly, Mr. Dibernardo's swelling was
21 getting worse in the weeks before he passed away?

22 A. The -- some of the swelling, yeah.

23 Q. And he was concerned about the increase in
24 swelling?

25 A. Not to the -- he wasn't incapacitated.

1 Q. Well, my question was, was he concerned about
2 it?

3 A. He was always concerned about the swelling.

4 Q. Well, I heard you say a moment ago that he was
5 concerned about the increase in the swelling before
6 he went in the hospital.

7 A. Yeah.

8 Q. Now, you don't have medical training yourself,
9 do you?

10 A. I do.

11 Q. Oh, you do? What is your training?

12 A. Medical office assistant.

13 Q. I'm sorry?

14 A. Medical office.

15 Q. And what do you do?

16 A. Well, I don't do anything right now.

17 Q. You don't -- you're not employed now?

18 A. Huh-uh.

19 Q. When did you last work in a medical office?

20 A. I didn't. I was actually disabled before I got
21 to actually begin.

22 Q. So you haven't worked in a medical office?

23 A. (Shakes head.)

24 THE COURT REPORTER: You need to answer
25 verbally.

1 A. No, sir.

2 Q. All right. And you haven't reviewed his
3 medical records, have you?

4 A. I'm sorry?

5 Q. Have you reviewed his medical records?

6 A. Who? Anthony Dibernardo?

7 Q. Yes.

8 A. No, sir.

9 Q. And you were not present the day that Lorrie
10 talked with his doctor about the decision to take
11 him off the vent?

12 A. Was I back there when she talked to the doctor?

13 Q. That's correct. You were not present because
14 you were at home?

15 A. I was not there when he was taken off the life
16 support.

17 Q. Right. And you weren't there at that time that
18 decision was made --

19 A. No, sir.

20 MR. BEIGHLEY: Okay. Thank you. No further
21 questions, Your Honor.

22 MR. MCGOWAN: That will be all from this
23 witness, Judge.

24 THE COURT: All right. Thank you, ma'am. You
25 can step down.

1 MR. MCGOWAN: Plaintiff would call Dr. J. K.
2 Shah.

3 THE CLERK: Dr. Shah, I'm going to have you
4 step forward here to be sworn. Place your left hand
5 and raise your right.

6 (Witness was duly sworn.)

7 DIRECT EXAMINATION

8 BY MR. MCGOWAN:

9 Q. Dr. Shah, my name is Chad McGowan. I represent
10 Ms. Lorrie Dibernardo in this case. Do you
11 understand that, sir?

12 A. Yes.

13 Q. All right. You're a cardiologist with Carolina
14 Cardiology; is that right?

15 A. Yes, sir.

16 Q. And that is the same group that Dr. Mori works
17 for?

18 A. Yes, sir.

19 Q. And you have been at Carolina Cardiology much
20 longer than Dr. Mori, right?

21 A. Yes, sir.

22 Q. All right. Now, you've had occasion to treat
23 Mr. Dibernardo in the years leading up to his death;
24 is that right?

25 A. Yes, sir.

1 Q. And, in fact, we have the medical records here.
2 It looks like you saw him from about 2005 till the
3 time of his passing; is that right?

4 A. Yes, sir.

5 Q. He would come in regularly at your direction;
6 is that fair?

7 A. Uh-huh.

8 Q. Yes?

9 A. Yes, sir.

10 Q. All right. And did you ever tell him that he
11 had four to six months to live no matter what
12 happened?

13 A. No, I did not say that.

14 Q. Okay. Because it wasn't true, was it?

15 A. I can't determine the date so I didn't say
16 that.

17 Q. You didn't tell him, you have four to six
18 months to live no matter what you do?

19 A. (Nonverbal response.)

20 Q. Okay. Now, Dr. Shah, let's get to really why
21 you're here. Let me ask you, you know what happened
22 with Mr. Dibernardo, right?

23 A. Yes, sir.

24 Q. Okay. He died from respiratory failure?

25 A. Yes, sir.

1 Q. And that was caused by what?

2 A. He had right-sided heart failure. He had
3 Noonan's syndrome which is a congenital heart
4 disease where, you know, narrowing of the artery in
5 the lung which is connected to the right ventricle
6 which increased the pressure on right side.
7 Ultimately it increased the volume or load on the
8 right side of the heart.

9 Q. Okay. So he developed what is called a
10 pericardial effusion, right?

11 A. Correct.

12 Q. That is a collection of fluid between the wall
13 of the heart and the bag that it's in, the
14 pericardium?

15 A. Correct.

16 Q. And during -- he had a pericardiocentesis,
17 right?

18 A. Yes.

19 Q. And that pericardiocentesis led to an injury to
20 his heart, right?

21 A. Yes.

22 Q. And then that led to surgery and ventilator?

23 A. Correct.

24 Q. And then that led to respiratory failure that
25 killed him, right?

1 A. Yes.

2 Q. So he died -- he had respiratory failure that
3 was due to or as a consequence of the ventilator and
4 the surgery?

5 A. Say it again.

6 Q. He had respiratory failure due to or as a
7 consequence of the emergency surgery?

8 A. Well, let me say more.

9 Q. Please.

10 A. He had respiratory failure to begin with. He
11 had right-sided failure of -- he had multiple,
12 multiple medical issues when I was following him.
13 He had a heart failure. He had a large heart. He
14 had a chronic pericardial effusion. He had chronic
15 atrial fibrillation. He had anemia, liver failure.
16 When I saw him last two times he had a big ascites
17 which is fluid in the abdomen. He had leg edema
18 which is secondary condition to heart failure. So
19 he had some respiratory failure to begin with.

20 Q. But what killed him was the events from the
21 pericardiocentesis?

22 A. I won't use the word kill him. Most of the
23 cardiac procedures are not benign. Many times you
24 have -- the most common complication of any cardiac
25 procedure is bleeding. He can bleed from the heart;

- 1 he can bleed in the groin; he can bleed anywhere.
2 That simply happened here, bleeding in the
3 pericardial sac and then subsequently -- I was not
4 there in the cath lab but subsequently, I think
5 rightfully so, he did a pericardiocentesis, pulled
6 out the blood, pulled back, sent him to surgery and
7 I think it was right approach.
- 8 Q. But for the injury to his heart he would not
9 have died when he did. Would you agree?
- 10 A. Say it again.
- 11 Q. But for the injury to his heart he would not
12 have died when he did.
- 13 A. That's about true. Yeah.
- 14 Q. Okay. You actually certified the death?
- 15 A. Yes.
- 16 Q. And that's Exhibit No. 10?
- 17 A. Yes.
- 18 Q. Now, this is an important piece of paper, isn't
19 it? The death certificate.
- 20 A. Yes.
- 21 Q. And it is required by South Carolina law?
- 22 A. Yes.
- 23 Q. You have to certify it, true?
- 24 A. Yes.
- 25 Q. And you were certifying this on behalf of being

1 his physician, right?

2 A. Yes.

3 Q. At Carolina Cardiology?

4 A. Uh-huh.

5 Q. And this form requires certain things be in it,
6 doesn't it?

7 A. Right.

8 Q. And this form goes to the state government,
9 yes?

10 A. Yes.

11 Q. And if you go to probate court you need to have
12 a death certificate so the court would know what's
13 up, right?

14 A. Yes.

15 Q. And frequently this is the only piece of paper
16 that families would ever see, right?

17 A. That I don't know.

18 Q. Okay.

19 A. They can reach any medical record they want to
20 see.

21 Q. Well, do you know that this goes to the -- the
22 funeral homes will print out the death certificates
23 and they will provide them to the family?

24 A. Correct.

25 Q. So it's important that this be correct and

1 complete, yes?

2 A. Yes.

3 Q. And it's important that the state law requires

4 it be complete, right?

5 A. Yes.

6 Q. And not misleading, right?

7 A. Correct.

8 Q. And not misrepresenting?

9 A. Correct.

10 Q. And not incomplete?

11 A. Correct.

12 Q. Right?

13 A. Right.

14 Q. In fact, there are specific instructions on how

15 you're supposed to fill this thing out, right?

16 A. (No response.)

17 Q. I'm looking at this section. I want to read

18 it. You see where you put respiratory failure in

19 there?

20 A. (No response.)

21 Q. You see that, Doctor, on your form?

22 A. Yes.

23 Q. All right. I'm going to read that part because

24 it's hard to see on the thing. Where it says

25 Section 32, Part 1: Enter the chain of events,

1 diseases, injuries or complications that directly
2 caused the death.

3 That's what it says?

4 A. Yes.

5 Q. Do not enter terminal events, cardiac arrests,
6 respiratory arrests or ventricular fibrillation
7 without showing the ideology.

8 Ideology is cause, right?

9 A. Right.

10 Q. Do not abbreviate. Enter only one cause on the
11 line. Add additional lines, if necessary:

12 Did I read that right?

13 A. Uh-huh.

14 Q. And then it says, immediate cause, final
15 disease or condition resulting in death.

16 And you put respiratory failure?

17 A. Correct.

18 Q. Then the next part it says, sequentially list
19 conditions, if any, leading to the cause listed on
20 Line A. Enter the underlying cause, disease or
21 injury that initiated the events resulting in death
22 last.

23 Right?

24 A. Correct.

25 Q. You just put, pericardial effusion led to

1 respiratory failure. That's what you put, right?

2 A. Right.

3 Q. But what really happened here is that his cause
4 of death was due to the injury to his heart which
5 was due to pericardiocentesis which was due to the
6 effusion, right?

7 A. Respiratory failure happened because of the
8 procedure.

9 Q. Yes.

10 A. Ultimately it's what he -- is what happened.

11 Q. Right. So because of the --

12 A. It really was respiratory failure. In my
13 judgment the cause of death was respiratory failure.

14 Q. I'm with you. But it was caused by the
15 procedure?

16 A. Caused by pericardial effusion and the
17 procedure.

18 Q. Okay. But you didn't put the procedure in
19 here.

20 A. No, I did not.

21 Q. You're supposed to, right?

22 A. I don't know if I'm supposed to because there
23 are so many reasons I can put in there.

24 Q. We just read it. In this case with the injury
25 to his heart the procedure should have been in

1 there, right?

2 A. Yeah, I -- I had no intention to do that. I
3 just really...

4 Q. I understand. But this does not speak the
5 whole truth about what his cause of death was, does
6 it?

7 A. Well, there are medical records for proof if
8 you want to see that.

9 Q. Well --

10 A. This is a pericardial -- he had -- ultimately
11 he had respiratory failure. He was intubated for
12 breathing.

13 Q. I understand. I understand, Doctor. But that
14 was due to or as a consequence of a procedure,
15 right?

16 A. Yeah.

17 Q. Which was due to or as a consequence of
18 ultimately a pericardial effusion, right?

19 A. Yeah.

20 Q. So you left the injury from the procedure off
21 the death certificate, right?

22 A. Yeah.

23 Q. And then there's another section where it talks
24 about an injury, Section 38, 39, 40, 41, 42 and 43.

25 You see those sections?

1 A. (No response.)

2 Q. You see those?

3 A. (No response.)

4 Q. It says, date of injury; time of injury; place
5 of injury.

6 A. Yes.

7 Q. Injury at work? Location of injury; describe
8 how injury occurred.

9 You didn't put anything in those places, did
10 you?

11 A. No, I did not.

12 Q. But there was clearly an injury to this man's
13 heart which led to his death?

14 A. Yes.

15 Q. Okay. So this death certificate does not tell
16 the whole truth about what happened, does it?

17 A. You can't write so many things in a small
18 place. I wrote major thing which was respiratory
19 failure. If you want to go into detail, you have
20 medical records.

21 Q. You didn't put what the real cause of death was
22 up here, did you?

23 MR. BEIGHLEY: Object to the form, Your Honor.
24 Asked and answered.

25 THE COURT: Sustained.

1 BY MR. MCGOWAN:

2 Q. You didn't mention anything about the injury,
3 did you?

4 A. No, I did not mention anything about injury.

5 Q. And if somebody just looks at this death
6 certificate they would have no idea that this man
7 actually had an injury to his heart from a medical
8 procedure which led to his respiratory failure and
9 death, right?

10 A. Yes.

11 Q. So this does not represent the whole truth,
12 does it?

13 MR. BEIGHLEY: Objection, Your Honor. Asked
14 and answered and sustained.

15 MR. MCGOWAN: No, that's a different question.

16 THE COURT: Different question. Overruled.

17 A. Say it again.

18 Q. This does not represent the whole truth about
19 his cause of death?

20 A. No.

21 Q. And therefore, this is not a -- well, this is
22 then a misrepresentation of the whole truth about
23 his cause of death, right?

24 MR. BEIGHLEY: I object, Your Honor. There's
25 no foundation of a misrepresentation.

1 MR. MCGOWAN: I thought that's what we just

2 did.

3 THE COURT: Rephrase the question.

4 BY MR. MCGOWAN:

5 Q. This is not the whole truth. It does not

6 represent the whole truth, does it?

7 A. This represents the final event. The

8 respiratory failure was the cause.

9 Q. Yes. But you skipped over the part where your
10 partner injured his heart, right?

11 A. I did not mention that. I did not mention
12 that.

13 Q. Okay. So anybody that was looking at this
14 would have no idea that there was a medical injury
15 that occurred that caused his death, right?

16 A. Right.

17 MR. MCGOWAN: Okay. Thank you.

18 CROSS-EXAMINATION

19 BY MR. BEIGHLEY:

20 Q. Doctor, let's talk about the death certificate.

21 Did you at any time attempt to deceive anybody?

22 A. No.

23 Q. Did you -- did you attempt to mislead anyone?

24 A. Never.

25 Q. Did you think that the medical records

1 contained in -- from your review, do they contain an
2 accurate according of what happened to this man?

3 A. Yes.

4 Q. And when you're asked to put a form and put a
5 cause on a form do you go through the record for
6 everything that happened to somebody from birth to
7 death?

8 A. We don't do that.

9 Q. All right.

10 A. We just write the final things.

11 Q. Okay. Can you tell this jury, were you trying
12 to mislead anybody by the way you filled out that
13 form?

14 A. No.

15 Q. Now I want you to -- since you were the man's
16 cardiologist, give them a little bit of a history
17 about the conditions that he displayed over the time
18 he was your patient and how he progressed and how
19 you tried to manage it.

20 A. Since he moved from New Jersey I started
21 following him. He came to me. He understood his
22 medical issues. He had multiple medical issues. I
23 started sending him to various doctors also. But he
24 never wanted to do anything surgically with his
25 heart. He refused and that's been documented in the

1 chart. One time I saw him maybe two or three months
2 ago before the last visit; I sent him to surgeon.
3 Surgeon wanted to do stripping of the pericardium.
4 He refused.

5 He also had ascites. I sent him to stomach
6 doctor. He -- he had what you call nonalcoholic
7 liver cirrhosis. So he had multi-system failure.
8 Last time when he came on July 22nd --

9 Q. The 19th?

10 A. 19th -- when I saw him in the office he told me
11 that he can't even walk in the house without losing
12 the ability to breathe so I tried to talk to him. I
13 convinced him that I need to send him to the
14 hospital. So ultimately he agreed and I sent him to
15 the hospital.

16 Dr. Mori happened to be in charge of cath lab
17 on that day, so would go and talk with the family
18 and ultimately they decided to do the pericardial
19 effusion just to make him comfortable. And then
20 this happened. It's a mild procedure. You can have
21 bleeding from anywhere and that can happen under any
22 cardiac procedure. Bleeding is number one common
23 complication of any cardiac procedure.
24 Unfortunately that happened with him.

25 But he had multiple issues, multiple problems.

1 He was on a blood thinner and when he was in the
2 hospital his blood was very thin so we had to wait
3 till the weekend. So he was admitted on Friday and
4 Monday he was taken to the cath lab. We did a
5 repeat blood test. His thinning time was somewhat
6 adequate to take him to the cath lab. So he took
7 him to the cath lab and put a needle in.

8 Unfortunately, you know, he had consequences.

9 Q. Doctor, let me show you what we've marked as
10 Defendant's 1, and I'll represent to you it's a copy
11 of your Carolina Cardiology chart. You mentioned
12 some history that Mr. Dibernardo gave you.

13 And if you would, I'm going to show you page 6
14 of the office chart, a June 14th note, and look
15 under subjective and read -- slowly read the history
16 that you received that day?

17 A. June 14 he came to the office and he said that
18 -- he complain about increasing difficulty
19 breathing, complication, also complain about ankle
20 swelling. He also told me that when he walks in the
21 house more difficulty breathing. Those are the
22 symptoms that he came.

23 Q. And were his symptoms staying the same, getting
24 better or getting worse?

25 A. He's getting worse.

1 Q. Doctor, you, as his primary cardiologist, saw
2 him, if I'm correct, after his pericardiocentesis
3 and his heart surgery; is that right?

4 A. Yes.

5 Q. All right. And can you explain to the jury how
6 that works in your group that if somebody -- you
7 told us that Dr. Mori was in the cath lab the day
8 that he was getting the procedure, which was as soon
9 as you could get him in after the waiting period for
10 his blood thinners, right?

11 A. Yes.

12 Q. And then after he went to surgery and was put
13 in ICU how was the cardiology service covering him?

14 A. Then essentially when the patient goes from OR
15 or from the cath lab to the intensive care unit
16 there are intensive care specialists and one becomes
17 the primary -- they take over from patient; however,
18 we also sought around with him, around with
19 Dr. Saris was also following, myself. But basically
20 Dr. Wooten happened to be intensive care specialist.
21 She was the one who was seeing constant monitoring.

22 Q. Were you available for consultation --

23 A. Yes.

24 Q. -- with Dr. Wooten as well as following --

25 A. Yes. Anywhere there was a need, she would call

1 us and we would go over there.

2 MR. BEIGHLEY: Thank you, Dr. Shah. Appreciate
3 it.

4 MR. MCGOWAN: Nothing further, Your Honor.

5 THE COURT: Thank you. You may step down.

6 MR. MCGOWAN: We would call J. C. Gregory.

7 THE CLERK: Mr. Gregory, can I have you step
8 forward to be sworn? Place your left hand on the
9 Bible and raise your right.

10 (Witness was duly sworn.)

11 DIRECT EXAMINATION

12 BY MR. MCGOWAN:

13 Q. Tell us who you are.

14 A. I'm J. C. Gregory.

15 Q. Who are you married to?

16 A. Kelly Gregory.

17 Q. Who is that related to Lorrie?

18 A. That is her sister.

19 Q. All right. What do you do for a living?

20 A. I am a plumber.

21 Q. All right. You live here in York County?

22 A. Yes, sir.

23 Q. You knew Anthony Dibernardo?

24 A. Yes, sir.

25 Q. All right. So let's start off with what you

1 remember about his time in the hospital. Did you go
2 visit him in the hospital before the procedure we're
3 here about?

4 A. Yes, sir.

5 Q. Tell me what he was like.

6 A. He was nervous, walking around. He was
7 talking. Real, real nervous because he was really
8 concerned with the procedures and stuff they were
9 going to try to do to him.

10 Q. Okay. Was he able to get out of bed, walk
11 around and talk?

12 A. Yes, sir. Yes, sir. Yes, sir. Like I said,
13 we walked in the room together several times.

14 Q. All right. So there would have been a couple
15 of days that he was in the hospital before the
16 actual procedure, right? He went on the 19th and
17 the procedure was on the 22nd.

18 A. Yes, sir.

19 Q. Did you visit him every day?

20 A. Yes, sir.

21 Q. Now, there came a time when he had the
22 procedure and that didn't go as planned?

23 A. Exactly right.

24 Q. How did you learn that?

25 A. How did I learn that?

1 Q. Yeah.

2 A. I was at work that day. My wife was down there
3 at the hospital, so she had to come back to pick us
4 up because we only had one car at the time. So it
5 was her daddy that called and said that he had
6 passed and so we was --

7 Q. That would have been the 24th?

8 A. Yes.

9 Q. But before that when he had the -- he had the
10 procedure and had another surgery. Were you there
11 at the hospital anytime between the time he had the
12 procedure and the time that he passed?

13 A. Yes, sir.

14 Q. Okay. Tell me what you saw when you were
15 there.

16 A. I seen a -- one of my best friends laying in
17 ICU from a -- somebody that did not -- that --

18 Q. Can't go into that.

19 A. Yes, sir. I seen somebody laying in there that
20 did not need to be laying there at that time.

21 Q. Okay. You were not physically present for the
22 discussion about not putting him back on the vent,
23 true?

24 A. No, sir.

25 Q. Okay. Were you there the day before when he

1 was taken off -- when the ventilator was unplugged?

2 A. No, sir. No, sir. I came up there after that.

3 Q. Okay. So you only saw him on the ventilator
4 the last time?

5 A. Yes, sir.

6 Q. Okay.

7 A. And talked to the doctor inside the ICU at that
8 time.

9 Q. Tell me what kind of person Anthony Dibernardo
10 was.

11 A. He was tough as nails, as the old saying goes.
12 Fell in love with the man as soon as I met him. I
13 had to go to Greensboro, I believe it was, the
14 airport to pick him up, and I'll be darned if he
15 just wasn't a character. Just talking, laughing.
16 He would be there for you. Even amongst all the
17 pain that he was in, he's that type of fellow that
18 he would drop what he's doing to come help you out.
19 I would say that he's a brother. I got one brother
20 but he was more of a brother to me.

21 Q. Okay.

22 A. I would -- like my wife said, at an
23 establishment somebody made fun of him and I was
24 going to bat for him. He was that type of fellow.

25 Q. Okay. I think you told me he was probably the

1 best wing man you ever had?

2 A. Yes, sir. Yes, sir. Most definitely. You
3 know, for people to say that, you know, he couldn't
4 get around that well, we laid tile down inside his
5 master bath shower. He was there helping. Put air
6 conditions inside his house. He was there helping.
7 I'm talking about at midnight.

8 Q. So in the months leading up to this procedure
9 was he still active, getting around, going out,
10 joking, laughing, having a good time?

11 A. Yes, sir. Yes, sir. He can dance on a pole.

12 Q. Tell me what kind of loss this has been, in
13 your observation, for Lorrie.

14 A. Well, it pretty much ripped her heart out.

15 Q. Now, tell me about -- it was at Christmas and
16 there was a Panthers jersey. Tell us about that.

17 A. Oh, yes. It was back when Julius Peppers was a
18 Panther and it was tearing him apart. He wanted --
19 he was like a big kid. He got me the present.

20 Q. Right.

21 A. And it was -- it was just tearing him apart for
22 me to open it.

23 Q. I understand that you wanted a Peppers jersey,
24 couldn't find one anywhere?

25 A. Yeah.

1 Q. Everybody had come up empty?

2 A. Yep.

3 Q. But Ant found one?

4 A. Yes, sir. Yes, sir.

5 Q. And he couldn't contain himself?

6 A. That's exactly right. I believe it was the day

7 before Christmas he brought it to the house and so

8 he was jumping up and down before I even opened it,

9 you know. So when I opened it I gave him a big hug

10 -- picked him up, gave him a big hug. Just an

11 outstanding, outgoing person.

12 Q. That's the kind of guy he was?

13 A. Yes, sir.

14 Q. Liked to make other people happy?

15 A. Yes, sir, most definitely.

16 Q. You miss him?

17 A. Oh, heck yeah.

18 Q. Think Lorrie does?

19 A. Yes, sir.

20 MR. MCGOWAN: Great. Thank you.

21 THE WITNESS: Yes, sir.

22 MR. BEIGHLEY: Just a couple questions,

23 Mr. Gregory.

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CROSS-EXAMINATION

BY MR. BEIGHLEY:

Q. Do you agree that his swelling problems were getting worse in the weeks before he went in the hospital?

A. Yes, sir. I'd say that.

Q. And would you agree his breathing problems were getting worse during that time period?

A. I cannot speak to his breathing problems.

Q. You don't know either way?

A. No, sir.

MR. BEIGHLEY: All right. Thank you.

THE WITNESS: Can I say something?

MR. BEIGHLEY: No, sir. Thank you.

THE WITNESS: Okay.

THE COURT: Thank you, sir.

THE WITNESS: I'm good?

MR. MCGOWAN: Yes, sir.

THE COURT: You can step down.

MR. MCGOWAN: That would be the extent of our witnesses for the day, Judge. We'll resume first thing in the morning.

THE COURT: All right. Ladies and gentlemen of the jury, in consulting with the attorneys we have reached a natural breaking point -- I believe the

1 next witnesses are going to be very lengthy
2 witnesses -- so I'm going to go ahead and let you go
3 home rather than keep you late tonight. And my
4 instructions are the same: Don't talk about the
5 case with any third parties; don't deliberate
6 amongst yourselves; and don't do any independent
7 research.

8 We will begin at nine o'clock in the morning so
9 be back in the jury room shortly before nine
10 o'clock. I hope everyone has a good evening.

11 Mr. Bailiff?

12 (The jury panel exits the courtroom.)

13 THE COURT: All right. Gentlemen, before we
14 break do you want to put on the record what exhibits
15 y'all have agreed on and -- because you've been
16 referring to exhibits but nothing's been formally
17 put into evidence yet.

18 MR. MCGOWAN: Yes, sir. Plaintiff would
19 formally move into evidence Plaintiff's Exhibits 1
20 through 13, and I have, Your Honor, a copy of 1
21 through 10 just for the Court or Your Honor's clerk,
22 if you wish.

23 THE COURT: Okay.

24 MR. MCGOWAN: There is an issue outstanding on
25 Exhibit No. 12, which is -- this is 608 pages of the

1 entire Piedmont record, and in that is some of the
2 objectionable stuff that we've been talking about
3 relative to Dr. Wooten. So we would object to that
4 going in, that piece of the Number 12.

5 THE COURT: Okay.

6 MR. MCGOWAN: And then 13 are photos of
7 Mr. Dibernardo.

8 THE COURT: All right. Mr. Beighley?

9 MR. BEIGHLEY: Defendant has Exhibit 1, Your
10 Honor, consisting of 260 pages. It's the Carolina
11 Cardiology Associates' chart for Mr. Dibernardo.

12 THE COURT: Okay. All right. So Plaintiff's 1
13 through 13 would be admitted without objection with
14 the exception of some statements in the Dr. Wooten's
15 records in Exhibit 12. You want to deal with that
16 before you call Dr. Wooten? How do you --

17 MR. BEIGHLEY: She's going to be presented by
18 video deposition in the defendant's case.

19 THE COURT: Okay.

20 MR. MCGOWAN: It may be best to do that sooner
21 rather than later, so if the video has to be edited
22 there's plenty of time so George is not in a bad
23 spot.

24 MR. BEIGHLEY: I think there's only one --
25 really only one page that is at issue.

1 MR. MCGOWAN: We could do that whenever you
2 want, Judge.

3 MR. BEIGHLEY: And whatever you want --

4 THE COURT: All right. Well, let's -- why
5 don't you -- do you have a copy of that page so I
6 could look at it? Or we can do that in the morning.
7 That will give y'all an opportunity to isolate the
8 portion of the testimony that --

9 MR. BEIGHLEY: Well, what I was going to
10 suggest is I've got a memo and you can have the page
11 of the record and then just let us know in the
12 morning.

13 THE COURT: Okay.

14 MR. BEIGHLEY: We can argue it at that point.
15 Then you'd have a chance to --

16 THE COURT: That way will work. I can look at
17 it --

18 MR. BEIGHLEY: That will save the Court time
19 and work.

20 THE COURT: That's good. I'll be able to look
21 at it tonight. All right. And then we've got
22 Defendant's Exhibit No. 1, which is 260 pages. So
23 all those exhibits will be admitted into evidence
24 and then we'll take up the one page of Exhibit 12.
25 Are there any other matters that we need to deal

1 with before we go into recess?

2 (Plaintiff's Exhibit Nos. 1 through 13 were
3 admitted into evidence.)

4 (Defendant's Exhibit No. 1 was admitted into
5 evidence.)

6 MR. MCGOWAN: Not from the plaintiff, Your
7 Honor.

8 MR. BEIGHLEY: I've got two copies for you and
9 the clerk, Your Honor. Judge, if you don't mind,
10 can I substitute that original for a copy?

11 THE COURT: Yes, sir.

12 MR. BEIGHLEY: I can give you the number if you
13 want to just pull it out of that exhibit.

14 MR. MCGOWAN: I don't know how you want to do
15 this, Judge, but it's this note in this 600-plus
16 pages.

17 MR. BEIGHLEY: It's page, I've got, 0027.

18 THE COURT: Okay. If you'd just make me a copy
19 of that, please.

20 All right. Anything further before we go into
21 recess?

22 MR. MCGOWAN: Not from the plaintiff, Your
23 Honor.

24 MR. BEIGHLEY: No, Your Honor.

25 THE COURT: Okay. Thank you. Gentlemen, we'll

1 go into recess.

2 Ms. Greer, I hope today has been an educational
3 and interesting day for you. I appreciate your
4 candor this morning telling me about your beliefs.
5 I'm not going to make you come back tomorrow, but
6 refer to the telephone number that the clerk gave
7 you earlier today. So you are dismissed and I hope
8 you have a good evening.

9 All right. We'll go into recess..

10 (Court was adjourned for the day.)

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2 THE BAILIFF: All rise.

3 THE COURT: Thank you. Y'all be seated. Good
4 morning.

5 MR. BEIGHLEY: Good morning, Your Honor.
6 Mr. McGowan is outside with his expert. I'll check
7 and see where my client is.

8 (Discussion off the record.)

9 THE COURT: All right. Before we bring our
10 jury in let me hear from the attorneys on this
11 motion in limine. Now, I read the materials you
12 submitted and have looked at the exhibit.

13 And specifically, Mr. Beighley, I want to know
14 your position -- the problem that I have with these
15 statements is the declarant is unknown. We have not
16 positively identified the declarant in the records.
17 It says the family. I don't know who that is and --
18 that's one problem that I have with the statement.

19 The other problem is that two of these
20 statements are not factual but opinion statements.
21 The -- specifically according to them his quality of
22 life has been extremely poor for the last three to
23 four months. The other one is they basically stated
24 that he has outlived his life expectancy by multiple
25 years. So that's -- how -- I want to hear from you.

1 How do you feel that those two statements are
2 admissible under 803?

3 MR. BEIGHLEY: Your Honor, they would be
4 admissible as the medical records if the statute
5 allowing visits records as evidence and they were
6 part of the history. The record will show that the
7 physician who was attending to patients -- she's
8 testified under oath -- met with the wife and
9 discussed with the wife her recommendation,
10 suggestion to put the man back on the ventilator.
11 While she went out to get that started before she
12 could do it -- came back and said that we'd like to
13 talk with you.

14 The wife was present throughout these
15 conversations, according to the doctors, and there
16 were family members present. We know today, based
17 on yesterday's testimony, it was not either of the
18 witnesses who testified in court. The record of the
19 plaintiff's testimony shows that in addition to the
20 folks that were called yesterday the only other
21 people who came to the hospital at any time were the
22 deceased's mother and father and siblings. So that
23 would have had to have been the group of people
24 there. They were giving history for purposes of a
25 medical judgment.

1 The physician Dr. Wooten testified that she
2 relied on that testimony in acquiescing and agreeing
3 with the patient's family's decision, primarily his
4 wife who was the next of kin and would have been in
5 a position to make that decision under the
6 circumstances. So it's an inescapable part and
7 parcel of the medical decision made by Dr. Wooten
8 concerning this patient's end of life. She's
9 testified to that in her deposition.

10 THE COURT: Thank you, Mr. Beighley.

11 Mr. McGowan?

12 MR. MCGOWAN: Yes, sir. The issue -- every
13 statement in the medical records has to be subject
14 to its own exception, so to say that it's a business
15 record or a medical record is not going to get it
16 there. The question we have is that this is not --
17 there's no proof that this is an adopted admission
18 or an adopted statement by Mrs. Dibernardo.

19 In fact, all the evidence is that this is just
20 not true. I mean, this guy was up. He was around.
21 I mean, according to the testimony we heard, a
22 couple weeks before this he was at a party with his
23 niece.

24 It is being admitted solely for the purpose of
25 showing that he had a poor quality of life and

1 outlived his life expectancy. That's the only
2 reason they want it in, and it's a completely
3 hearsay statement and it needs to be excluded. We
4 don't know its origin. It's clearly not credible
5 because it's just not true, based upon the evidence
6 of actual witnesses.

7 And we don't think that this has anything to do
8 with medical diagnosis or treatment because this is
9 an explanation of why the family decided not to put
10 him back on the ventilator. It had nothing to do
11 with the doctor making her decision. It was her
12 putting -- mistakenly or not, her putting what she
13 believed to be the family's reasons for their
14 decision, which is different than medical diagnosis
15 and treatment.

16 We believe that it should not be admitted, and
17 if it is admitted, it needs to be with the limiting
18 instruction that it is not being admitted for the
19 truth of the matter or certainty to limit the damage
20 that it would do because that's the only reason they
21 want it in. Thank you.

22 MR. BEIGHLEY: Judge, just in responding, if I
23 might.

24 THE COURT: Yes, sir.

25 MR. BEIGHLEY: Just briefly. I don't know what

1 would be a more significant medical decision than to
2 accept the family's wishes. If the testimony of the
3 -- or the records showing the history the physician
4 relied on and the physician's testimony that, I
5 relied on that and put it in my note and based on
6 that I made my medical decision -- I don't see how
7 you could find a more relevant piece of history from
8 the records or the family that a physician relies on
9 to make an end-of-life decision.

10 I think it's clearly something that was history
11 relied on and the record will show that in what
12 treatments the physician made. So I think it
13 clearly falls within that section.

14 THE COURT: All right. I am going to grant
15 your motion in limine on the statements of his
16 quality of life has been extremely poor for the last
17 three to four months and they basically state that
18 he has outlived his life expectancy by multiple
19 years. So I think those are expressing opinion and
20 not fact. I think they're outside the scope of the
21 exception.

22 And I'm also concerned that it does not specify
23 the declarant. The record does say the wife was
24 there, and certainly the wife is a witness in the
25 case and would be subject to cross-examination,

1 Mr. Beighley.

2 But I'm not going to allow either one of those
3 statements, so redact those two from the medical
4 record and you can put the rest of it in.

5 The other two statements in there that he is
6 unable to do anything; he's not been able to get out
7 of the bed by himself, those are factual-based
8 statements and not opinion-based statements. I
9 recognize those are statements that are being
10 contested but I will allow you to put those in since
11 those are -- the evidence has been put in and that
12 is a subject of fact in the case. So that will be
13 the ruling of the Court on that issue.

14 All right. Anything further before we bring
15 our jury in?

16 MR. MCGOWAN: We just need to make sure we get
17 our video stuff working.

18 THE COURT: All right. Let's go ahead and test
19 that and then we can proceed.

20 MR. MCGOWAN: Yes, sir.

21 MR. BEIGHLEY: Judge, while they're doing that
22 can you -- I want to make sure I redact what you --
23 could you mark --

24 THE COURT: Yeah, I could mark it on the one
25 you gave me. I'll just underline the --

1 MR. BEIGHLEY: Just underline the words and
2 then I'll -- it will be in the record and I'll do
3 the same.

4 THE COURT: If you'll look at --

5 MR. BEIGHLEY: Yes, sir.

6 THE COURT: I just -- Mr. McGowan?

7 MR. MCGOWAN: Yes, sir?

8 THE COURT: I underlined that, if you want to
9 take a look at what I did there. I underlined those
10 two statements so he can redact them from --

11 MR. MCGOWAN: Yes, sir.

12 THE COURT: Are we operational?

13 MR. MCGOWAN: Yeah. IT had to bring a cable.

14 THE COURT: Okay. We had a trial over here --
15 what was it? Last September -- and the solicitor's
16 office went through -- we were on the third computer
17 before we finally found one that would play the
18 solicitor's DVD. We had to use my law clerk's
19 computer so -- the IT fellow, his didn't work
20 either.

21 MR. MCGOWAN: Problem I find is that the jury's
22 expectation of razzle dazzle keeps going up with
23 every trial. Foam boards in general doesn't cut it
24 anymore.

25 It appears we're good, Judge.

1 THE COURT: Okay. All right. Mr. Bailiff, if
2 you'll go get our jury for us please, sir.

3 THE BAILIFF: Yes, sir.

4 (The jury panel enters the courtroom.)

5 THE COURT: Good morning, ladies and gentlemen.

6 JURY MEMBERS: Good morning.

7 THE COURT: Did anyone have any third parties
8 attempt to discuss the case? Did anyone do any
9 independent research, or were there any
10 deliberations?

11 JURY MEMBERS: (No response.)

12 THE COURT: Let the record reflect that there
13 are no positive responses. Very good.

14 Mr. McGowan, call your next witness.

15 MR. MCGOWAN: Thank you, Your Honor. Plaintiff
16 calls Alan Schob, MD.

17 THE CLERK: Dr. Schob, I'd have you step here
18 to be sworn please, sir. Place your left hand on
19 the Bible, raise your right.

20 (Witness was duly sworn.)

21 DIRECT EXAMINATION

22 BY MR. MCGOWAN:

23 Q. Dr. Schob, you're from Miami?

24 A. Correct.

25 Q. All right. And you're a cardiologist?

1 A. Yes, sir.

2 Q. What is a cardiologist?

3 A. Cardiologist is a physician who takes care of
4 problems with the heart.

5 Q. Do you do interventions, as they're known?

6 A. Yes, sir.

7 Q. And what's an intervention or what's
8 interventional cardiology?

9 A. Interventional cardiology is a teaching and
10 practice where physicians learn how to, without
11 operating on patients, take care of various problems
12 such as blockages in the arteries of the heart,
13 valve problems that may relate to the heart and in
14 this case -- as in this case fluid that may
15 accumulate around the heart.

16 There are other procedures as well but we
17 basically diagnose problems related to the heart by
18 taking tubes and running them up to the heart,
19 measuring pressures, injecting dye or contrast and
20 evaluating issues that may pertain to problems with
21 the heart.

22 Q. So if a patient needed a heart cath, as people
23 commonly believe that to be, that would be something
24 that would be within interventional cardiology?

25 A. Correct.

1 Q. And a stint, for instance? You'd do an
2 angioplasty which is the balloon procedure or a
3 stint? That would also be interventional
4 cardiology?

5 A. Yes, that's correct..

6 Q. All right.. Tell us about your medical
7 training. Where did you go to medical school?

8 A. I went to medical school University of South
9 Alabama Mobile.

10 Q. And then where did you -- you had some
11 fellowship training after that?

12 A. Yes. I did internship and fellowship and
13 residency at the University of Miami, including a
14 year of interventional fellowship.

15 Q. Are you board-certified?

16 A. Yes, sir.

17 Q. In what specialties?

18 A. Internal medicine, cardiology, and
19 interventional cardiology.

20 Q. How do you become board-certified?

21 A. You have to complete the proper training and
22 then take an exam.

23 Q. And that exam is both an oral exam and a
24 written exam?

25 A. It's a written exam.

1 Q. Are there a certain number of cases of various
2 kinds that you need to have under your belt before
3 you're allowed to sit for the exam?

4 A. Correct.

5 Q. And you have to have certain fellowship
6 training and whatnot in order to sit for the exam?

7 A. That's correct.

8 Q. And are you currently board-certified?

9 A. Yes, sir.

10 Q. Do you have any teaching appointments in the
11 field of medicine?

12 A. I do. I'm an associate professor of medicine
13 at the University of Miami.

14 Q. And tell us about your work experience in
15 cardiology from your fellowship until now.

16 A. After fellowship I was lucky to be taken on
17 board as a cardiologist at University of Miami and I
18 run the cardiac catheterization at the Miami VA
19 Hospital. I also work at the University of Miami
20 Hospital. I've taken care of thousands of patients
21 with heart disease over the years and done thousands
22 of procedures.

23 Q. You ever give any lectures or courses to other
24 cardiologists or medical providers in the field of
25 cardiology?

1 A. Yes, sir.

2 Q. Are you a member of any professional cardiology
3 societies?

4 A. I've been a member of the American College of
5 Cardiology. I am presently a member of the National
6 VA Cardiac Catheterization group. I was one of the
7 founding members of the peer-review organization
8 that goes over cases from all the VA hospitals in
9 the country where there might have been a
10 complication or a problem related to a
11 catheterization.

12 Q. Now, in an average week, tell us what your
13 professional activities entailed in an average week.
14 Patient care? Procedures? Tell us what you do.

15 A. It's about 50 to 60 percent procedures. The
16 rest would be divided up between seeing patients in
17 clinic and research and teaching.

18 Q. So when is the last time you would have seen a
19 live patient?

20 A. Yesterday.

21 Q. Okay. Do you routinely do interventional
22 procedures as part of your daily work?

23 A. Yes.

24 Q. Are you familiar with a procedure known as a
25 pericardiocentesis?

1 A. Yes.

2 Q. Explain to us generally what that is before we
3 get into the details of it.

4 A. Pericardiocentesis is a procedure where we take
5 a -- simply a tube or a catheter, it's called, and
6 insert it into the space around the heart. Why?
7 Because there is usually some fluid around the heart
8 in various disease states and when there is fluid
9 around the heart it can be a problem, especially if
10 it gets very large. If it gets very large it can
11 squeeze the heart and prevent the heart from
12 functioning normally.

13 Additionally, there may be other reasons why we
14 do that, to diagnosis why there is fluid, because
15 normally there should be very little fluid around
16 the heart. But when we see on an echocardiogram or
17 a chest x-ray or a CAT scan an enlargement of the
18 heart, many times it may be due to fluid
19 accumulation around the heart, not enlargement of
20 the heart itself. And we need to find out why
21 that's happening so we may, at times, take those
22 tubes, those catheters, insert them around the heart
23 to withdraw fluid either to help the patient's blood
24 pressure or in many cases just to diagnose why there
25 is a problem to begin with.

1 Q. Do you do these kinds of procedures?

2 A. Yes, sir.

3 Q. Is this part of what you teach med students?

4 A. Well, I don't teach med students because they
5 don't have enough experience but we teach our fellow
6 trainees to do this.

7 Q. Okay. So the people that are in training to be
8 cardiologists?

9 A. Well --

10 Q. Fellows?

11 A. Right. Fellows who are in training to be
12 cardiologists, and even more appropriately fellows
13 who are taking that extra time to learn how to do
14 interventional cardiology.

15 Q. And are cardiologists taught how to do a
16 pericardiocentesis in the safest way possible?

17 A. Correct.

18 Q. And the methods by which you do that which
19 we'll get into in just a minute?

20 A. Yes, sir.

21 Q. All right. All right. So tell us what you
22 reviewed -- well, are the right procedures pretty
23 well accepted by cardiologists across the country on
24 the ways to minimize the risk of injury during a
25 pericardiocentesis?

1 A. Yes, sir.

2 Q. All right. Is it -- what have you reviewed in
3 connection with your testimony in this case? What
4 materials have you looked at and what brings you --
5 what's your basis for this opinion?

6 A. Well, I've looked at all the records that were
7 available from the hospital, which would include the
8 medical records, the angiograms or x-ray images that
9 were taken during the procedure, the
10 echocardiograms, the hospital notes, the
11 electrocardiograms. That's pretty much it.

12 Q. Did you review the testimony of the witnesses?

13 A. Yes. I reviewed the depositions that were
14 taken.

15 Q. You believe that you have enough information at
16 this time to give reliable testimony?

17 A. Yes.

18 Q. All right.

19 MR. MCGOWAN: Your Honor, at this point we
20 would move to qualify Dr. Schob in the fields of
21 cardiology and interventional cardiology.

22 MR. BEIGHLEY: No objection, Your Honor.
23 Prefer cross-examination.

24 THE COURT: All right. Dr. Schob would be
25 admitted as an expert in cardiology and --

1 MR. MCGOWAN: Interventional cardiology.

2 THE COURT: -- interventional cardiology
3 without objection.

4 BY MR. MCGOWAN:

5 Q. All right, Doctor. Let's get the formalities
6 out of the way. First, is it your view that Dr.
7 Mori deviated or fell below the standard of care in
8 one or more ways?

9 A. Yes.

10 Q. Did one or more of those deviations from the
11 standard of care cause or substantially contribute
12 to the death of Mr. Dibernardo?

13 A. Yes.

14 Q. Are all of your opinions in this case held to a
15 reasonable degree of medical certainty unless you
16 tell us otherwise?

17 A. Yes.

18 Q. All right. So let's talk about how this is
19 supposed to happen and then let's talk about what
20 happened here. Okay?

21 MR. MCGOWAN: Your Honor, may the witness come
22 off the stand?

23 THE WITNESS: Yes, sir.

24 BY MR. MCGOWAN:

25 Q. Dr. Schob, come on down and let's first talk

1 about what this procedure is and what we're trying
2 to accomplish. What we have up here --

3 MR. MCGOWAN: Can some of these lights go out?

4 Thank you.

5 BY MR. MCGOWAN:

6 Q. What do we have here? What's going on?

7 A. Well, on the left-hand side, as you can see, it
8 says normal heart. Around the heart is the
9 pericardium which is typically a very pliable, thin
10 layer of fibrous tissue. Now, as I stated earlier,
11 there are various disease states that can cause
12 fluid to build up around the heart, and as you can
13 see here this would indicate such a phenomenon. We
14 call that a pericardial effusion.

15 Many things can cause it. We don't need to go
16 into all of them, but suffice it to say that there
17 are a bunch of things such as cancer, inflammation,
18 infection, things like that that can cause buildup
19 of fluid around the heart.

20 That's what happened in this case. This
21 gentleman had a large pericardial -- a very large
22 pericardial effusion, as documented both in the
23 hospital and prior to the patient coming to the
24 hospital.

25 Q. Now, can these fluid buildups be acute, like,

1 they happen quickly, and then can they be chronic?

2 A. They -- no. They can be both. They can be
3 acute; they can be chronic. Patients who have car
4 accidents -- for example -- trauma, injury to the
5 chest can develop acute effusions. That means right
6 away large effusions that affect the function of the
7 heart. All right?

8 But in this case this was what we call a
9 chronic effusion. There was some process that was
10 causing this fluid to build up slowly over time and
11 kept getting bigger and bigger and bigger, as
12 documented in the medical records.

13 Q. That had been for years documented?

14 A. Correct.

15 Q. Okay. So was this an emergency procedure?
16 Something that had to be done right then and there?

17 A. No.

18 Q. All right. So what do you do to treat --
19 what's -- what do you do to do a pericardiocentesis?

20 I understand we have another picture here and
21 we have some devices. Tell us generally speaking
22 how we do this and then show us what tools you
23 actually use to get it done.

24 A. Okay. So this is just a diagrammatic
25 representation of what we do. You can see here

1 there's a syringe with a needle, and the needle gets
2 inserted right below the xyphoid or sternum and it's
3 directed up to the shoulder. And the needle is
4 supposed to be directed right into that space right
5 there where the fluid is, not to the heart but to
6 the fluid.

7 Q. Okay. How do you make sure you're going in the
8 right place, in the right direction?

9 A. We use various techniques to make sure that
10 things are going appropriately and maybe we can go
11 into the next --

12 Q. Yeah. All right. Tell us what we're looking
13 at.

14 A. So here's -- and I apologize for my drawing but
15 it's the best I could do. So here we have
16 representation of the heart right here. The yellow
17 represents the pericardial effusion. Now, as we saw
18 in that earlier -- you take a needle and that needle
19 is supposed to be directed right into this space
20 here called the pericardial space where the
21 accumulation of the fluid occurs.

22 And as you can see from here -- here's our
23 needle -- we have -- and as was documented in this
24 case -- what we call an alligator clip, and the
25 alligator clip is placed right on that needle. Then

1 we connect it to an EKG. The EKG is there because
 2 it will tell us if we go too far. If we actually
 3 hit the heart with that needle, the EKG will change.
 4 We've all seen EKGs on TV shows and you know the
 5 squiggles and so forth. Those squiggles will change
 6 if we actually go too far and hit the heart.

7 Q. Okay.

8 A. So that's one of the ways -- one of the ways
 9 that we safeguard the procedure to make sure that we
 10 don't do any accidental damage to the heart.

11 Q. Is an EKG the same thing as an ECG?

12 A. Yes, correct.

13 Q. It's just --

14 A. It's the same exact thing. It's just what
 15 acronym you want to use.

16 Q. All right. So in this case how would you
 17 characterize the size of this pleural effusion in
 18 Mr. Dibernardo? How big of a landing spot was
 19 there?

20 A. It was a pericardial effusion.

21 Q. Pericardial effusion. I'm sorry.

22 A. It was very big. It was very big. Well
 23 documented on multiple echos previously. It was
 24 very large.

25 Q. Does a bigger effusion give you more margin for

1 error --

2 A. Yes.

3 Q. -- or margin of safety?

4 A. Yes. Absolutely.

5 Q. And why would that be?

6 A. Because you have a much bigger space. And when
7 you insert those needles, as you cross the
8 pericardium you feel a pop, so it's a combination of
9 various things that we do including EKG. We also
10 have an echo machine where we can actually look and
11 look at the effusion and see where our needle is
12 going to make sure that we're getting into the right
13 place. And additionally, we use x-ray images to
14 ensure, to know that we're taking that needle and
15 we're putting it in the right place.

16 So with a large effusion it's usually very easy
17 to get that needle into the pericardial space and
18 it's extremely unlikely that you're going to injure
19 the heart.

20 Q. Okay. So if you're putting the needle in this
21 is -- what's the riskiest time of a
22 pericardiocentesis?

23 A. When you're inserting the needle.

24 Q. When you're -- okay. So in order to minimize
25 that risk you use fluoroscopy which is the x-ray

1 video; is that right?

2 A. Correct.

3 Q. And then we have echo, which is the ultrasound?

4 A. Correct.

5 Q. And then when you hook a clip up to the metal
6 of the needle that essentially turns the needle into
7 an electrode that should signal if it hits the
8 heart?

9 A. Absolutely right.

10 Q. Is there any -- to your knowledge, if you touch
11 an artery or a vein and it's on the surface of the
12 heart will it give you that signal?

13 A. It should. Absolutely, yes.

14 Q. Okay. All right. So once we have our needle
15 in safely or once we have our needle in what do we
16 do to verify it's in the right spot?

17 A. Once we have our needle in and we have a
18 syringe connected to the needle -- everybody's been
19 to the doctor and had their blood taken out from
20 their vein. It's the same thing here. We have a
21 syringe. We're aspirating -- we're pulling back on
22 that syringe. And once you get into that
23 pericardial space what do you see? You see fluid.
24 You don't see blood. You see fluid.

25 You may see pink tinged fluid because sometimes

1 these effusions can be what we can hemorrhagic,
2 especially in patients with cancer where the cancer
3 may have spread to the pericardium. It can
4 sometimes cause what we call bloody effusions but in
5 -- in the most part, in most patients those
6 effusions are generally yellow pink fluid and when
7 we aspirate -- when we withdraw fluid from the
8 pericardial space it usually is fairly clear so we
9 know we're not damaging the heart. We're not inside
10 the heart getting blood back.

11 Q. Okay. Is this the kind of thing that you'd
12 use?

13 A. Yeah.

14 Q. But it would be bigger?

15 A. The needle would be bigger.

16 Q. Okay. So you insert this in the patient and
17 you do what? Pull back on it?

18 A. Correct.

19 Q. And that's called aspirating?

20 A. Right.

21 Q. And you expect to see, if you do that, if
22 you're in the right spot, pericardial fluid?

23 A. Correct.

24 Q. And it may be pinkish or tannish or yellowish
25 A or something like that?

- 1 A. That's correct.
- 2 Q. What happens if you see frank blood, actual
- 3 blood? What if it's red blood?
- 4 A. Well, then you have to think that maybe you
- 5 either damaged the heart or you have what I was just
- 6 talking about, hemorrhagic effusion.
- 7 Q. Okay. Was there any indication in this case
- 8 that Mr. Dibernardo had a hemorrhagic effusion?
- 9 A. No.
- 10 Q. Okay. So if the needle's in and you pull back
- 11 and you don't see blood, what does that tell you?
- 12 A. That you're in the right spot.
- 13 Q. Okay. All right. And then it's a matter --
- 14 A. And then just to add on, that was what was
- 15 found here. Fluid was described as pinkish
- 16 initially, not blood.
- 17 Q. If there had been needle injury to the heart as
- 18 this was going in, would you expect to see blood in
- 19 there?
- 20 A. If there was injury to the heart?
- 21 Q. Right.
- 22 A. Yes.
- 23 Q. Or if he nicked an artery or vein at that
- 24 point?
- 25 A. Correct.

1 Q. All right. But there was no indication that
2 blood was found?

3 A. Correct.

4 Q. All right. So what do you do next? You've got
5 your needle -- you've got your needle and then you
6 verify the tip of your needle is in the right spot.
7 What do you do next?

8 A. So next after we've established that we're in
9 the right place we take what we call a guide wire --
10 this guide wire is really important. It's key as to
11 what happened in this case. So the guide wire --
12 should I just give it to the jury?

13 MR. MCGOWAN: Your Honor, can we pass --

14 A. The guide wire --

15 THE COURT: He can demonstrate.

16 MR. MCGOWAN: Okay.

17 A. -- is like this and if you -- if you get a
18 chance to play with it -- but you can see at the tip
19 it's very soft and it's curved. It's called a J
20 curve. That is there to protect the structures that
21 we're inserting these tubes into. So we want to
22 take this guide wire and insert it far into wherever
23 we're going, be it the vein, the artery or in this
24 case the pericardial space.

25 As you get further along here it becomes much

1 stiffer, and it's stiffer because it needs to be a
2 rail. It needs to be a strong, stable platform to
3 be able to advance other tubes into that space.
4 Because if we don't have that there what happens is
5 this will not support any other structure, any
6 catheters and so forth that we're -- that we're
7 inserting.

8 Q. Okay.

9 A. So...

10 Q. So once you get your wire in there what do you
11 do next?

12 A. So we have -- we have the wire and the wire
13 needs to go in fairly far to be able to, again,
14 serve as the stable platform. Right?

15 Q. Is the -- is the insertion of the wire going to
16 cause injury to the heart?

17 A. No. The wire is not because that tip, as I
18 showed you, is very soft, pliable J. That's why --
19 that's what it's designed for, not to be traumatic.
20 It's designed to get into those spaces really easily
21 and safely and then provide a stable, stable rail to
22 be able to insert other tubes that we're going to be
23 inserting shortly.

24 Q. Okay. So you get your wire in there and then
25 what happens next?

1 A. Okay. So -- again, I apologize for my drawing.

2 The next step is to insert what we call a dilator.

3 Q. Okay. So the -- we had our needle in. Wire

4 goes in through the needle. Needle comes out.

5 That's left us with what in the patient? Just the

6 wire?

7 A. Just the wire.

8 Q. Okay. Now what do you do?

9 A. The needle's out. Now we -- over the wire we
10 insert one of these dilators.

11 Q. And it's something like that?

12 A. And it's something like this. This is a
13 typical dilator and you -- when you get a chance to
14 handle it, you'll see that it's much stiffer and the
15 tip is very sharp. It's a sphere. Okay? But it
16 has to be placed over that wire and it has to be
17 placed over that strong, solid part of the wire.

18 Q. And why do you do that?

19 A. Well, we -- why do we put it in? We put it in
20 to create space for passage of another tube that
21 will be in there to drain the fluid.

22 Q. Okay. So if we're doing this how do you insert
23 this sharp object safely into that pericardial
24 space?

25 A. By maintaining good wire position. As you can

1 see, the wire is all the way in so that that soft
2 tip is as far away from the tip of this dilator as
3 possible. Because if this tip gets too close to the
4 soft part of the dilator -- of the wire, the guide
5 wire, what will happen is that this will not -- this
6 will go where it wants to go.

7 Q. Okay. So you insert the wire -- this over the
8 wire?

9 A. Right.

10 Q. And then the wire protects the end of this?

11 A. Correct.

12 Q. Now, should you ever allow the wire or the tip
13 of this dilator to be revealed without having a wire
14 on the end of it?

15 A. No.

16 Q. Okay. Why would that be?

17 A. Because that would -- as I said, without this
18 wire -- I'm sorry. Without this wire being advanced
19 far enough into the -- into the structure, into the
20 artery/vein or in this case the pericardial space,
21 what happens is this wire will not serve as a stable
22 rail for this dilator and so what happens -- so all
23 of a sudden if this wire is not out far enough what
24 happens is this dilator will go where it wants to
25 go. When the wire is out far enough the dilator has

1 no choice but to go where the wire is. So it's
2 really important -- that's what happened in this
3 case. It's really important that this wire be out
4 far enough to protect either the vein or artery or
5 in this case the heart from damage from this.

6 Q. Okay. So let's keep going now. The dilator is
7 to make a bigger space to get the catheter in; is
8 that right?

9 A. Correct.

10 Q. All right. So once we have our wire in and
11 we've put our dilator in we then remove the dilator?

12 A. Correct.

13 Q. And then what do we do?

14 A. Then we have -- that wire stays where it was,
15 far out, and now after we've created that space
16 through the tissues over here we can advance what we
17 call a pigtail catheter. Pigtail catheter, you note
18 here, is got a pigtail at the tip. And why is that?
19 Because it's atraumatic. It's not going to damage
20 the heart. It's not going to damage an artery or
21 vein. It's soft and it has a little loop so it will
22 not create any havoc wherever it's located.

23 Q. Okay. And then once you've got your catheter
24 in there, then you verify placement?

25 A. Yes.

1 Q. All right. Was that done in this case?

2 A. Yes.

3 Q. All right. You've seen this form before?

4 A. Many times.

5 Q. Tell us what this shows.

6 A. So this was the first x-ray image taken in this
7 case, and what you can see is this is what we call a
8 pigtail catheter and it's inserted around the heart
9 to the -- close to the side wall of the heart. And
10 at this juncture there is some dye injected --
11 contrast, dye, same thing.

12 Q. And how would that show up on a picture like
13 this? Is it darker?

14 A. So -- we've got to let it -- so you can see the
15 contrast being -- the dye being injected and it's
16 just flowing out. It's diffusing throughout that
17 pericardial space. The catheter's perfectly placed.
18 It's in the 100 percent right position. It is what
19 we would say Miller time. You're done. You hook it
20 up to a drain. You take out the fluid. You send
21 the patient to the intensive care unit. Let it sit
22 there for a day or two to keep draining all that
23 fluid out. You're done.

24 Q. Was the fluid coming out of Mr. Dibernardo at
25 this point?

1 A. Yes.

2 Q. Was it coming out pretty vigorously, based upon
3 the records?

4 A. Based upon the records they got out over a
5 liter of fluid.

6 Q. For a pericardial effusion is that a lot of
7 fluid?

8 A. That's a lot of fluid.

9 Q. Okay. So if Dr. Mori had stopped here would we
10 even be here?

11 A. No, we wouldn't be here.

12 Q. All right. What happened next with
13 Mr. Dibernardo?

14 A. Okay. So for some reason Dr. Mori, in his
15 deposition, states that he decided he needed to
16 change this to what we call a sheath. A sheath is
17 another tube. It's not a catheter. It's another
18 tube that we use to insert catheters through when
19 we're doing procedures of the heart such as the
20 arteries and the veins. This is what we would call
21 a standard sheath. So normally we would take -- do
22 you have a catheter?

23 Q. I do. I've got all kinds of stuff over here.

24 A. So normally we would take catheters that we use
25 to inject dye, check out patients' blood pressures

1 and heart pressures and so forth and usually we
2 would put these in through the sheaths just like
3 that. He said that he wasn't getting enough blood
4 return -- he wasn't getting any blood return or
5 fluid return and that the color had changed and that
6 the patient's blood pressure and clinical situation
7 was deteriorating, blood pressure was dropping and
8 that he needed to change to be able to get the fluid
9 out because he thought he had created a problem
10 initially with the needle space. That's what he
11 said in his deposition.

12 Q. Okay. Let's talk about what the medical
13 evidence would show. If Dr. Mori testified that he
14 put the sheath in because the blood pressure was
15 dropping, does the medical record actually support
16 that?

17 A. No.

18 Q. Okay. When was the sheath put in?

19 We had a timeline done. You've seen this.
20 When the sheath was put in that was around eleven
21 o'clock?

22 A. Correct.

23 Q. And then the blood pressure started dropping
24 around 11:26, 11:29?

25 A. Correct.

1 Q. So the blood pressure started dropping 26 to 29
2 minutes after the sheath was put in?

3 A. Correct.

4 Q. Okay. Is there any indication in any medical
5 record that the -- that there was blood coming out
6 of the catheter before the sheath went in?

7 A. No.

8 Q. Okay.

9 A. And furthermore, the blood pressure was fine.
10 Blood pressure was normal. Up to that point the
11 hemodynamics or blood pressure, heart rate, all
12 those things were completely dead normal.

13 Q. Okay. So let's assume you have in your mind
14 you want to put a sheath in the patient. How would
15 you do that process safely?

16 A. Well, first of all, you shouldn't put a sheath
17 in.

18 Q. Fair enough.

19 A. Okay? I mean, the sheath is not a pigtail
20 catheter. The sheath doesn't have that rounded tip
21 at the end. It's pretty -- it's pretty stiff at the
22 tip and you've got a beating heart next to it. So
23 you can imagine this -- this tip, even the
24 atraumatic ones can cause damage to a heart that's
25 actively beating against it like that. Okay? So

1 that was -- that was one of the -- the errors in
2 this case.

3 Q. Okay.

4 A. And --

5 Q. But we had a catheter that's in a good
6 placement?

7 A. Uh-huh.

8 Q. That was the first fluoro, right?

9 A. Right.

10 Q. All right. Now, we've got this catheter in the
11 patient and we want to swap out for whatever reason
12 to put a sheath in. How do we do that? What is the
13 procedure for replacing the catheter with a sheath?

14 A. Okay. 'So again, the -- the critical part --
15 I've gone over it. I apologize for going over it
16 again. The critical thing is that when you're
17 exchanging any of these devices you need to have
18 good wire position. The wire needs to be well out
19 into that space.

20 Q. All right. But you've got your catheter into
21 your patient. What do you do with the wire?

22 A. You reinsert the wire.

23 Q. Okay. So you put the wire down the catheter
24 and you take the catheter out?

25 A. Correct.

1 Q. And that leaves you with a wire in your
2 patient?

3 A. Correct.

4 Q. Now what?

5 A. Now you take whatever device you're going to
6 put in, in this case a sheath or whether it's
7 another catheter, and you insert that over that wire
8 that you have, securing the space where you want to
9 be.

10 Q. And the sheath is put in with this sort of
11 introducer part?

12 A. Correct.

13 Q. And the sheath is supposed to be -- and the
14 introducer are slid down the wire, right?

15 A. Correct.

16 Q. And you're supposed to do -- make sure the wire
17 doesn't come too far because it won't protect you?

18 A. That's correct.

19 Q. All right. If you do this properly, are you
20 going to have this sheath and introducer causing
21 injury to the patient?

22 A. No.

23 Q. Okay. So what did Dr. Mori -- and what do the
24 fluoros show that Dr. Mori did after the catheter?

25 He had a catheter in a good spot and then what

1 happened?

2 A. Right. So again, for reasons that are not
3 absolutely clear, he decided to change out that
4 pigtail, which was in a perfect position, and put in
5 one of those sheaths, which as we've seen is
6 potentially traumatic to the heart. What he chose
7 was what we call a long sheath so it's much longer
8 than the ones that I just showed you before.

9 Q. Is it closer to the one with ring size on it?

10 A. Yeah.

11 Q. Okay.

12 A. Okay. So he has to pull the wire back in order
13 to get that sheath completely on because you have to
14 have control of that wire all the time. The wire,
15 you have to have -- as you're inserting that sheath
16 you have to have control of the wire. The wire
17 can't be so far in that you don't have it.

18 So what do you do? You pull the wire back
19 until you can get the sheath inserted, but now you
20 have a longer sheath and so what you wind up doing
21 is pulling that wire back. Now when you're
22 inserting that long sheath, as you can see, you're
23 over the soft part of the wire and this is what
24 happened in this case. The wire came back so far
25 that it did not serve to protect the placement of

1 that new device, that sheath with that very, very
2 hard tip as I showed you, and it damaged the heart
3 as it was being pushed in.

4 Q. All right. Do we have proof of that?

5 A. Yes.

6 Q. All right. Now, there was another fluoro done,
7 according to the medical record, after the sheath
8 was put in?

9 A. Correct.

10 Q. All right. And this is that fluoro?

11 A. Right.

12 Q. Tell us what we're looking at here before we
13 play it.

14 A. Okay. So here is the sheath up to this point
15 here.

16 Q. It appears as though it gets kind of thicker
17 near the top. Is that the top end of the sheath?

18 A. This is the sheath right there and this is the
19 pigtail catheter.

20 Q. Okay. So what does that tell us? That tells
21 us that --

22 A. It tells us that the wire came back. Why?
23 Because if it hadn't this would be going to the same
24 exact spot where we saw that pigtail catheter but
25 now you can see there's this acute angulation in the

1 sheath here and it's because it had got butted
2 against the heart. So normally -- it should have
3 been that nice, broad, sweeping curve that we saw
4 previously. Maybe you can go back just to --

5 Q. Sure.

6 A. Like this. You can see here: nice broad, wide
7 curve on that catheter. But now -- go forward.

8 Q. Is there a sheath in this picture?

9 A. No. All right. Now it's changed, right? It's
10 no longer here; it's here. Okay. Now we should let
11 it play.

12 Q. Let's -- what we're seeing here is a different
13 catheter?

14 A. We're seeing the sheath and we're seeing the
15 catheter -- pigtail catheter.

16 Q. Okay. So what that would mean is what? You
17 have the wire in, put the sheath through the
18 introducer and you pull the wire out?

19 A. No. In this case what he did is he put the
20 sheath in over the wire but the wire wasn't in far
21 enough so it created damage.

22 Q. Okay.

23 A. The wire is still there. And then he put the
24 pigtail catheter, that same catheter he had
25 initially, back in through this sheath.

- 1 Q. Okay. So do you put this over the sheath --
2 inside the sheath?
- 3 A. Yes.
- 4 Q. Okay. So what he would have had then is in
5 order to get the sheath in to begin with it has this
6 introducer with this stiffer part, right?
- 7 A. Correct.
- 8 Q. This whole mechanism goes over the wire?
- 9 A. Correct.
- 10 Q. And then you remove the inside -- this
11 introducer part?
- 12 A. Correct.
- 13 Q. Now what you've got in your patient is a sheath
14 plus a wire?
- 15 A. Correct.
- 16 Q. And then what do you do with the catheter?
- 17 A. The catheter gets put in over the wire.
- 18 Q. So you feed the catheter over the wire, through
19 the sheath, into the patient?
- 20 A. Correct.
- 21 Q. Then you pull the wire out?
- 22 A. Correct.
- 23 Q. And then you get to this point?
- 24 A. Correct.
- 25 Q. All right. So what is this area right here?

1

A. This area is what we call stained.

2

Q. Okay. The way that loop goes, is this a catheter?

3

4

A. (No response.)

5

Q. Is that a catheter?

6

A. Yes, sir.

7

Q. All right. Okay. So where is the tip of the catheter in this picture?

8

9

A. The tip of the catheter is here.

10

Q. Okay. Let's play it and you can explain this along.

11

12

A. Okay. So what you can see here now is dye

13

being injected through the catheter. All right?

14

Some of it is diffusing like we saw on the first

15

image but some of it isn't. What you're seeing is

16

dye being injected directly into the heart muscle.

17

That's called the stain. You can see it here

18

because it doesn't clear. It doesn't go away. It

19

stays there. The insertion of these devices has

20

damaged the heart where it's actually gone through

21

part of the heart structure, and now those catheters

22

are actually injecting the dye into the top surface

23

of the heart.

24

Q. Does this picture show us the tip of the

25

catheter is in contact with the heart?

- 1 A. Yes.
- 2 Q. And then the staining tells us there's damage
- 3 to the heart?
- 4 A. Right.
- 5 Q. So what does this picture prove in this --
- 6 that's germane to this case?
- 7 A. This picture proves that the insertion of this
- 8 sheath and catheter damaged the heart to sufficient
- 9 capacity to cause bleeding which resulted in the
- 10 patient's blood pressure dropping, subsequent events
- 11 having to go to emergency surgery.
- 12 Q. If you followed the normal standard and put the
- 13 device in properly, should you get this injury?
- 14 A. No.
- 15 Q. Okay. Now, there was -- back on our timeline
- 16 there was another -- a pigtail catheter was removed,
- 17 according to the records; is that right?
- 18 A. Yes.
- 19 Q. 11:14 is when it says?
- 20 A. Correct.
- 21 Q. All right. And we have a third fluoro -- we
- 22 have a third x-ray?
- 23 A. Correct.
- 24 Q. All right. Let's look at that and tell us what
- 25 it is. Is this it, the third one?

1 A. That's it.

2 Q. Okay. What does this show us, just as a still
3 right now?

4 A. Okay. So in this image, which is the third in
5 sequence, shows that there's now just the sheath
6 there, so the pigtail catheter -- the one with the
7 little pigtail tip on it -- was pulled out so we
8 have just the sheath left in that pericardial space.

9 Q. Okay. What --

10 A. Now it's even more dramatic. You can see the
11 contrast, the dye is really dark here. So what is
12 this that's not floating away and diffusing? That's
13 dye injected -- directly injected into the heart
14 muscle and it shouldn't be. It should be directly
15 into the space but now because of the way the --
16 because of the technique, because the way the
17 catheters were inserted, the way the wire wasn't
18 protected it's caused damage to the heart resulting
19 in staining or dye directly injected into the heart.

20 Q. Okay. So this -- this video -- the catheter in
21 it seems to pulse. What does the movement of the
22 catheter indicate?

23 A. That it's embedded into the heart tissue.

24 Q. Okay. What can you tell us about the tip of
25 this thing moving the way it does? Does that tell

1 us it's on the heart or in the heart at that point?

2 A. Well, it's certainly -- it's certainly against

3 the heart and probably into at least the top surface

4 of the heart.

5 Q. Okay. And that should not be that way?

6 A. Right.

7 Q. All right. And then the -- the dark sort of

8 trails coming down from that dark spot is what?

9 A. All this is staining. All this is contrast/dye

10 injected right into the heart muscle and it

11 shouldn't be.

12 Q. What does staining like that indicate to you

13 relative to the heart muscle? That it's okay? That

14 it's normal? That it's what?

15 A. No, it's not normal. It's indicative of injury

16 to the heart.

17 Q. All right. Is there any question about all of

18 this in your mind?

19 A. No, none whatsoever.

20 Q. Okay. So the pigtail catheter was removed at

21 11:15, right? So that would be -- this image would

22 have been made after that pigtail was removed,

23 right?

24 A. Correct.

25 Q. All right. And then what happened to the

1 patient thereafter?

2 A. So shortly thereafter the patient's blood
3 pressure started dropping and started dropping and
4 started dropping even more. It went from where it
5 was, which was a 90s rate -- top number 90s rate --
6 it started dropping to 80 and then to 70 and then to
7 60 and then to 40. So he was very hypotensive for
8 quite a long time. Blood pressure was shocky for a
9 long period of time. Severely shocky for at least
10 for at least eight to 10 minutes.

11 Q. Mean arterial pressure, what is that and why is
12 that important?

13 A. Well, because that is what keeps your organs
14 alive. If the blood pressure drops too low, the
15 organs don't get enough blood. There's not enough
16 oxygen delivering to all the tissues and they start
17 to die. You get failure of the kidneys. You get
18 failure of your lungs. You can get failure of all
19 your organs and result into a shock syndrome, which
20 may be very hard to survive.

21 Q. All right. Doctor, now, Dr. Mori dictated a
22 note within minutes of this accident; is that right?

23 A. Yes, sir.

24 Q. All right. That's Plaintiff's Exhibit 3. Have
25 you had a chance to review this before?

1 A. Yes.

2 Q. All right. Just go ahead and read to the jury
3 what happened and what this means, Doctor, from your
4 perspective as a cardiologist.

5 MR. BEIGHLEY: Your Honor, could we ask the
6 witness to return to the stand if he's done using
7 demonstrative --

8 THE COURT: Yes.

9 MR. MCGOWAN: Sure.

10 THE COURT: Dr. Schob, if you'll come around.

11 A. So under title, Description of Procedure --

12 Q. What time was that dictated?

13 A. (No response.)

14 MR. BEIGHLEY: Excuse me. Can you identify the
15 page Plaintiff's 3 is?

16 MR. MCGOWAN: There's a --

17 THE WITNESS: 0043.

18 MR. BEIGHLEY: Thank you.

19 A. Dictated, it looks like from the notes, on
20 July 22nd, 2013 at 12:28 Eastern daylight time.

21 Q. Okay. So the patient would have been in
22 surgery or thereabouts at that point?

23 A. Or on his way.

24 Q. Or on his way? Because the last number here is
25 11:35 on our chart so that would have been about an

1 hour after this last -- but there's more data after
2 that, correct?

3 A. That would be fair.

4 Q. All right. Tell us -- go ahead and read what
5 Dr. Mori dictated within about an hour of all of
6 this happening.

7 A. Okay. So -- do you want me to dictate
8 everything or just --

9 Q. Yeah. Go ahead and read -- you don't have to
10 read it all. Read the stuff that he actually
11 authored himself.

12 A. So Number 1, pericardiocentesis for large
13 pericardial effusion -- this is under Procedures
14 Performed -- Number 2, left and right heart
15 catheterization which was to be done to evaluate for
16 constrictive physiology; could not be done because
17 of complications after pericardiocentesis.

18 Next paragraph, Brief History: A 50-year-old
19 gentleman with history of Noonan's syndrome had a
20 history of large pericardial effusion and came for
21 left and right heart catheterization and also a
22 pericardiocentesis.

23 Paragraph, Description of Procedure: We
24 started out with pericardiocentesis. The area under
25 the sternum was prepped and draped. Next, the

1 pericardial space was entered using a large bore
2 needle. Next, initially more than one liter of
3 pericardial fluid was drained; however, later on the
4 fluid turned hemorrhagic with the blood pressure
5 also going down. This raised the suspicion of
6 myocardial injury during pericardiocentesis and
7 hence the right femoral vein was cannulated. Lots
8 of blood was aspirated from the pericardial space
9 and then eventually given back to the patient.
10 Emergency cardiac surgery evaluation was called for.
11 The pericardial window placement and also repair
12 myocardial injury.

13 Conclusions: Pericardiocentesis was done with
14 a result in complication of hemodynamic instability
15 and probable injury to the myocardium during
16 pericardiocentesis. Patient went for emergency
17 surgery for pericardial window and also pericardial
18 biopsy and repair of myocardial injury.

19 Q. Okay. Now, back on the first page of that did
20 Dr. Mori mention anything about putting the sheath
21 in at all?

22 A. No.

23 Q. Did he mention any reasoning for putting the
24 sheath in?

25 A. No.

1 Q. He does say that there was fluid turned
2 hemorrhagic with the blood pressure also going down.
3 What do you take that to mean?

4 A. That there was an injury to the heart and
5 bleeding creating a syndrome we call tamponade,
6 which, as I said earlier, can strip the heart,
7 prevent it from functioning normally.

8 Q. Okay. So let's just summarize this. Tell us
9 what the -- how Dr. Mori fell below the standard of
10 care, just in summary. I know that there's one or
11 two points we talked about.

12 A. So the first point was the decision to change
13 the pigtail catheter and replace it with a sheath.
14 As I mentioned earlier, the pigtail catheter was
15 placed and looked great. The procedure was going
16 according to -- it was perfect. It should have been
17 stopped at that point and everything was fine.
18 There was absolutely no indication for any damage to
19 the heart with the -- with the needle stick. I
20 mean, if there had been, it would have been much
21 more apparent than being able to draw out over a
22 liter of fluid without any blood.

23 Q. Okay. Let's get to that. The second issue
24 dealt with putting the sheath in itself; is that
25 right?

1 A. And then Number 2, fell below the standard of
2 care because the technique was below the standard of
3 care. As I pointed out to you, insertion of that
4 sheath with that stiff tip dilator created damage to
5 the heart as we demonstrated on the x-ray images.

6 The x-ray images clearly without a doubt
7 demonstrate that that was the key point -- that was
8 the point where the heart was damaged and it was
9 damaged because the technique fell below the
10 standard of care because that wire was not
11 positioned appropriately, as we've gone over.

12 Q. Otherwise you wouldn't have gotten that injury?

13 A. Correct.

14 Q. Okay. Now, there's been some claim that the
15 needle -- initial needle insertion caused the
16 injury. What does the medical evidence show, that
17 you've looked at, about whether it was the initial
18 needle stick that did it?

19 A. There was absolutely no evidence to show that
20 it was that.

21 Q. Okay. Even if it was the needle, in this case
22 would that be below the standard of care if the
23 needle insertion in this case caused that kind of
24 injury?

25 A. Yes. This was a very large effusion. This was

1 -- the only way a needle injury could have created
2 damage would have been with a technique that was
3 well below the standard of care. This was an
4 extremely large pericardial effusion. Echo, EKG
5 guides were being used to help prevent -- make it
6 safe. The needle in no way should have damaged that
7 heart.

8 MR. MCGOWAN: Okay. All right, Doctor. That's
9 all I have. I'm sure Mr. Beighley will have some
10 questions for you. Thank you, sir.

11 THE COURT: Mr. Beighley, your witness.

12 MR. BEIGHLEY: May it please the Court.

13 CROSS-EXAMINATION

14 BY MR. BEIGHLEY:

15 Q. Good morning, Doctor.

16 A. Good morning.

17 Q. Doctor, as I understand it, you are employed by
18 both University of Miami and United States
19 Government Veterans Association?

20 A. Yes, sir.

21 Q. And the Government has certain restrictions on
22 your ability to serve as an expert witness; is that
23 right?

24 A. Not that I'm aware of.

25 Q. Well, I thought you told me that there were

1 places you could testify and places you couldn't in
2 the State of Florida.

3 A. That's correct.

4 Q. All right. So if that's --

5 A. But that's not the Government.

6 Q. That's not the VA?

7 A. No, sir.

8 Q. Who puts those restrictions on you?

9 A. University.

10 Q. Are you required to take vacation time when you
11 come up here and testify?

12 A. Yes, sir.

13 Q. You're on vacation now?

14 A. Yes, sir.

15 Q. One of your primary duties is to supervise
16 other physicians working in the cath lab; is that
17 right? About 60 percent of your time?

18 A. Correct.

19 Q. And they are performing procedures you are
20 observing?

21 A. We are performing procedures together.

22 Q. In fact, it would be rare for you to perform a
23 procedure by yourself?

24 A. No.

25 Q. Totally by yourself?

1 A. No. That's not correct.

2 Q. All right. Then let's look at the deposition,
3 Doctor, see what you said at that time.

4 MR. BEIGHLEY: Your Honor, at this time I ask
5 the Court to explain the deposition and use of.

6 THE COURT: Okay. Ladies and gentlemen of the
7 jury, sometimes during a trial testimony will be
8 presented to you through a deposition. A deposition
9 is the sworn, recorded answers to questions of a
10 witness in advance of the trial. Deposition
11 testimony is entitled to the same consideration and
12 it is to be weighed and otherwise considered by you
13 insofar as possible the same way as if the witness
14 had been present and testified from the witness
15 stand in court.

16 BY MR. BEIGHLEY:

17 Q. Doctor, do you remember when I took your
18 deposition April 26, 2016?

19 A. Yes, sir.

20 Q. Let's take a look at page 7, if you will. Tell
21 me when you get to that page.

22 A. Got it.

23 Q. Line 24. "Question: And how many times do you
24 do and how many of them do you do entirely by
25 yourself versus doing part of it versus

1 supervising?"

2 And what was your answer on page 8, line 1 and
3 2?

4 A. "I would say the exception is doing it totally
5 by myself. That would be rare."

6 MR. MCGOWAN: Can he read the rest of it?

7 MR. BEIGHLEY: Yeah, certainly.

8 A. "Most of the time since we have a training
9 program where we are teaching fellows it is standard
10 practice for them to be doing what they've been
11 doing. When they can't perform whatever needs to be
12 done I take over."

13 Q. So --

14 A. "That's only when the fellows are absent or out
15 on vacation -- things like that -- that I will do
16 the procedure myself."

17 Q. So then it would be rare for you to do it
18 solely by yourself?

19 A. It depends on what procedure we're talking
20 about.

21 Q. Procedures in general. Any procedures.

22 A. Well, very different procedures require
23 different amounts of my participation, and there are
24 certain procedures like pericardiocentesis where the
25 fellow is precluded, even though they may be there

1 in the procedure room watching.

2 Q. But the question I asked you generally was, as
3 far as procedures -- all procedures done in the cath
4 lab, it would be rare for you to do it all by
5 yourself?

6 A. No cardiologist does any procedure all by
7 themselves. They have techs there with them helping
8 them as well, so I'm not really quite sure what
9 you're getting at with that question.

10 Q. Well, I thought you understood it, sir, in the
11 deposition. Was there anything tricky or confusing
12 about that question?

13 A. Well, when you're saying all by yourself, the
14 implication is I'm the only operator there without
15 assistance.

16 Q. No. My question is, you're the only physician
17 doing the procedure.

18 A. That wasn't your question.

19 Q. Well, let's go back and read it again, Doctor.
20 Look on page 7. Let's start back there. I'll read
21 you line 20 when you get there.

22 A. Where do you want me to start?

23 Q. Well, are you ready there?

24 A. On page 7?

25 Q. Yes.

1 A. Yes.

2 Q. Line 17: "What percent of your professional
3 time is spent in the lab?"

4 And your answer?

5 A. "Sixty to 70 percent."

6 Q. "Question: And in that role are you actually
7 doing invasive procedures or supervising others or
8 some combination?"

9 And your answer?

10 A. "Combination."

11 Q. "Question: How many of them" -- meaning
12 procedures -- "done in the cath lab do you do
13 entirely by yourself versus doing part of it versus
14 supervising?"

15 And your answer was, "I would say the exception
16 is doing it totally by myself. That would be rare."

17 Is that what you said?

18 A. That is what I said.

19 Q. All right. Thank you.

20 A. But I think it deserves some explanation.

21 Q. Not if you've read it, Doctor.

22 You've been reviewing cases as an expert
23 witness for attorneys since sometime in the 1990s?

24 A. Correct.

25 Q. More than 20 years?

1 A. Correct.

2 Q. And you average somewhere four to eight cases
3 every year?

4 A. Correct.

5 Q. Probably 80 then to 160 cases that you've been
6 hired to review for attorneys?

7 A. Correct.

8 Q. You've given 50 or 60 depositions by your
9 estimate?

10 A. Correct.

11 Q. And you've reviewed at least four or five cases
12 for Mr. McGowan or attorneys in his firm?

13 A. Correct.

14 Q. Regarding the procedure known as
15 pericardiocentesis there are various approaches or
16 methods a cardiologist could use to do that?

17 A. Correct.

18 Q. And the most common would be the subxiphoid
19 approach that was used in this case?

20 A. That's correct.

21 Q. Performing a pericardiocentesis on a patient
22 has a number of risks associated with it; is that
23 true?

24 A. That's true.

25 Q. And bleeding is one of those risks; is that

1 true?

2 A. Yes.

3 Q. And bleeding can occur even when the procedure
4 is performed within the standard of care, can it
5 not?

6 A. Yes, sir.

7 Q. And the fact that bleeding -- a bleeding
8 complication occurred by itself doesn't mean the
9 physician did something wrong, does it?

10 A. In general, no.

11 Q. And when a bleeding complication occurs during
12 this procedure some of those require surgical
13 intervention to correct?

14 A. Yes, sir..

15 Q. And I believe you've told us that the
16 pericardiocentesis that Dr. Mori performed on
17 Mr. Dibernardo was initially performed correctly?

18 A. Yes, sir.

19 Q. In fact, you said it was a classic or textbook
20 example.

21 A. Yes, sir.

22 Q. And I think you agree with me that it was an
23 appropriate procedure for Mr. Dibernardo to have
24 based on his longstanding cardiac problems?

25 A. No question.

1 Q: If I understand your testimony, the basic
2 disagreement that you have with Dr. Mori is in his
3 decision to remove the pigtail catheter that was
4 originally placed and attempt additional efforts to
5 try to get better flow out of the pericardium. Is
6 that a fair statement?

7 A. Yes.

8 Q. And in your opinion the appropriate course of
9 action would have been to simply hook the catheter
10 that was in place to drainage and send the patient
11 to the intensive care unit?

12 A. Correct.

13 Q. Now, you have told us multiple times that you
14 believe that the sheath is what caused injury to the
15 heart. I need to know if you are testifying that
16 all of the bleeding that was described and
17 encountered here was due to the sheath, or if you
18 agree that there was some bleeding that occurred
19 which precipitated Dr. Mori's decision to change to
20 the sheath.

21 A. No. As we discussed earlier, there was no
22 evidence for bleeding prior to the decision to
23 replace the pigtail catheter with the sheath, and
24 the timing upon the record would clearly support
25 that.

1 Q. So from the records and your review of all the
2 imaging studies and so forth you saw no evidence to
3 support a bleeding complication until after the
4 sheath was inserted?

5 A. Correct. The surgeon also, when he operated on
6 the patient, noted some oozing from the right
7 ventricle which would also coincide and support that
8 assessment.

9 Q. That raises a good point and I think you said
10 this but let's be clear: It's not your testimony
11 that Dr. Mori punctured the wall of the heart and
12 was inside the heart?

13 A. Correct.

14 Q. It was contact with the wall of the heart
15 enough to allow dye to enter the muscle?

16 A. Right. So as the sheath and dilator were being
17 inserted they scraped and to some extent even
18 embedded into the heart muscle. And if you saw in
19 my initial drawings, there are veins and arteries
20 that cross the surface of the heart, so as you're
21 inserting that sheath with the dilator you're
22 potentially interrupting those vessels as well so
23 that could lead to more pronounced bleeding.

24 Q. And that can happen when you insert a needle as
25 well?

1 A. In general it can, but it shouldn't in this
2 case.

3 Q. And wouldn't you agree with me that the needle
4 which you demonstrated would be a sharper instrument
5 than the sheath or catheter?

6 A. Sharper, yes.

7 Q. That would be the sharpest device that was
8 placed in this operation. You would agree with
9 that?

10 A. (No response.)

11 Q. Utilized in this operation?

12 A. I'm sorry?

13 Q. That the needle would be the sharpest object
14 that had been used in this procedure?

15 A. Yeah. The needle is clearly the sharpest
16 device that was placed in this patient. The issue
17 is that a needle puncture in and of itself should
18 not create the amount of bleeding that occurred, and
19 if it had it would have been much more readily
20 apparent much earlier in the procedure.

21 Q. Now, you were asked about the -- the
22 hypotensive or low blood pressure readings there
23 that went on for -- that show on this chart for five
24 or six minutes, but if we added onto the rest of the
25 chart we'd see that those blood pressures came back

1 up, wouldn't we?

2 A. Yes, sir.

3 Q. And the patient was stabilized in the OR -- I'm

4 sorry -- was stabilized in the cath lab?

5 A. Is that a question?

6 Q. Yes.

7 A. Yes.

8 Q. And was able to go to surgery?

9 A. Correct.

10 Q. So the hypotensive episode per se didn't cause

11 him any specific injury?

12 A. That I would disagree with.

13 Q. Well, what -- was he able to talk?

14 A. In the cath lab?

15 Q. Yeah.

16 A. Before the -- yes, before the blood pressure

17 started dropping --

18 Q. Throughout the process?

19 A. There is some evidence that he was somewhat

20 responsive.

21 Q. All right. So he never lost consciousness or

22 was unresponsive?

23 A. As far as I could tell.

24 Q. All right. And in the descriptions that were

25 given by his other physicians, particularly Dr.

1 Wooten -- I'm sure you saw her record. She was able
2 to communicate with him even when he was on the
3 ventilator so -- you saw that, right?

4 A. Yes, sir.

5 Q. All right. Doctor, I believe you told me that
6 you are clearly not an expert on Noonan's syndrome.

7 A. I would agree with that.

8 Q. And in fact, you had to look it up yourself in
9 this case?

10 A. Correct.

11 Q. But you do know that Noonan's syndrome can have
12 very significant effects on a patient's heart?

13 A. Yes, sir.

14 Q. It would be rare for a cardiologist to --
15 yourself included to treat Noonan's heart patients.
16 Would you agree?

17 A. I would agree.

18 Q. In fact, I think you told me if you've seen
19 more than two or three yourself it'd be a lie?

20 A. Correct.

21 Q. And you have yourself never done a
22 pericardiocentesis on a Noonan's patient; is that
23 right?

24 A. That's correct.

25 Q. Tell us some of the heart problems that -- as a

1 cardiologist with just your basic Noonan's
2 knowledge, what are some of the problems a Noonan's
3 patient can have with their heart?

4 A. So the heart is probably the primary organ
5 that's affected by Noonan's syndrome. There are
6 various things that can -- that can happen to
7 patients with Noonan's syndrome with regards to the
8 heart. There are valve problems. There are muscle
9 problems.

10 In this case there was a question of a valve
11 problem; however, the echocardiogram didn't really
12 substantiate that there was a severe valve problem.
13 There was what we call thickening of the heart
14 muscle called cardiomyopathy. The heart function
15 itself was okay, was normal, but -- the main pumping
16 chamber squeezed normally but there was thickening
17 of the heart muscle. We call that cardiomyopathy.
18 There are various other valve problems that can
19 occur in Noonan's syndrome.

20 Q. And Mr. Dibernardo had a massively enlarged
21 heart.

22 A. He had a big heart, but massively enlarged
23 because he had a pericardial effusion.

24 Q. And pericardial effusion -- we had pictures up
25 there showing it. You would agree with me that in

1 the anatomy it's not a nice, perfect circle around
2 the heart? The dimensions of the pericardial
3 effusion can vary at various points around the
4 heart?

5 A. That's correct.

6 Q. Now, we've talked about earlier that you agreed
7 with the patient's decision to seek treatment, and a
8 pericardiocentesis was the appropriate treatment,
9 correct?

10 A. Yes, that's correct. The pathology report that
11 was sent to the lab -- the pathology report -- a
12 piece of the pericardial tissue was taken during the
13 surgery and sent to the pathology lab where it was
14 looked at under a microscope. That clearly showed
15 that there was what we call inflammatory
16 pericardium, that the pericardium was very thick and
17 inflamed, which would indicate that there was some
18 process going on that was affecting the heart and
19 creating all that fluid around the heart and,
20 indeed, confirmed that the indication for the
21 pericardiocentesis was appropriate and that there
22 would have been opportunity at some point down the
23 line to eliminate the pericardium by a surgery which
24 would hopefully have led to improvement in the
25 patient's overall heart function, symptoms, et

1 cetera.

2 Q. And if Mr. Dibernardo -- we know from testimony
3 in the record that he did not want surgery, but if
4 he had taken no steps, not had any treatment for his
5 heart, his symptoms would have continued to
6 progress, wouldn't they?

7 A. Well, not necessarily, not if the procedure had
8 been performed appropriately.

9 Q. No. I'm saying if he had not done anything, if
10 he had not had any procedure -- pericardiocentesis
11 or any procedure on his heart. Left untreated his
12 heart condition would have caused him to have a
13 continued downhill progression?

14 A. Most likely.

15 MR. BEIGHLEY: Your Honor, would you indulge me
16 one moment?

17 THE COURT: Yes, sir.

18 BY MR. BEIGHLEY:

19 Q. Doctor, is there a specialty board for
20 echocardiography?

21 A. Yes, sir.

22 Q. Are you board-certified in echocardiography?

23 A. No, sir.

24 Q. Finally, what structure in the heart is
25 adjacent to the xiphoid process?

1 A. The diaphragm.

2 Q. Of the heart?

3 A. You're going to have to --

4 Q. If you're going through the subxiphoid approach
5 with your needle what's the closest part of the
6 cardiac anatomy at that approach?

7 A. The pericardium..

8 Q. And the actual heart itself?

9 A. Well, the right ventricle.

10 Q. Right ventricle?

11 MR. BEIGHLEY: Thank you.

12 THE COURT: Any redirect?

13 MR. MCGOWAN: Briefly.

14 REDIRECT EXAMINATION

15 BY MR. MCGOWAN:

16 Q. Did Noonan's syndrome really have anything to
17 do with how Dr. Mori chose to put in these catheters
18 and sheaths and stuff?

19 A. No.

20 Q. Did it have anything to do with his death,
21 other than maybe causing the big heart to begin
22 with?

23 A. Could you repeat the question?

24 Q. Did the -- was the Noonan's syndrome the reason
25 Dr. Mori injured his heart?

1 A. No.

2 Q. Okay. Would the landscape of the heart in this
3 case have been any mystery to a cardiologist with
4 the echo and fluoroscopy that was available in the
5 room?

6 A. No.

7 Q. Was this bleeding in this case indicative of
8 falling below the standard or was this the kind of
9 bleeding that's a mere complication?

10 A. As I've stated, this was below the standard due
11 to poor technique and decisionmaking.

12 Q. Okay. I want you to assume for the purpose of
13 my question that it was the needle that actually
14 caused the injury. Might not think that's true but
15 if it was the needle, in this case, given the
16 guidance techniques available, the echo, the fluoro;
17 the size of the effusion; and the method by which
18 you're supposed to insert this needle, would it have
19 been negligence to injure the heart with the needle
20 in this case under the particular circumstances then
21 and there?

22 A. Yes.

23 MR. MCGOWAN: Okay. That's all I have. Thank
24 you, Doctor.

25 MR. BEIGHLEY: May I?

1 THE COURT: Yes, sir, in response to his
2 redirect.

3 BY MR. BEIGHLEY:

4 Q. Needle injuries, equipment injuries, any kind
5 of an injury will cause bleeding with this
6 procedure; is that true?

7 A. In general, yes.

8 Q. And just because there's bleeding that doesn't
9 mean somebody's committed a malpractice?

10 A. In general, that's correct.

11 MR. BEIGHLEY: Thank you.

12 THE COURT: All right. Anything further from
13 this witness?

14 MR. MCGOWAN: No, sir, Your Honor. May he be
15 excused?

16 THE COURT: Any objection?

17 MR. BEIGHLEY: No, Your Honor.

18 THE COURT: Thank you, Doctor. You are
19 excused.

20 THE WITNESS: Thank you.

21 THE COURT: All right. We're going to take a
22 short break before we do the next witness.

23 Mr. Bailiff, if you'll take our jury in the
24 jury room, we'll take about a 10-, 15-minute break.

25 (The jury panel exits the courtroom.)

1 (Recess was taken.)

2 THE BAILIFF: All rise.

3 THE COURT: Thank you. Thank you. Y'all can
4 be seated. All right. Anything from either party
5 before we bring our jury in?

6 MR. MCGOWAN: Just to let you know where we're
7 at, Judge, we have Ms. Dibernardo and that will be
8 our last witness.

9 THE COURT: Okay.

10 MR. BEIGHLEY: Judge, if you'd give it
11 consideration, it might be good to go to lunch early
12 when we get finished with this witness and then we
13 could handle any motions or whatever and then come
14 back and start the defense case.

15 THE COURT: Okay. That would be a natural
16 breaking point.

17 MR. BEIGHLEY: It will be a natural breaking
18 point.

19 THE COURT: All right. Mr. Bailiff, if you'll
20 go get our jury for us please, sir.

21 (The jury panel enters the courtroom.)

22 THE COURT: All right. Mr. McGowan, call your
23 next witness.

24 MR. MCGOWAN: Thank you. I call Lorrie
25 Dibernardo.

1 THE CLERK: Ms. Dibernardo, if I could have you
2 step around here, and be sworn.

3 (Witness was duly sworn.)

4 DIRECT EXAMINATION

5 BY MR. MCGOWAN:

6 Q. You are Lorrie Dibernardo?

7 A. Yes, sir.

8 Q. All right. You were married to Anthony?

9 A. That's right.

10 Q. All right. Tell me about how you and Anthony
11 met.

12 A. Anthony and I met online on the Internet --
13 through the Internet, I believe --

14 Q. Wait a minute. That's --

15 A. -- in 2004.

16 Q. 2004? Okay.

17 A. We started talking about and he asked for my
18 number. I was skeptic and -- so we talked a little
19 bit more on the computer, and then finally I gave in
20 and gave him my number and he called. And anybody
21 that would hear him on the phone would swear up and
22 down he sounds just like Sylvester Stallone. That's
23 just how he sounded. And even though -- I'm a
24 person who looks beyond the outward appearance. I
25 always have. I guess I have a thing for underdogs.

1 But when I asked for a picture of him he was
2 hesitant because of the way he looked and -- but he
3 sent one and he was shocked that I was still talking
4 to him. I said, why -- why should I not talk to
5 you? And I'm a firm believer; don't judge a book by
6 its cover.

7 Q. Okay. So you got to know him?

8 A. And -- open it up. Read a few pages, read a
9 few chapters. Find out what it's about before you
10 judge it. And I gave him that chance. Don't go for
11 the outward appearance. Get to know him first
12 before you pass your judgment and I did.

13 Q. And where was he from?

14 A. Anthony? He was originally born in Albany, New
15 York and he lived in Florence, New Jersey with his
16 parents at the time.

17 Q. Okay. So y'all started conversing and how long
18 was it until y'all first met in person?

19 A. We actually talked for a year before we met in
20 person.

21 Q. Okay.

22 A. And -- so I was kind of, you know...

23 Q. Easing into it?

24 A. Yeah.

25 Q. Okay. And over time y'all got pretty close,

1 I'd say?

2 A. Yeah.

3 Q. Y'all ended up getting married. How long were
4 y'all courting before you got married?

5 A. I'm going to say four and a half years.

6 Q. Okay. So there was a time where you and he
7 ended up getting married and families got together
8 and the whole bit, right?

9 A. Yes, sir.

10 Q. Did -- where did y'all live after you got
11 married?

12 A. Say it again.

13 Q. Did y'all live down here or did you go to New
14 Jersey?

15 A. No, we lived down here.

16 Q. Okay. What kind of person was Anthony?

17 A. He was an outgoing person. He wasn't big in
18 stature. He was only five-foot-two. But he was the
19 most kindest, sweetest man that I had ever met in my
20 life, and honestly I don't think there's another one
21 like him.

22 Q. Okay.

23 A. He was one of a kind.

24 Q. Now, we're here about what happened in July of
25 2013.

1 A. Right.

2 Q. Tell me about how he was physically, mentally
3 and otherwise leading up to that July visit, in the
4 month, two or three leading up to that.

5 A. He had some issues with his feet swelling some.
6 Mostly it was his left, you know, foot, you know.
7 Overnight it would go down. It would just swell up
8 some during the daytime when he was on his feet.

9 And then his right foot started swelling up some so
10 he got a little concerned, you know, wanted to make
11 sure there was nothing seriously going on with his
12 leg. He thought he might have had a blood clot or
13 something in his leg.

14 Q. Okay.

15 A. And -- but as far as doing things, it didn't
16 keep him down.

17 Q. Was he still active?

18 A. He was active. He drove me to work every
19 day -- back and forth to work every day.

20 Q. All right.

21 A. And...

22 Q. Was he pretty close to your brother-in-law?

23 A. Yes.

24 Q. And your sister? That would be Kelly and J. C.
25 From yesterday?

- 1 A. Right. Very close.
- 2 Q. All right. What kind of things did he like to
- 3 do?
- 4 A. (No response.)
- 5 Q. What kind of stuff would he like to do for fun?
- 6 What's a good time to Anthony Dibernardo?
- 7 A. He liked to shoot pool and pretty good at it.
- 8 He loved fishing. He just, you know, liked going
- 9 out and -- we'd go to the mountains. He loved going
- 10 to the mountains, riding the go-karts. Normal stuff
- 11 that, you know, people love to do.
- 12 Q. Okay. And July 19th is when he went to the
- 13 hospital?
- 14 A. That's right.
- 15 Q. How did he get to the hospital?
- 16 A. He drove himself.
- 17 Q. What was your understanding of why he was in
- 18 the hospital in July?
- 19 A. My understanding was that he was admitted to
- 20 have a heart catheterization done.
- 21 Q. And what did you understand that to be?
- 22 A. Just to go in and look around in his heart to
- 23 find out if there's anything in there blocking --
- 24 blockage or anything.
- 25 Q. In the years leading up to this July 2013 he

1 had seen a cardiologist; is that right?

2 A. Yeah.

3 Q. And which group was he going to?

4 A. (No response.)

5 Q. Which group? Who was his group of
6 cardiologists? Do you know?

7 A. Carolina Cardiologists.

8 Q. And that's the same one Dr. Mori's a part of.

9 Do you know if he ever actually saw Dr. Mori before
10 being in the hospital in July?

11 A. No.

12 Q. You don't know or he didn't?

13 A. I don't know if he did or not.

14 Q. Okay. So he's in the hospital and the plan was
15 to do a catheterization. Now, when he was there you
16 were with him the whole time?

17 A. Right.

18 Q. How was he in the hospital up to the time of
19 the heart procedure? How was he acting?

20 A. He was his fine, normal self. He was up. He
21 was nervous about the procedure because he'd never
22 had one done, you know, as far as something like
23 that, but he was his fun self, joking, cutting up,
24 laughing. You know, his normal self.

25 Q. Was -- were you there when Dr. Mori came in?

1 A. (No response.)

2 Q. I mean, was there a process before the
3 procedure where they come in and said, all right,
4 I'm your doctor. Here's what we're going to do?

5 A. I never saw anybody when I was there.

6 Q. In your presence while you were there with him
7 did anybody ever come in and say, all right,
8 Anthony, here's the deal. We put a -- we might cut
9 your heart when we do this?

10 A. No.

11 Q. Okay. He goes off on July 22nd for the
12 pericardiocentesis.

13 A. Right.

14 Q. When was the last time you saw him with your
15 eyes before that procedure?

16 A. When the orderly came in to wheel him away to
17 go have the procedure done.

18 Q. Now, had you been staying up there with him
19 that whole time?

20 A. Yeah.

21 Q. All right. So the orderly comes in and says,
22 it's time for your procedure, Mr. Dibernardo. Kiss
23 him goodbye and off he goes? Right?

24 A. I probably didn't even get to kiss him goodbye
25 because they had the rails up on the bed and I

1 couldn't lean over far enough to get him.

2 Q. I got you.

3 A. So I just blew him a kiss and said, I'll wait
4 for you downstairs.

5 Q. All right. And then he gets wheeled off down
6 the hallway?

7 A. Right.

8 Q. And then you go where?

9 A. Downstairs to the heart surgical waiting area.

10 Q. Were you there for a while?

11 A. Uh-huh.

12 Q. All right. What's the next thing that happens
13 that you recall?

14 A. The next thing that happened Dr. Mori come out,
15 pulled me into a consultation room and began to tell
16 me that they had started the heart catheter and had
17 to stop to relieve some fluid up from around his
18 heart and in doing that procedure they nicked a vein
19 and he had to be rushed into emergency surgery.

20 Q. All right. Now, the procedure to remove fluid
21 from the heart, had that been discussed in your
22 presence before that moment?

23 A. No.

24 Q. All right. So your understanding was they were
25 just going to do a catheterization?

1 A. Right.

2 Q. But you learned after the fact that they had
3 decided to do a pericardiocentesis?

4 A. Right.

5 Q. And Dr. Mori had told you they nicked a vein at
6 that time?

7 A. That's right.

8 Q. And then what happened next?

9 A. Then I went back out into the waiting area.
10 Then later on Dr. Savage came out and told me --
11 because he's the one that went in to repair the
12 damage to the --

13 MR. BEIGHLEY: Your Honor, I object --

14 A. -- that he -- because --

15 THE COURT: All right. Hold --

16 MR. BEIGHLEY: -- the witness --

17 THE COURT: All right. Hold on. Hold on. I'm
18 going to sustain the objection. Hearsay.

19 BY MR. MCGOWAN:

20 Q. So you had a conversation with Dr. Savage who's
21 the surgeon?

22 A. Right.

23 Q. All right. Did you speak with Dr. Mori again
24 later?

25 A. Yes. When my in-laws got to the hospital they

1 wanted to talk to Dr. Mori.

2 Q. And were you there for that conversation?

3 A. Yes, I was.

4 Q. And tell me what you recall Dr. Mori said at
5 that time.

6 A. He started telling us that they started to do
7 the heart catheterization, had to stop and go up and
8 relieve fluid up around his heart. He said in doing
9 so they nicked an artery.

10 Q. So this time it was an artery and not --

11 A. Right.

12 Q. Okay. Did you question him on that?

13 A. I did.

14 Q. And what was his response?

15 A. He just brushed it off like, you know, they're
16 the same thing.

17 Q. All right. Now, was this when Anthony was in
18 ICU after the surgery?

19 A. Yeah.

20 Q. All right. So he went from surgery to the ICU.
21 That's correct, isn't it?

22 A. Right.

23 Q. Now, were you with him during this time?

24 A. In ICU, yeah.

25 Q. Okay. Did you see him on the ventilator?

1 A. Yes.

2 Q. Was there a time where they -- he still had the
3 tube down his throat to breath but they took the --
4 the machine off of the tube?

5 A. No, I never did.

6 Q. No. I mean, did they? And then they put him
7 back on the ventilator?

8 A. They did.

9 Q. Okay. Did there come a time they took him off
10 the ventilator for a second time and actually took
11 the tube out?

12 A. Yes.

13 Q. Okay. Were you there for that?

14 A. Yes.

15 Q. What was -- what -- what did you see, observe
16 -- what did you experience that day when they took
17 the tube out for the -- for the second time? How
18 was Anthony? How did he appear?

19 A. Lifeless. He wasn't moving. He was like he
20 couldn't breathe.

21 Q. Did there come a time when the medical people
22 had a conversation with you about reintubating or
23 putting the breathing tube back in?

24 A. They did. Dr. -- she came in there and pulled
25 me out to the hallway.

1 Q. This would have been a female doctor in ICU?

2 A. (No response.)

3 Q. A female doctor in the ICU?

4 A. Right.

5 Q. Okay.

6 A. And she had told me that they took him off the
7 ventilator, took the tubes out and everything, and
8 he's still having trouble breathing and that he
9 needs to go back on it for another five to seven
10 days.

11 Q. Now, when you saw him not on the machine what
12 was your observation about how easy he was
13 breathing?

14 A. (No response.)

15 Q. Was he having difficulty based on what you saw
16 or was he just kind of out of it?

17 A. I never actually saw him, before she came out
18 and told me that, off the ventilator.

19 Q. Okay.

20 A. The only time I saw him off the ventilator is
21 after she come out there and told me they had taken
22 it out.

23 Q. And you had a conversation with this female
24 doctor that worked in ICU?

25 A. Right.

1 Q. And you got the impression or what she told you
2 was five to seven days back on the vent?

3 A. Right.

4 Q. And then what was the prognosis after that?
5 What were -- what -- because you ultimately made the
6 decision to not put him back on the --

7 A. Right.

8 Q. -- ventilator; is that right?

9 A. Yes.

10 Q. Why did you make that decision at that time?
11 What was your state of mind and what did you learn
12 from these doctors and nurses that pointed you in
13 that direction?

14 A. After I saw him in the ICU after the procedure
15 was done in my heart I know that I wasn't --
16 wouldn't take him home with me. After Dr. Wooten
17 spoke to me in the hallway it was under my
18 impression that he would get better if I put him
19 back on there for another five to seven days.

20 Q. Okay.

21 A. And -- so she had asked me if I wanted to do
22 that. I said, well, if he's going to get better,
23 yeah. And so I went and got my father-in-law and
24 sister-in-law and brought them out in the hallway,
25 and she went and got Dr. Wooten and brought her back

1 out. And they wanted her to tell them what she had
2 told me.

3 Q. All right.

4 A. And --

5 Q. And you were there for this conversation?

6 A. Right.

7 Q. All right.

8 A. And she had told -- told them what she told me,
9 and my sister-in-law asked her if she decides to put
10 him back on there for another five to seven days
11 what are his chances of pulling through and coming
12 out of here?

13 Q. Coming out of here being Piedmont?

14 A. Yeah.

15 Q. Okay.

16 A. Alive. And she said, well, he may live 24 to
17 48 hours. That's it.

18 Q. All right. So you were faced with a decision
19 at that point to put him back on a vent for five to
20 seven days and then based upon what the doctor told
21 you --

22 A. Right.

23 Q. -- he may live 24 to 48 hours after that and
24 then pass?

25 A. That's right.

1 Q. All right. So what decision did you -- did you
2 make?

3 A. To not put him back on it.

4 Q. Was that tough?

5 A. It was tough.

6 Q. What kind of loss has this been? What kind of
7 loss to you has this been?

8 A. A big loss. He was my heart. He was my life.
9 Even to this day I miss him so much, you know.

10 Q. Yeah. Now, we've had some pictures that you
11 provided. These are of Anthony; is that right?

12 A. Yeah.

13 Q. And this is probably one of the best ones where
14 he's smiling, right?

15 A. That was back in his younger days.

16 Q. Yeah? Okay. Is this one -- this one is 13(b).
17 Which one is that?

18 A. That was on our wedding day.

19 Q. That's where y'all got married?

20 A. (Nonverbal response.)

21 MR. MCGOWAN: All right. Thank you. That's
22 all I have. Mr. Beighley may have some questions
23 for you.

24 THE COURT: Mr. Beighley?

25 MR. BEIGHLEY: May it please the Court.

1

CROSS-EXAMINATION

2

BY MR. BEIGHLEY:

3

Q. Do you need some water or anything, ma'am?

4

A. (No response.)

5

Q. Would you like some water?

6

A. No, I'm fine.

7

Q. As you understand it, Mr. Dibernardo was born

8

with Noonan's syndrome?

9

A. You're going to have to speak up a little more.

10

Q. Yes. I'm sorry. Is it your understanding that

11

Mr. Dibernardo was born with a condition known as

12

Noonan's --

13

A. Yes.

14

Q. -- syndrome?

15

A. Yes.

16

Q. And as a result of that he suffered from a

17

large -- an enlarged heart?

18

A. (Nonverbal response.)

19

Q. And he had a stroke in his 20s?

20

A. Yes.

21

Q. And was disabled because of that?

22

A. Yes.

23

Q. He did not work outside the home during the

24

marriage?

25

A. Not during the -- not when we were married, no.

1 Q. And I think you told me that you worked the
2 night shift --

3 A. Yeah.

4 Q. -- and he kind of took care of things around
5 the house?

6 A. He said, you're the breadwinner and I'm the
7 housewife.

8 Q. And his medical problems caused his legs to
9 swell up?

10 A. Yeah, they would swell up some.

11 Q. And he was seeing for those problems
12 cardiologist Dr. Shah?

13 A. Yeah.

14 Q. And last time he went to visit with Dr. Shah
15 was a couple months before he went in the hospital?

16 A. Yeah.

17 Q. He went to most of his visits by himself?

18 A. Yeah. He made them early in the morning
19 because I worked late nights and he'd pretty much
20 make them all around 8:00 or 8:30 in the mornings.
21 He would just go and come back. It wouldn't take
22 long.

23 Q. And during the month or two before Dr. Shah put
24 him in the hospital his swelling problems were
25 starting to get worse, weren't they?

1 A. It wasn't too -- wasn't as -- wasn't too bad
2 but it was enough to where he was concerned.

3 Q. He was having increasing complaints?

4 A. About his -- he had something wrong with his
5 stomach and he had went to the emergency room, I
6 believe it was, and had it checked out and -- but
7 other than the swelling of his feet and stuff,
8 that's about it.

9 Q. His left leg was swollen --

10 A. Yeah. His left leg is the only one that really
11 gave him the problem for a long time.

12 Q. And then during the last month or so his right
13 leg also started --

14 A. His right leg --

15 Q. -- swelling?

16 A. -- started to swell up a little bit, yeah.

17 Q. And he was concerned about that?

18 A. Yeah.

19 Q. And Dr. Shah was concerned and sent him to see
20 the surgeon?

21 A. Yeah.

22 Q. And I believe you went with him to the visit
23 with the surgeon; is that right?

24 A. On that day?

25 Q. No. This was -- this was when Dr. Shah

1 referred him to see Dr. Savage for surgery.

2 A. Yeah.

3 Q. Before he went in the hospital.

4 A. Yeah.

5 Q. You were there?

6 A. Yeah.

7 Q. And Mr. Dibernardo made it clear he did not
8 want surgery?

9 A. That's right.

10 Q. And the last time he went to see Dr. Shah was
11 July 19th. You were not there that day?

12 A. Yeah, that's right.

13 Q. And Dr. Shah was so concerned about your
14 husband he put him in the hospital?

15 A. Right.

16 Q. His swelling was increasing and he was having
17 trouble breathing?

18 A. He didn't really have a whole lot of trouble
19 with his breathing unless he had to walk a good bit
20 of distance.

21 Q. Was his breathing troubles becoming more of a
22 -- more of a problem for him?

23 A. No. Most of it was the swelling in his legs.

24 Q. So you don't remember him having the breathing
25 problems?

1 A. No. I don't remember him getting any -- you
2 know, having a problem with it, no.

3 Q. So you got a call that Dr. Shah put him in the
4 hospital; is that right?

5 A. Right.

6 Q. Okay. And you were there -- you stayed -- I
7 think you told me you stayed in the hospital. You'd
8 go home and change and come back.

9 A. Right.

10 Q. But there were times that you weren't there at
11 the hospital?

12 A. Yeah.

13 Q. But during the time that you were there you
14 don't remember seeing any of the doctors before the
15 surgery?

16 A. Seeing what?

17 Q. Before the surgery?

18 A. (No response.)

19 Q. Let me back up. That was a bad question. When
20 he went in the hospital on the 19th that was a
21 Friday, and they kept him over the weekend, did the
22 cath lab procedure on Monday the 22nd.

23 A. Uh-huh.

24 Q. Is that right?

25 A. Yeah.

1 Q. That's what the records show? That's what you
2 remember?

3 A. Yeah.

4 Q. Okay. My question is, over that weekend you
5 were staying there but you would go home from time
6 to time, and during the time that you were there you
7 didn't talk to any of his doctors?

8 A. No.

9 Q. Okay. On the day of the procedure Dr. Mori
10 came out and told you that during the procedure
11 there had been a bleeding complication?

12 A. Right.

13 Q. And as a result of that bleeding complication
14 your husband had to be taken to surgery?

15 A. Right.

16 Q. He didn't try to hide it or deny it, did he?

17 A. Repeat that.

18 Q. He didn't try to hide what happened; he came
19 out and told you, right?

20 A. In so many words he did.

21 Q. Well, you just told me he said that during the
22 procedure there was a bleeding problem. I think you
23 said, I nicked an artery with the needle, or
24 something and he had to go to surgery. Didn't you
25 say that?

1 A. No, I did not.

2 Q. What did Dr. Mori tell you when he came out?

3 A. When Dr. Mori came out and spoke to me in a
4 consultation room he told me that they had started
5 to do the heart catheter, stopped it to go in to
6 relieve fluid out from around his heart but during
7 the process they nicked a vein --

8 Q. Okay.

9 A. -- and he had to be rushed to emergency
10 surgery.

11 Q. Right. So he told you there was a
12 complication. He said they nicked a vein during the
13 procedure; is that right?

14 A. Yeah.

15 Q. And he had to go to surgery?

16 A. Right.

17 Q. And that's -- that was what he told you at the
18 time. He didn't try to tell you anything else, did
19 he?

20 A. No.

21 Q. Okay. All right. Now, the second time you
22 spoke with Dr. Mori your -- there were in-laws
23 there? Mr. Dibernardo's, --

24 A. Right.

25 Q. -- parents? And was his sister and brother

1 there or sister?

2 A. His sister and brother were both there.

3 Q. So he was one of three children?

4 A. One of four. One had deceased before him.

5 Q. One had previously died but the -- the -- his
6 -- all his family by blood or marriage was there:
7 mom and dad, his brother and sister?

8 A. Right.

9 Q. And you, right?

10 A. I was there.

11 Q. And Dr. Mori came out and again said the
12 bleeding complication had occurred during the
13 procedure and that's why he had to go to surgery?

14 A. Yes.

15 Q. Now, Dr. Wooten, you say, was the doctor that
16 took care of your husband in the ICU?

17 A. Right.

18 Q. And Dr. Wooten spoke with you, I believe this
19 would have been, on the 24th; is that right? Two
20 days after the procedure?

21 A. She spoke with me on the 23rd --

22 Q. 23rd?

23 A. -- the first time.

24 Q. Okay.

25 A. And that's when she told us they had to try to

1 take him off the ventilator but they put him back on
2 it because he had trouble breathing.

3 Q. Okay.

4 A. And they were going to try it again on the
5 24th.

6 Q. All right. So on the 24th they tried it again
7 and she came out and told you that they had tried it
8 again. He just wasn't able to maintain his
9 respiration so she recommended putting him back on
10 the ventilator?

11 A. Right.

12 Q. And initially you instructed her to do that?

13 A. (No response.)

14 Q. After she said that you said, go ahead and put
15 him back on the ventilator?

16 A. Yeah, the first time I spoke to them.

17 Q. The first time. But then you and
18 Mr. Dibernardo's family talked to her shortly after
19 that?

20 A. That's right.

21 Q. All right. And you had conversations with
22 Dr. Wooten and she had conversations with you?

23 A. Right.

24 Q. Did she appear to answer your questions?

25 A. Yeah.

1 Q. Dr. Wooten has told us, and put in her medical
2 record, that you and the family told her Mr.
3 Dibernardo had not been able to do anything. Do you
4 remember making that statement?

5 A. Say that again.

6 Q. Do you remember that you or any family member
7 told Dr. Wooten that Mr. Dibernardo had not been
8 able to do anything lately?

9 A. No.

10 Q. Do you remember or did you hear a member of
11 your family or his family say that he had not been
12 able to get out of bed recently without help?

13 A. No.

14 Q. Did you or the family tell Dr. Wooten that
15 Mr. Dibernardo absolutely did not want to go to a
16 nursing home?

17 A. No.

18 Q. Did you or a member of his family tell
19 Dr. Wooten they did not want him to go to rehab?

20 A. No.

21 Q. So if Dr. Wooten has testified to that and put
22 that in her medical record, you would disagree with
23 it?

24 A. Right.

25 Q. Did Dr. Wooten, in addition to having these

1 discussions with you, answer any questions that you
2 had at the time?

3 A. Repeat that again.

4 Q. Did Dr. Wooten answer any questions that you or
5 the family had at that time about Mr. Dibernardo's
6 condition and her suggestion initially to try him
7 back on a ventilator?

8 A. Yes.

9 Q. Based on those conversations was it the
10 decision of you and the family not to put him back
11 on the ventilator?

12 A. Right.

13 MR. BEIGHLEY: May the Court indulge me one
14 moment, Your Honor?

15 THE COURT: Yes, sir.

16 MR. BEIGHLEY: Thank you.

17 Thank you, ma'am. I appreciate it.

18 THE COURT: Any redirect?

19 MR. MCGOWAN: Very briefly.

20 REDIRECT EXAMINATION

21 BY MR. MCGOWAN:

22 Q. Ms. Dibernardo, was it true that Mr. Dibernardo
23 never -- that's a double negative.

24 Was Mr. Dibernardo able to do his normal
25 living, normal life leading up to that July 19th

1 hospitalization?

2 A. Yes, he was.

3 MR. MCGOWAN: Okay. Thank you. That's all.

4 THE COURT: Thank you, ma'am. You can step
5 down.

6 MR. MCGOWAN: That would be the plaintiff's
7 case, Your Honor.

8 THE COURT: All right. Ladies and gentlemen of
9 the jury, the plaintiff has rested. It's a little
10 bit early but this is a natural breaking point in
11 the case so I'm going to send you to lunch early
12 today. My instructions are the same: Don't discuss
13 the case with any third parties; don't do any
14 independent investigation; and don't deliberate
15 amongst yourselves.

16 So be back in the jury room at one o'clock. We
17 will resume the case at one o'clock.

18 (The jury panel exits the courtroom.)

19 THE COURT: All right. Are there any motions
20 or any matters?

21 Any motions?

22 MR. BEIGHLEY: I didn't hear Chad say anything
23 so I was just thinking, Judge. I'm sorry.

24 MR. MCGOWAN: I don't know if I'm entitled to
25 but I'd like a directed verdict on everything, for

1 the purposes of the record.

2 THE COURT: For the purposes of the record that
3 would be denied.

4 MR. MCGOWAN: Thank you, sir.

5 THE COURT: All right. Mr. Beighley?

6 MR. BEIGHLEY: Your Honor, for the record we
7 would move for a directed verdict as to all
8 allegations and specifically as to any allegations
9 or claim for punitive damages since there's no
10 evidence that would support any such claim or such
11 allegations in the record.

12 THE COURT: All right. Mr. McGowan, how do you
13 respond to the punitive damage argument?

14 MR. MCGOWAN: I think that we've got clear
15 evidence in the record for which a jury could base a
16 finding of recklessness or willful and wantonness,
17 and that's important for not only noneconomic damage
18 questions which may become relevant but also for
19 punitive damages themselves.

20 The only -- the testimony has been from
21 Dr. Schob. The only way this can happen is from you
22 just ignore the basic technique on how you put these
23 things in. If you don't do it properly, you get
24 injuries like this. Cardiologists are well
25 knowledgeable about the risks that they have, and if

1 you don't do it right, it has to be a conscious
2 disregard for the rights of others because they know
3 the risks and yet they proceed forward anyway.

4 If this was the needle initially, that's what
5 the evidence could base -- the jury could base the
6 verdict on that. If you did this with the needle
7 that was so far outside the bounds that because of
8 the size of the effusion, the guidance that was
9 available, the method by which you're supposed to
10 do, that if you injure it with the initial needle,
11 then that's not even slight neglect. That's grossly
12 negligent and could be reckless.

13 Similarly, when you're putting in the sheath
14 that's so well known that you cover the end of that
15 sheath and dilator with a wire, every cardiologist
16 knows this and knows if you don't do that you're
17 going to expose your patient to unnecessary risks.
18 And we believe that that's a reasonable basis for a
19 jury to conclude that there was reckless, willful or
20 wanton misconduct in this case, if they believe
21 everything we had to say.

22 THE COURT: Mr. Beighley?

23 MR. BEIGHLEY: In response to that, the expert
24 -- the only testimony before the Court on the
25 standard of care is from the plaintiff's expert who

1 testified that bleeding is a known potential
2 complication. He testified you can get bleeding
3 from this procedure in the absence of failure. He
4 testified just because bleeding occurs doesn't mean
5 someone did something wrong.

6 At no time did he testify that the defendant's
7 conduct was reckless, willful, wanton or grossly
8 negligent and he simply said his opinions on how the
9 injury occurred and it shouldn't have, which are the
10 makings of dangerous, but there's nothing before the
11 Court that would support to a level of clear and
12 convincing proof evidence of reckless, willful or
13 wanton conduct.

14 Basically the plaintiff's arguing is that this
15 is a race gets it case, that because an injury
16 occurred reckless -- negligence and recklessness can
17 be presented and there's simply no basis on the
18 record to support that to allow punitives to go
19 forward -- would send something to the jury upon
20 which there's no evidence and they'd be purely
21 speculating on that. So we'd -- we think punitives
22 definitely should come out.

23 THE COURT: Okay. Thank you. All right. I
24 find there's sufficient evidence in the record to
25 make this a jury question, so Mr. Beighley, I'm

1 going to deny your motion at this point.

2 It's 11:30. We will be back at one o'clock so
3 we'll go into recess. Then we'll begin the defense
4 case.

5 (Lunch recess was taken.)

6 THE COURT: All right. Anything from either
7 side before we bring our jury back in?

8 MR. MCGOWAN: Not from the plaintiff, Your
9 Honor.

10 THE COURT: Anything from the defense?

11 MR. BEIGHLEY: No, Your Honor.

12 THE COURT: Okay. Thank you. Mr. Bailiff, if
13 you'd get our jury for us please, sir.

14 THE BAILIFF: Yes, sir.

15 (The jury panel enters the courtroom.)

16 THE COURT: Thank you. All right. Ladies and
17 gentlemen, I hope everyone had a good lunch. We are
18 now ready to proceed with the defense case.

19 Mr. Beighley?

20 MR. BEIGHLEY: If it pleases the Court, Your
21 Honor, thank you. At this time we call Dr. Mori.

22 Dr. Mori, would you come around and be sworn
23 please?

24 THE CLERK: Dr. Mori, place your left hand on
25 the Bible and raise your right.

1 (Witness was duly sworn.)

2 DIRECT EXAMINATION

3 BY MR. BEIGHLEY:

4 Q. Doctor, if you will, turn and this microphone
5 here is so the court reporter and the ladies and
6 gentlemen of the jury can hear you.

7 Doctor, please state your full name for the
8 jury and tell us where you live.

9 A. Good afternoon, everyone. My name is Naresh
10 Mori. I live in Fort Mill, South Carolina.

11 Q. And what is your professional employment?

12 A. I'm sorry?

13 Q. What is your professional employment?

14 A. I am a physician at Carolina Cardiology
15 Associates. I'm an interventional cardiologist by
16 profession.

17 Q. And how long have you been practicing
18 cardiology in Rock Hill?

19 A. For five years.

20 Q. Tell the jury where you were born and where you
21 grew up.

22 A. I was born in London in England. I grew up --
23 I spent most of my life in India and then went back
24 to England, then came to America.

25 Q. Where did you get your medical degree?

1 A. My medical degree is from University of Mumbai
2 in Bombay, India.

3 Q. And after graduating from medical school tell
4 us the additional training that you received in
5 medicine.

6 A. After graduating from medical school I went for
7 about a year to -- did an internship -- a house
8 office job in England and then I did an internship
9 back here in Brooklyn in New York. I did residency
10 in internal medicine in Long Island College Hospital
11 in Brooklyn, New York and I did a year of chief
12 residency at Long Island College Hospital in
13 Brooklyn, New York. I did fellowship in
14 cardiovascular diseases and that was through medical
15 center in New York and fellowship in interventional
16 cardiology at University of Louisville in
17 Louisville, Kentucky.

18 Q. And have you also had specialized training in
19 echocardiography?

20 A. Yes. I am board-certified in echocardiography,
21 in cardiovascular diseases, in internal medicine,
22 interventional cardiology, and also nuclear
23 cardiology which is a subspecialty of cardiology.

24 Q. Did you have to be examined and take tests to
25 get those board certifications?

1 A. I had to do oral examinations for the boards
2 that I mentioned, the specialties.

3 Q. Dr. Mori, please tell the jury when and how you
4 became involved in the care of Mr. Dibernardo.

5 A. I first met Mr. Dibernardo in the afternoon of
6 July 19th in 2013. Mr. Dibernardo had been admitted
7 by his primary cardiologist Dr. Jay Shah to
8 hospital. Apparently he had been doing poorly. He
9 wasn't doing well over the last few weeks. That was
10 the reason for his admission. I met him that
11 afternoon. I think I spent about half an hour with
12 him. Of course I didn't get a chance to meet Ms.
13 Dibernardo but I did spend quite some time with Mr.
14 Dibernardo, and I, you know, went over his medical
15 history. I had actually read his echocardiogram
16 just that afternoon and so I discussed with him what
17 I felt was going on and discussed with him about the
18 plan of care.

19 Q. During the time that he was treated at Carolina
20 Cardiology can you share a summary of his medical
21 history, his major complaints and problems just
22 generally?

23 A. I had a chance to review his medical chart, you
24 know, that afternoon when I saw him. He had a
25 history of Noonan's syndrome, as we've all learned

1 so far. He also had a condition called atrial
2 fibrillation for which he was on a blood thinner
3 Coumadin, Warfarin. He had a history of
4 cardiomyopathy, specifically a type of condition
5 where there is a grading within the heart probably
6 secondary to Noonan's syndrome. He had a valve
7 disorder of the mitral valve. He also had clinical
8 history of congestive heart failure prior to me
9 seeing him.

10 Amongst -- these were his main, primary cardiac
11 conditions. He also had thyroid condition. It was
12 some documentation of cirrhosis of liver, most
13 likely secondary to his cardiac condition, and there
14 were things associated with Noonan's syndrome which
15 were more apparent on his physical appearance.

16 Namely, he had bulging his of eyes called his
17 exophthalmos. He had a defining chest where you
18 have something called ectis exoskeleton which is the
19 chest -- normally our chest, this bone is flat. He
20 had like an exoskeleton. So these are the
21 conditions he had documented in his chart.

22 Q. As his problems increased over time was surgery
23 ever a consideration?

24 A. I believe he -- I hadn't seen him until then
25 but his primary cardiologist Dr. Shah had been

1 seeing him and felt that he needed a surgical
2 evaluation for his worsening of fluid around the
3 heart, which we call a pericardial effusion. He was
4 actually sent to surgery and apparently, from the
5 notes, I believe the patient did decline surgery.

6 Q. Since he did not want surgery was there some
7 therapy that you felt as an invasive cardiologist
8 that you could offer to try to improve his
9 condition?

10 A. I felt it was reasonable to offer him the
11 condition called a pericardiocentesis because he had
12 what we later learned was a massive pericardial
13 effusion. What that was doing is it was causing,
14 first of all, high pressures within his heart
15 chambers and then it was also causing, you know, the
16 area of the heart to be increased and that
17 essentially was causing him to be short of breath.

18 Q. Are there risks associated with the
19 pericardiocentesis procedure?

20 A. There are risks with all cardiac procedures.
21 What happened with Mr. Dibernardo is a very common
22 risk with the procedure of pericardiocentesis, and
23 when given a chance I'll explain and show you
24 pictures of what I mean when I say the bleeding is a
25 complication of pericardiocentesis. The risk of

1 pericardiocentesis -- one is when you get access you
2 can have, first of all, bleeding. Next you can have
3 arrhythmia, you know, cause arrhythmia when you're
4 doing the procedure, and rarely you can introduce
5 infection when you're doing this procedure.

6 Q. Did you discuss those risks with Mr.
7 Dibernardo?

8 A. Yes, I did.

9 Q. Did you discuss what your goal was to recommend
10 the procedure to him?

11 A. Yes, I did. I did do that.

12 Q. And following your discussions of the procedure
13 and the risks and potential benefits, what decision
14 did Mr. Dibernardo make?

15 A. Mr. Dibernardo, he understood all the risks of
16 the procedure. He understood what I was basically
17 trying to do when I, you know, explained to him --
18 because I met him on Friday evening and then I was
19 going to be doing to procedure on Monday, so I
20 explained to him that this is what I'll be doing.
21 He actually verbalized that he understood
22 everything; he understood what the complications
23 were, and he did not want surgery so he felt it was
24 reasonable that we do this to try and improve his
25 symptoms.

1 Q. And did he, in fact, sign an informed consent
2 form authorizing the --

3 A. He -- Mr. Dibernardo did sign an informed
4 consent so he -- after he understood the procedure
5 he did sign consent for the procedure. Yes, sir.

6 Q. And is that in the medical record?

7 A. That is in the medical record, yes.

8 Q. Now, Doctor, you've mentioned several terms.
9 We've heard some of them before but I want to show
10 you some demonstrative aids here to illustrate as
11 necessary your testimony. If you don't mind coming
12 down --

13 MR. BEIGHLEY: May he come down?

14 THE COURT: Yes, sir. Yes, sir.

15 BY MR. BEIGHLEY:

16 Q. I want you to now go back and explain what the
17 pericardiocentesis is, and just start by showing the
18 jury there, if you will. I'll hold this up.

19 A. I'm actually going to use the same equipment
20 that was used that day, rather than saying things
21 like this but I'm going to use the same thing that
22 was used.

23 Q. Before we get into that kit, I want you just to
24 give us the basics here so we'll know what you're
25 talking about.

1 A. We have here the heart like this. This is the
2 xiphoid process and this becomes important later.
3 The way we get access is we put some local
4 anesthetic here. We make a little cut and then we
5 get access this way. All this is being done under
6 monitoring so, you know, potentially we should not
7 have injury but, you know, I'll explain later that
8 there is always a risk of injury. Because this
9 thing is not just static moving. It's actually
10 swinging within this pericardial space. We have
11 images to show that.

12 There is risk of bleeding with this procedure
13 because you're entering with a sharp object and
14 there is a chance of injury by entering in your
15 blood vessels, either vein or artery, or even the
16 heart muscle. We do have evidence that Mr.
17 Dibernardo had an enlarged heart. There's no
18 refuting that. So that does increase the risk of
19 potential complications.

20 He also had an abnormal anatomy. He had slight
21 deformity in this area and that made the procedure
22 difficult in getting access in there. So that's
23 just the basic summary.

24 Q. Now this is showing the pericardium. Again,
25 what is the pericardium?

1 A. Pericardium is fluid and it's like a fibrous
2 membrane covering the heart.

3 Q. All right. Now, we talked about fluid
4 accumulation in that space. Can you tell the jury
5 what -- what is shown here?

6 A. Right. So this is showing -- I've not seen
7 this before but this is showing the heart. This is
8 the pericardium and then this is the pericardial
9 fluid -- fluid within the pericardium. It's very
10 important to note that this fluid is not distributed
11 evenly, so if you see the width of this fluid over
12 here is different from here, is different from here.
13 And this does increase injury when we get access, so
14 if the fluid's as much here and if the same amount
15 here, then, you know, it becomes easy. If there is
16 a difference in how much fluid is adjacent to this
17 structure versus this structure, then, you know, you
18 can have potential complications. That's -- that is
19 something I did discuss with Mr. Dibernardo.

20 Q. Let's look at this illustration and tell us
21 what this demonstrates.

22 A. So this is the -- the way to -- like, sort of a
23 simple way to do the procedure. We get access here
24 and we direct our needle into the pericardial space.
25 We do it under, you know, echo, under fluoroscopy,

1 under telemetry monitoring also called as ECG
2 guidance.

3 But at some point the procedure does become
4 blind because as you're entering in there is an
5 initial point which is blind and then you feel that
6 -- you get blood back and then you can -- not blood
7 back, fluid back. Usually it's fluid. Rarely you
8 get, you know, blood effusion as the expert on the
9 other side mentioned but usually it's fluid back.
10 Once you get that you know you're in the pericardial
11 space. You then enter the wire, pass the guide wire
12 and then you pass the pigtail catheter. Can I have
13 a chance to --

14 Q. Yes. Now I want you to -- I wanted you to set
15 the stage with these. Now feel free -- I
16 interrupted you. You were going to show the actual
17 tools that were used -- if you want me to hold the
18 tray there for you.

19 A. Okay. So the first step here is this step
20 where we put some local anesthetic here, go under
21 the sternum -- the sternum bone here, inject it to
22 anesthetize the area, and then you make a little
23 nick so the needle enters easily. That's step
24 number one. Step two, this is attached like this
25 and we go here.

1 Q. Is that the needle that you're demonstrating?

2 A. Right. So this is the needle that actually was
3 used in -- in the procedure. This was the actual
4 needle. Then we go ahead and angle here, about a
5 45-degree angle, try and get access into the
6 pericardial space, and once you feel that, you know,
7 you get some fluid back -- you don't hear a pop but
8 you just feel it. There's no noise associated with
9 it. It's a -- you feel some fluid coming back you
10 know you've entered the pericardial space. You get
11 fluid back. Then you take this out and then you
12 pass the guide wire. This is all the guide wires.

13 Q. Would it help if I hold that one up here?

14 A. Yeah. So --

15 Q. Would that make it easier for you?

16 A. Then you pass the guide wire like this and it
17 goes in the pericardial space. You take this out.
18 You pass a little dilator -- sorry. Okay. Then you
19 pass a dilator to put in -- so your sheath -- your
20 pigtail catheter goes easily so once you've made a
21 track here then you pass this. So you're like this.
22 Your wire out here and then you get this catheter in
23 like this. You see on fluoroscopy you're in a
24 satisfactory position and then you take the wire
25 out. And that stays in. Then we try and get all

1 the fluid out. You take all the blood out from
2 here.

3 And you know, we'll see -- we confirm the
4 position. You've seen images of the fluoroscopy
5 this morning that confirm position that you're in
6 the right space. You inject dye. You see fluid in
7 the pericardial space. I'll show you images on
8 echocardiogram. We use two techniques to confirm
9 our position. On echocardiography we -- and this
10 syringe -- what we do is we get some saline in. We
11 shake it up, agitate it, and then we push it through
12 this. So this is like this. We push saline in it
13 and it goes in the pericardial space and we see that
14 on echocardiogram. So that's -- that's done
15 basically to confirm that we're in the right place.

16 Q. All right, sir. Is that the way it was done in
17 this case?

18 A. Yes, it was done like that in this case.

19 Q. All right.

20 A. You know, you've seen the expert say that
21 everything was good until one particular point and
22 then for reasons unknown a decision was made to
23 change this sheath -- this pigtail catheter to
24 something else.

25 Q. And we're going to come back and I want you to

1 show that in a minute so let's -- you can take your
2 seat there and let me --

3 A. You know, there are a few things that -- there
4 are -- you know, first of all, size of the heart,
5 this is normal size. Mr. Dibernardo, as has been
6 documented, had massively enlarged heart, so the
7 entire thing was coming all the way here. We've
8 seen the extent of how wide on fluoroscopy so he did
9 have a massively enlarged heart. That led to me
10 using, you know, longer wire to try and get my
11 second sheath in and we'll go with that.

12 Q. Okay. Well, I want to let you explain that but
13 let's -- let's just go back now to the -- after all
14 the things you've shown us had been done -- you've
15 got your pigtail catheter in place. You've
16 confirmed placement.

17 A. Right.

18 Q. What happened next in Mr. Dibernardo's case?

19 A. Okay. So this is where -- this is the whole
20 thing of dispute now so everything's well and I
21 decide to change something. There's a reason for
22 that and the reason is bleeding. We started out
23 with pinkish fluid and then it gets frank bloody.
24 And I know there's dispute over that and I have -- I
25 have a few things that I'll show. It's very

1 important in showing that there was bleeding, even
2 before the first exchange.

3 Q. Tell -- tell -- you said you started the
4 procedure and then you encountered frank bleeding.
5 Tell us what that means.

6 A. So there's a definite change in color of what
7 I'm getting from the pericardial space as we
8 pericardial effused it. So there's definite change
9 in that and, you know, I also note that blood
10 pressure's going down slightly. There is blood
11 pressure going down. I make a decision that, you
12 know, if this gentleman keeps bleeding he's going
13 into a position called cardiac tamponade which is
14 fatal.

15 So because of the situation at that time that,
16 you know, I'm having a change in his medical status,
17 change in his blood color and change in -- you know,
18 I have imaging studies to show what I'm saying. But
19 because of this I feel that, you know, I'm going to
20 be faced with a condition called cardiac tamponade
21 if I don't act.

22 And what happens is, you know, when I get this
23 change in blood -- in the color -- I also want to
24 show one thing.

25 Q. Yes.

1 A. Pigtail...

2 Q. Yes. I put everything right in the bag.

3 A. So this is a pigtail catheter here. It's got
4 holes here through which we get fluid back and I was
5 -- I was -- when I noticed bleeding I was not
6 getting blood return back, and when I wasn't getting
7 that there was -- the blood was accumulating there.
8 It was going to compress the cardiac chambers and
9 cause tamponade and cause him to have blood pressure
10 going down. That's the reason -- because I was not
11 getting adequate blood back through this, that's why
12 I decided to change to a large -- like a sheath
13 which will allow me to get blood back.

14 Q. All right. We've got an illustration and you
15 mentioned cardiac tamponade where blood fills up
16 that pericardial space. What is show -- is that
17 what's shown here?

18 A. Right. Right. So you have cardiac tamponade
19 where you have fluid -- a lot of fluid. In this
20 case it was bleeding. But you have a lot of fluid
21 compressing on the cardiac chambers. The right side
22 of the heart is low pressure chamber and can be
23 easily compressed. The left side of the heart --
24 and I'll show you a model. The left side is thicker
25 -- cannot be compressed by this rising pressure.

1 The right side of the heart can easily be
2 compressed.

3 If the right side of the heart is compressed it
4 does not fill. If the right side of the heart does
5 not fill, you don't get enough blood going to the
6 lungs. If there's not enough blood going to the
7 lungs, you don't get enough blood going to the left
8 side of the heart, and with that you get a drop in
9 blood pressure. That's all from the heart. So
10 that's cardiac tamponade essentially.

11 Q. All right, sir. Now, you told us that based on
12 your concerns about bleeding and the patient's
13 overall condition you made a decision to change the
14 catheter status of the patient --

15 A. Yes.

16 Q. -- is that right?

17 A. That is correct. Yes.

18 Q. All right. I would ask you then to share with
19 us, what did you do? And if you -- if you need to
20 take the equipment and show us that's -- but just
21 tell us first what -- what step did you take in
22 reaction to your concern for bleeding?

23 A. Okay. First of all, I took -- I show you
24 images of Mr. Dibernardo's echocardiogram, which,
25 you know, gives us more of an idea of his anatomy.

1 Q. All right. Feel free to come down --

2 A. And then, you know, I also want to show you
3 that -- you know, we heard the earlier expert saying
4 that the way the needle injury was caused is also
5 not meeting standard of care but I want to show you
6 why it's a known complication that bleeding can
7 occur here. Here's my explanation for that.

8 Can we turn the lights down please? Thank you.

9 Okay. So this is echocardiogram. Basically
10 this is the left ventricle -- do we have the heart
11 model?

12 Q. Yes.

13 A. This is our heart like this. That's the left
14 ventricle. This is the left ventricle. You see how
15 thick this is? That's the thick left ventricle.
16 This is the right ventricle. This is a thinner
17 ventricle, lower pressure, and that's the right
18 ventricle there. This is fluid. This is called
19 pericardial effusion. And remember I said that --
20 you know, people say if you have such a large amount
21 of fluid why should you get injury? There's so
22 much, you know, room to play with. You see how much
23 fluid is near the right ventricle.

24 This is our heart like this. This is here.

25 This is the right ventricle. There's not much fluid

1 near the right ventricle. Most of the fluid is
2 around the left ventricle which is posterior. Okay?

3 So the -- this -- this access -- there's not
4 much fluid around there so there is risk of
5 bleeding. Plus, he had enlarged heart. It was very
6 close to the pericardium in this space. So that's
7 -- that's -- that's one of the reasons why this
8 gentleman had bleeding here.

9 So we also want to make -- see that our heart
10 is not staying static; it's swinging around in the
11 pericardial fluid. So it's not a fixed target. If
12 it's swinging like this, there is a risk of injury.
13 There is the known complication you can have
14 bleeding. That particular -- you see the swinging
15 motion there?

16 Okay. Next I want to show you the size -- the
17 size of the effusion but I also want to show you
18 that most of the effusion -- this is the left
19 ventricle. Most of the effusion is posterior to the
20 left ventricle.

21 Q. Tell us what posterior means so we'll know.

22 A. Okay. Posterior -- I'm sorry. This is
23 anterior; this is posterior. So anterior is in
24 front; posterior -- so the left ventricle is here.
25 Most of the effusion is behind the left ventricle.

1 The right ventricle is here.

2 Now, we learned in the morning with the
3 expert's testimony the structure which is adjacent
4 to the -- adjacent meaning next to. When we get
5 access to the subxiphoid process it's actually the
6 right ventricle. And we see that there is not 4
7 centimeters of fluid there and I'll show you why I'm
8 saying that.

9 Let's go down to -- okay. So that is -- that
10 is the right ventricle, left ventricle and that's
11 the amount of fluid behind the left ventricle. This
12 is measuring 4.8 centimeters how much is
13 behind/posterior to the left ventricle. Okay. So
14 they were different measurements, 3.8, 4.8 was what
15 they have but definitely -- if this is 3.8 this is
16 -- this is not 4 centimeters there.

17 And that's why you -- you know, we take consent
18 saying usually nothing happens but there is risk of
19 bleeding, specifically for that reason, and
20 unfortunately, you know, we had bleeding here.
21 Let's come back to -- so we've established there's
22 swinging motion of the heart and there is risk of
23 complications. Here in this case dependent on the
24 amount of the effusion, the location of the
25 effusion, that's very critical here.

1 And the other critical thing is, you know,
2 echocardiogram, it's connected to system. This is
3 the time it was done: 7/19/2013 11:42 a.m.

4 I'm going to show you pictures now of the day
5 of the procedure when we brought the echo machine
6 into the cath lab and we're taking live pictures at
7 the time of doing the procedure. Okay. So this is
8 -- normally the first image is the time 7/22/2013
9 10:34 a.m. We see the same thing: left ventricle,
10 right ventricle, effusion around the left ventricle,
11 not much around the right ventricle.

12 I also mentioned when we get access to the
13 pericardial space we want to confirm its position.
14 We did that with fluoroscopy and with echo. We had
15 to take the saline and inject it. That's agitated
16 saline injection. That's 10:40 a.m. Same thing,
17 agitated saline injection to confirm position.

18 Next, we look at this particular image, not
19 much different from -- not much different from the
20 first image where you have pericardial effusion.
21 We're trying to drain the fluid. This is massively
22 enlarged heart. You see these big chambers here?
23 Massively enlarged.

24 Watch this: 10:49 a.m., 10:50 a.m. and we see
25 something different here. That is our first sign of

1 clot at 10:53 a.m. Let's focus our attention on
2 this very nice timeline that we have thanks to our
3 colleagues here. 10:53 a.m. is here and on
4 echocardiogram that's our first sign of bleeding.

5 Now, I know it was a difficult procedure for
6 him. It wasn't easy. I've done these before. This
7 was one of -- this was my most challenging one
8 because of his anatomy but I knew I had bleeding
9 way, way before the sheath got put in. That's our
10 first sign of bleeding, 10:53 a.m. The timeline
11 says that this is a needle injury. I disagree
12 respectfully that this bleeding occurred from the
13 sheath. That's 10:53 a.m. That's clot in there.
14 That is -- that is a blood clot in that space and
15 then it gets more pronounced because there's ongoing
16 bleeding. It gets more pronounced. We'll see
17 pictures of it.

18 That's blood clot there, 10:56 a.m. Sheath
19 inserted at 10:59 a.m. You have a blood clot
20 sitting in there 10:56 a.m. So needle injury was
21 recognized early by me. I had definite change in
22 dark color from initial pink to frank blood towards
23 the end.

24 I'm not -- I'm not taking pictures to try and
25 defend myself in court. I'm trying to save this

1 patient's life. I'm taking pictures to find source
2 of bleeding and we have evidence of bleeding here.
3 The images we saw, the reason I changed to a sheath
4 was to try and treat that bleeding because I was not
5 getting enough -- I was not getting enough effusive
6 through this space, these chambers, which I suspect
7 could have clogged off and that's the reason I did
8 what I did.

9 Now, we -- we can -- we can always say that,
10 you know, you could have left him and he would have
11 been fine, but it's very difficult for us to leave
12 someone --

13 MR. MCGOWAN: Your Honor, maybe we could have a
14 little less narrative and a little more question.

15 THE WITNESS: I'm sorry I have to explain
16 everything the way it was.

17 MR. MCGOWAN: I haven't heard a question in
18 about nine minutes.

19 THE COURT: Okay. Mr. Beighley, if you would
20 ask --

21 BY MR. BEIGHLEY:

22 Q. Doctor, are you -- is there any more of the
23 echos that --

24 A. Yes, yes.

25 Q. We'll get into just the visual echos that you

1 want to show.

2 A. Yes. I want to show -- I will show how towards
3 the end of the procedure -- and we see that's a
4 blood clot there. The heart is surrounded by blood
5 clots. Is there anything else I should --

6 Q. I think that's good for now. If we need to
7 come back, we definitely will do it.

8 All right. Now, you've shown us evidence on
9 echo of bleeding before the sheath was put in. Can
10 you explain to us how you reacted to the bleeding
11 when you took out one catheter and put another in?

12 And again, feel free to demonstrate just so
13 they can see what happened, what your response was
14 to the bleeding as far as the change of equipment.

15 A. Okay. So the --

16 Q. This is yours.

17 A. The sheath is the same.

18 Q. Okay. Whatever works for you.

19 A. So we've got this in the patient's heart like
20 this. We go in with the wire. We take this out and
21 we pass our sheath in there. The reason I -- the
22 big sheath was chosen over the small sheath is
23 because of the size of the heart of this patient, so
24 I felt I wouldn't have enough sheath in here as
25 opposed to here. That's the reason this was chosen.

1 And the basic principle -- just like Dr. Schob,
2 I've done thousands of interventional procedures.
3 The basic principle is we've got to have enough wire
4 to exchange our catheters. We can't -- we can't
5 just say that I left less catheter -- I left less
6 wire and the catheter change was incorrect because
7 I've done the procedure. I know for a fact that I
8 did not leave less wire and push this sheath without
9 having wire in there. This is -- I've done the
10 procedure and I can state that as a fact.

11 Q. All right, sir. So you exchanged out the
12 sheath as you described; is that right?

13 A. Yes.

14 Q. All right. Now, one thing I didn't ask you, or
15 if I did bear with me, but this is the needle,
16 right?

17 A. Uh-huh. The red one, pink one.

18 Q. From the -- I'm backing up a little to the
19 initial -- the initial approach --

20 A. Right.

21 Q. -- with the needle. That would be this.

22 A. Yeah. The red, pink needle in there.

23 Q. Same --

24 A. Similar.

25 Q. Same size?

1 A. Yeah.

2 Q. When you put that in initially did you have
3 success or did it take more than one attempt?

4 A. No, it took more than one attempt. As I
5 mentioned, Mr. Dibernardo's was difficult anatomy
6 and it did take more than one attempt for me.

7 Q. The fluid that was drawn off initially, you
8 described it as pinkish?

9 A. Uh-huh. Yes, yes. Sorry. Yes.

10 Q. And at what point in time or how long --
11 however you can measure it -- did it start to turn
12 to frank blood?

13 A. So if we get access in then we use that big
14 syringe -- we have a big syringe in there?

15 Q. They got a lot of stuff in here. This one?

16 A. So we get our pigtail catheter in. We inject
17 this, put it out into a bag like this. It goes in
18 the bag. It connects. Then you also can connect it
19 to Vacutainer. If you have a large effusion you can
20 connect it to suction bottles. After like -- after
21 about a few minutes I would see that my -- there was
22 a change in color from pink to bloody.

23 Q. All right. I was just trying to --

24 A. I -- I can't tell you exact but I did notice
25 it...

1 Q. After a few minutes?

2 A. Yeah. About a few minutes, yeah.

3 Q. All right. Now, the suggestion has been made
4 by Plaintiff's expert that you should have just left
5 the original pigtail in place and attach that to
6 drainage and sent the man to the intensive care
7 unit. Can you tell the jury why you did not do
8 that?

9 A. So we had definite evidence of bleeding.
10 Clinically I was getting blood back and on
11 echocardiogram we had blood clot. It is difficult
12 to just leave it there and send him to the unit,
13 hope that, you know, he'll stop bleeding and he'll
14 be fine. The downside is you could have the
15 condition called cardiac tamponade where you have
16 compression of the cardiac -- of the heart chambers
17 and you can have drop in blood pressure and then
18 ultimately cardiac arrest.

19 So that was a clinical decision at that time.
20 I felt that was the best thing to do for the
21 patient. In hindsight, you know, people could
22 argue, well, you could have done this, but in my
23 clinical judgment at that time I felt you can't
24 allow ongoing bleeding there and risk tamponade by
25 sending him to the unit and then deal with it later

1 when he's worse -- worse off.

2 Q. In response to the bleeding emergency did you
3 call for assistance?

4 A. Yes, I did. I -- when I recognized significant
5 bleeding, as I did here, I immediately called for
6 the surgeon. As I mentioned, I -- with this degree
7 of bleeding I'm worried about injury to the heart
8 and I called for the surgeon saying, you know, we
9 need to find the source of bleeding and take care of
10 it. That's what we did.

11 Q. Was the surgeon immediately available?

12 A. The surgeon was in the middle of another case.
13 He was not immediately available. And as we see in
14 the timeline, the blood pressures are dropping.
15 What's happening here is that fluid is accumulating
16 there, as evidenced there. Blood is there. And
17 he's exsanguinating, losing blood and causing a drop
18 in blood pressure.

19 And what I did at that time is got access into
20 the vein here and cannulated the vein, cannulated
21 the artery here to get invasive blood pressuring
22 monitoring and remove blood from the source of
23 bleeding, the pericardium, put it back in the -- in
24 the vein of the -- the femoral vein. It's called
25 autotransfusion. I'm taking blood from you, giving

1 it back to you.

2 Q. Were your efforts to autotransfuse the patient
3 successful in stabilizing the patient until the
4 surgeon could get there?

5 A. Yes, they were. And I would like to
6 demonstrate the charting of the blood pressures to
7 exactly show what I mean that what we did improve
8 his blood pressure. First, we've only seen -- we've
9 only seen --

10 Q. Let's -- just tell us the time spot where the
11 -- it looks like sort of an L-shaped curve?

12 A. Right. So it looks like -- we've only seen
13 this part but we haven't seen what happens
14 afterwards. I'm going to show you --

15 Q. All right. If you'll just sit down --

16 A. I'll show you --

17 THE COURT REPORTER: I'm sorry. They're
18 talking at the same time.

19 THE COURT: All right. Gentlemen -- gentlemen,
20 talk one at a time. The court reporter can't get
21 you when you're talking together.

22 BY MR. BEIGHLEY:

23 Q. If you'll just have a seat I'll get the record
24 for you and let you refer to it. See, what we need
25 to do, we've got it marked in the Court's exhibits.

1 A. Yes.

2 Q. Piedmont record and then I'll give you the page
3 number so you can go right to that section.

4 All right, Doctor. If you would -- I know
5 that's a lot of paper there but turn to 00602 and
6 0063 and 64. I'll let you pull those out.

7 A. (Witness complies..)

8 Q. All right. Now, so the court reporter can keep
9 up with us, as you refer to one of these please tell
10 her the page number, if you would.

11 A. Okay. So page number 600603 -- okay. Can I
12 show it now?

13 Q. Yes.

14 MR. BEIGHLEY: Are you done with this?

15 THE WITNESS: Yes, yes.

16 MR. BEIGHLEY: We'll turn that off. If Lynn
17 could dim the lights for us, thank you.

18 A. All right. We've seen these numbers, that
19 blood pressure 44, 31. Then it starts coming up.
20 So we've seen this over -- right over here and then
21 it starts coming up. I'm going to show you next
22 page here to show that the blood pressure actually
23 does come up significantly right here. Then 141 71
24 over 59 mean of 64 -- 62, mean of 64; 61; 58; 62;
25 79. This is as a result of autotransfusion where we

1 got blood out from the pericardial space and back
2 into the vein, also as a result of patient getting
3 IV fluids and also him receiving pressors which is
4 medicine to improve his blood pressure. So that's
5 -- that's what happened.

6 Around this time after the surgeon was
7 available he came; he saw the patient; and he agreed
8 that the patient needed to go for surgery because
9 there was significant bleeding.

10 Q. All right. Thank you, sir. Doctor, there have
11 been two -- several or more, at least two exhibits
12 -- I don't want to have to reload the machine but
13 the jury has seen these on film here. This is
14 marked as Exhibit 11 (a) to (c) and what I want you
15 to do -- come down here and I'll ask you what they
16 show.

17 This is 11(a). What is that?

18 A. This is the first image we saw. It's in right
19 space. Then I stopped here and then I explained why
20 I could not stop here because of bleeding. Next
21 image is --

22 Q. What's the next image? Just flip that over.

23 A. Next image is where after my sheath goes in and
24 I'm having a lot of bleeding with all the blood
25 pressure drop that we see I pause the catheter

1 trying to make sure I'm not within the right
2 ventricle. I'm trying to make sure that I am not
3 within this particular chamber. I'm trying to see,
4 why is there so much bleeding? That's number two
5 where I'm in with the catheter and the pigtail
6 trying to see my location.

7 As you saw in the images, you still -- we still
8 are within the pericardial space but there is
9 staining and here is contact with the right
10 ventricle. There is contact here. But as we see
11 the surgical report, there's no through and through
12 injury.

13 Q. And then what have we got in the third image?

14 A. Third image is the sheath without the pigtail
15 catheter with evidence of staining, contact with the
16 right ventricle.

17 Q. Now, when there's staining does that mean that
18 the sheath has poked a hole in the heart?

19 A. No, it does not mean that. We did not have it
20 in the heart.

21 Q. Is contact with the right ventricle in this
22 case and the resulting staining that we saw, is that
23 a known potential risk of trying to do this
24 emergency procedure?

25 A. Yes, it is known. I did -- we did take that

1 risk that you can have contact with the right
2 ventricle. In this case was to help with bleeding.
3 Q. Dr. Mori, you told us that the patient was then
4 taken to surgery, and according to the medical
5 record what did the surgeon find?

6 A. The surgeon found that the catheter was -- I'll
7 have to read the notes.

8 Q. I'll give you that opportunity if you'll just
9 bear with me. I'm going to give you the record so
10 to speak since those are all loose pages. I'll get
11 you the number in just a second.

12 Please look at page 0034. It's the third and
13 fourth page from the front.

14 A. Okay. So this is the surgical report. The
15 surgeon, this is what he found in the -- after this.
16 I'm going to read the operative report: Drains of
17 28 chest drainage. Patient remains in critical
18 condition. Procedure in details. I was called STAT
19 to the cath lab out of a previous case, which I was
20 in the middle of. There was a left-side
21 para-xiphoid pigtail drain placed. The patient was
22 on rhinotropes and pressors. The [unintelligible]
23 effect was quite poor but short new fibrinous and
24 existence of blood. Dr. Dash was clearly aspirating
25 blood from the pericardium and putting it back in

1 the vein. The patient was clearly unstable;
2 therefore, he was also known to be -- he was also
3 known to be on blood thinners though his INR was
4 less than 1.5 preprocedure. Because of the
5 patient's critical state and also hemodynamic
6 compromised of ongoing bleeding we took the patient
7 to surgery. A gram of Ancef was given -- which is
8 antibiotic. A Foley and SCDs were placed. A
9 subxiphoid incision was made. The xiphoid bone was
10 removed. Pericardium was entered. A quarter-size
11 area was sent for biopsy. The large clot was
12 evacuated. The heart was not pumping well. Though
13 in my impression that patient was acidotic -- it's
14 one of the states -- I communicated with anesthesia.
15 I saw the point of ingress of the catheter in the
16 facia. It looked like it went across the acute
17 margin of the right ventricle. There was some mild
18 oozing but no significant ongoing bleeding. I
19 placed a piece of SurgiSeal just in case and after
20 evacuating the clot with ring forceps closed the
21 layers and finished with staples.

22 Q. What is SurgiSeal?

23 A. I believe it's a kind of gel they use over
24 there.

25 Q. Did they have to put any stitches in the heart?

1 A. No. Based on this report, there was no
2 stitches required to repair the heart.

3 Q. And looking again at Exhibits 11(a) through
4 (c), particularly item (c), which we've talked about
5 at length.

6 A. Right.

7 Q. Is that contact with the heart wall sufficient
8 to account for all the blood that you had to pull
9 out of Mr. Dibernardo?

10 A. No.

11 Q. And was the blood that you've shown us on the
12 echo present before this sheath placement occurred?

13 A. Yes. As we have seen, it was present before
14 the sheath was placed inside.

15 Q. Dr. Mori, did you perform the
16 pericardiocentesis on Mr. Dibernardo in accord with
17 generally accepted standards of care?

18 A. I did, yes.

19 Q. Did you perform it in the way that you'd be
20 taught to do it within your professional training?

21 A. Yes, I did. Yes.

22 Q. And finally, Doctor, when a complication was
23 discovered did you manage that complication in
24 accord with generally accepted standards of care?

25 A. Yes; I did.

1 Q. Is that -- are those your opinions to a
2 reasonable degree of medical certainty?

3 A. Yes. Yes, they are.

4 Q. Did Mr. Dibernardo survive the emergency heart
5 surgery?

6 A. Mr. Dibernardo did survive the emergency heart
7 surgery, yes.

8 Q. Now, he was placed on a ventilator. We know
9 that. Is that standard protocol for anyone who has
10 open heart surgery?

11 A. Yes, it is.

12 Q. Following the surgery did other physicians
13 render care to Mr. Dibernardo as well as the
14 physicians from Carolina Cardiology?

15 A. Yes, they did. Yes.

16 Q. And who was the intensivist?

17 A. Intensivist was Dr. Sally Wooten.

18 Q. And at the point in time that he was in
19 intensive care you had -- would she had been the
20 primary speciality with skill to handle this
21 condition?

22 A. Yes.

23 Q. Did Carolina Cardiology continue to follow this
24 patient throughout the remaining days of his life?

25 A. Yes, they did.

1 Q. And can you tell us who all charted from your
2 recollection as having been there checking on this
3 patient during those days?

4 A. Dr. Shah and Dr. Wooten.

5 Q. And did you yourself check on the patient and
6 make a note of it?

7 A. I did, yes.

8 Q. Now, you've been asked a number of questions.
9 and you've told me a number of questions about how
10 the complication occurred. I want you to tell me
11 what, in your opinion, Mr. Dibernardo's course would
12 have been with his condition if he had not had any
13 treatment whatsoever based on your knowledge of his
14 history and of his condition.

15 A. I believe his symptoms -- the initial
16 presenting symptoms that he came with -- shortness
17 of breath, swelling of the legs, swelling in the
18 belly -- these are mainly symptoms of heart failure
19 that he had. I believe they would have
20 progressively become worse.

21 Q. Now, you wrote two notes; one a procedure note
22 and then one a death summary; is that correct?

23 A. Yes.

24 Q. And they are in the medical record. And I will
25 ask you, at any time did you attempt to conceal or

1 hide anything of significance at all that happened
2 to this man?

3 A. No, I did not. No.

4 Q. Could any medical professional or layman for
5 that reason read your notes and realize that a
6 bleeding complication occurred during your surgery?

7 A. Yes.

8 Q. During your procedure?

9 A. Yes, they could. Yeah.

10 Q. And as a result of that bleeding complication
11 he had to go to surgery?

12 A. Yes. Yeah.

13 Q. And as a result of surgery and his underlying
14 comorbidities he was not successful in coming off
15 the ventilator and the family elected to terminate
16 ventilation?

17 A. Yes.

18 Q. At any time did you try to make any notes or
19 references to confuse --

20 A. No, I did not.

21 Q. -- or mislead anyone?

22 A. No.

23 Q. And you've read Dr. Wooten's note. We're going
24 to have her testimony in a little while. So you
25 know that the family had a discussion with Dr.

1 Wooten --

2 A. Yes.

3 Q. -- and they expressed their reasons?

4 A. Yes.

5 Q. Record shows that. There's some dispute about

6 what was said. In any event, do you have any

7 disagreement with Mrs. Dibernardo's decision to

8 terminate the -- or not to reintubate her husband at

9 the time?

10 A. No. No, I don't.

11 Q. And were you called about that decision?

12 Anybody --

13 A. I was not primary at that time. My colleague

14 Dr. Shah who was following the patient was called

15 about that.

16 Q. And you saw that referenced --

17 A. Yes.

18 Q. -- in the notes of Dr. Wooten?

19 A. Yes.

20 Q. Dr. Mori, starting from Friday the 19th up

21 until this patient was under the care of Dr. Savage

22 and Dr. Wooten did the care you rendered at all

23 times comply with generally accepted standards of

24 care?

25 A. Yes. Yes, it did.

1 Q. And is that your opinion to a reasonable degree
2 of medical certainty?

3 A. Yes, it is.

4 MR. BEIGHLEY: Thank you. Please answer
5 counsel's questions.

6 THE COURT: Mr. McGowan?

7 CROSS-EXAMINATION

8 BY MR. MCGOWAN:

9 Q. Dr. Mori, you're a member of the medical staff
10 at Piedmont Medical Center; is that correct?

11 A. Yes.

12 Q. And as a result you have agreed to abide by the
13 rules and regulations that pertain to the medical
14 staff; is that true?

15 A. Yes.

16 Q. And part of your job as a doctor is the
17 completion of medical records?

18 A. Yes.

19 Q. And Piedmont is pretty specific about what
20 needs to be in the medical records, right?

21 A. Yes.

22 Q. Significant -- anything you do with the
23 patient, observations, interventions, diagnoses,
24 treatments, outcomes. All of that under your
25 agreement with the hospital has to be in the medical

1 records, right?

2 A. Yes.

3 Q. Okay. And that's part of the deal that you
4 made with Piedmont that says if you let me be a
5 doctor at your hospital I agree that I will fill out
6 medical records the way you want which includes --
7 well, I'll read it for you.

8 This whole paragraph is about medical records:
9 Licensed, independent practitioner and as applicable
10 any surgical or consulting practitioner shall be
11 responsible for the preparation of a complete and
12 legible medical record for each patient. Its
13 content shall be pertinent and current; shall
14 include emergency [unintelligible] of the patient
15 prior to arrival, if any, the recorded findings;
16 patient's assessments, conclusions or impressions
17 drawn; the medical history and physical examination;
18 diagnoses; diagnostic impressions; reasons for
19 admission or treatment; goals required by hospital
20 policy; diagnostic and therapeutic orders; all
21 diagnostic and therapeutic procedures; test results
22 -- and it goes on and on.

23 You've read it before, right?

24 A. Yes.

25 Q. So your obligation as a physician is to make

1 sure that your medical records speak the truth and
2 speak the whole truth?

3 A. Yes.

4 Q. And you knew that from the day you started
5 practicing medicine at Piedmont?

6 A. Yes.

7 Q. Okay. Let's talk about this whole echo
8 business. You say that there's a clot on that echo
9 before the sheath goes in?

10 A. Yes.

11 Q. And where is it --

12 A. Can I interrupt?

13 Q. Sure.

14 A. The timing results are there, so it's not just
15 my statement.

16 Q. Okay. So -- but --

17 A. Did you see the timing?

18 Q. Of course. That's why we're having this
19 discussion, Doctor.

20 A. Thank you.

21 Q. Now, in the cath lab report the timeline --
22 it's in there please. Thank you -- there is a
23 minute-by-minute, second-by-second time cap of
24 everything that happens in the cath lab, right?

25 A. Yes.

- 1 Q. It's this thing that we saw, right?
- 2 A. (No response.)
- 3 Q. Yes?
- 4 A.. Yes.
- 5 Q. Can you show me anywhere where it says echo
- 6 shows clot?
- 7 A. I think the people documenting this, they're
- 8 not paid to read echos.
- 9 Q. Okay. So we need somebody that can read echos?
- 10 A. That would be myself.
- 11 Q. Okay. Let's look at that. You -- you wrote a
- 12 note within an hour of this, didn't you?
- 13 A. Yes.
- 14 Q. And that note is in the records and it's
- 15 Exhibit No. 3, yes?
- 16 A. (No response.)
- 17 Q. Yes?
- 18 A. I don't have Exhibit No. 3.
- 19 Q. It's Tab Number 3.
- 20 A. Yes.
- 21 Q. So show me where you say there was a clot on
- 22 echo in the medical record that you dictated back an
- 23 hour after the patient went from your cath lab to
- 24 emergency surgery.
- 25 A. It's not there.

1 Q. It's not there?

2 A. Yes.

3 Q. How about your discharge summary? You wrote
4 that, right?

5 A. What page is that?

6 Q. I'll find it for you. Behind the progress
7 notes.

8 Your discharge summary, which you dictated four
9 months later, is Tab Number 9. That's your
10 discharge summary, right?

11 A. Yes.

12 Q. Where in that did you put clot seen on echo?

13 A. I did not put it in there.

14 Q. Okay. So so far up to right this second, in
15 the records at least, we have the cath lab that says
16 nothing about a clot seen on echo, right? Timeline
17 didn't say it?

18 A. Timeline doesn't usually say it.

19 Q. Okay. Your record, which you dictated within
20 an hour, didn't mention anything about it, right?

21 A. Yes.

22 Q. And your discharge summary that you personally
23 dictated four months later didn't say anything about
24 it?

25 A. Yes. Dr. Savage's note did mention it.

1 Q. Well, that's because he saw it when he took it
2 out, right?

3 A. No, no. He had mentioned it on echo, if you
4 look at the report. You want me to read the report?

5 Q. The issue here, Doctor, is whether it is, in
6 fact, true that, number one, that is a clot, and
7 number two, that you saw it and acted upon it as
8 such. And these are the purposes of my question.

9 Are you with me?

10 A. Yes, I am.

11 Q. Okay. We know there was a clot because we know
12 he had bleeding, right?

13 A. (No response.)

14 Q. We know that.

15 A. , I'm trying to understand one thing and pardon
16 me if I repeat this. You're disputing there is
17 clot?

18 Q. I'm disputing the fact, Doctor, that it shows
19 up nowhere in your medical records, does it?

20 A. It shows up in Dr. Savage's note who mentioned
21 there is a fibrinous thing on echocardiogram.

22 Q. I know there's a clot in there. The question
23 is, whether --

24 A. The question is, are you disputing that is
25 clot? I'm trying to understand that.

- 1 Q. Yes. Yes, I am.
- 2 A. You're disputing that is clot?
- 3 Q. Yes. And the reason is, Doctor, the truth is
- 4 it's nowhere in any of your medical records, right,
- 5 that that's true? Until today you have never said
- 6 that was clot on that echo before today, right?
- 7 A. But that is clot.
- 8 Q. I understand. But you haven't said that before
- 9 today in court, right?
- 10 A. (No response.)
- 11 Q. Right?
- 12 A. In court? Yeah, this is the first time I'm in
- 13 court. Yes.
- 14 Q. No. The first time that you've ever said that
- 15 that's clot on that echo?
- 16 A. Yes.
- 17 Q. Okay. The first time was today?
- 18 A. Yes.
- 19 Q. So it's not in any of your medical records --
- 20 and in fact, I had a chance, an obligation to take
- 21 your sworn testimony, right? And I asked you maybe,
- 22 what, four times why you put the sheath in?
- 23 A. (No response.)
- 24 Q. You want your transcript I can get it for you.
- 25 A. No, I reviewed it.

1 Q. Did you ever say in your sworn testimony when I
2 asked all those questions that there was clot on
3 echo before the sheath went in?

4 A. The reason the sheath went in was because a
5 change in clinical status. The main reason was
6 change in color. Echo was there to confirm
7 diagnosis. The main reason was the hemorrhagic
8 conversion from a pinkish fluid to bloody fluid.
9 That was the main reason.

10 Q. Wasn't my question. My question was, when I
11 asked you in your deposition over and over when you
12 were under oath and I said why did you put the
13 sheath in, you never said -- you never came up with
14 this there was a clot on an echo prior to putting
15 the sheath in. Never said that was one of the
16 reasons, did you?

17 A. But that -- that was there to confirm
18 diagnosis. My clinical reason was the main reason I
19 put it.

20 Q. All right. So the truth is, you never --
21 despite all of my questioning, you never said, oh,
22 by the way, there was a clot on echo and that's one
23 of the reasons I put the sheath in? You never said
24 that, right?

25 A. I said it today.

1 Q. Said it today?

2 A. Yes.

3 Q. And I'm a lawyer, as you know, and there are
4 procedures in place. You're aware of the legal
5 procedures, yes?

6 A. (Nonverbal response.)

7 Q. And part of those is the exchanging of what are
8 called interrogatories. You remember getting some
9 of these and answering them, helping out, right?

10 A. (Nonverbal response.).

11 THE COURT REPORTER: Please answer verbally.

12 A. Yes.

13 Q. I sent some to Mr. Beighley related to this
14 case. You're aware of that, right?

15 A. Yes.

16 Q. Okay. One of the questions I asked -- and I'll
17 hand this to you -- is Question Number 9 on my first
18 set of interrogatories, and these are your answers.

19 They're provided by your lawyer but they're
20 your answers, aren't they?

21 A. Number 9 is my answer.

22 Q. Well, the bold part is your answer to my
23 question. Go ahead and read Question Number 9.
24 We're all on pins and needles.

25 A. Describe any treatments or actions that

1 Defendants could have implemented that may have
2 prevented Mr. Dibernardo's injuries and death.

3 Q. Okay. That's the wrong one. Number 10. Do
4 Number 10.

5 A. Identify all observations, diagnoses or
6 treatment of Mr. Dibernardo which are not reflected
7 in the medical records.. In answering this
8 interrogatory please describe in detail the
9 observations, diagnoses and treatment provided to
10 Mr. Dibernardo.

11 Q. Okay. So what is that asking you?

12 A. (No response.)

13 Q. It's asking you for any observations,
14 treatments, anything you did medically that was not
15 in the medical record, right?

16 A. I believe echocardiogram is part of medical
17 records.

18 Q. I asked you the question: What observations
19 were there -- right?

20 A. Yes.

21 Q. -- that were not in the medical record, right?

22 A. Echocardiogram is in medical records.

23 Q. I understand. But what was your answer?

24 A. As medical records are still being collected,
25 the defendant can only state that at this time all

- 1 observations, diagnoses, treatments of Mr.
2 Dibernardo are reflected in the medical records;
3 however, discovery is still ongoing. Defendant
4 reserves the right to supplement this answer as
5 discovery progresses.
- 6 Q. Okay. And that was never done, you know that?
7 A. I'm sorry?
- 8 Q. That -- the answer to that question was never
9 supplemented, right?
- 10 A. (No response.)
- 11 Q. You know that. —
12 A. No, I'm not aware.
- 13 Q. Okay. Well, I'm telling you.
14 A. Okay.
- 15 Q. And your observation that there was clot on
16 that echo we know was not in the medical records,
17 right?
- 18 A. I think it's part of Dr. Savage's note.
- 19 Q. Your observation about the clot that you claim
20 is a clot before the sheath goes in is not in the
21 medical records, right?
- 22 A. I didn't -- I did not write it or dictate it
23 that there is clot in there.
- 24 Q. Okay.
25 A. But to say that it's not part of medical

1 records would be untrue, sir.

2 Q. Well, the echo is. My --

3 A. And Dr. Savage's observation and our discussion
4 about that is part of medical record, sir.

5 Q. The problem I have, Doctor, is that you get up
6 here and you say that you're an echocardiographer
7 and whatnot and you want --

8 A. I'm board-certified in echocardiography.

9 Q. Okay. Fine. And you want us to believe what
10 you say about an echo, right?

11 A. Well, I think your -- your witness had a chance
12 to observe it also.

13 Q. Was there contrast put into the pericardium at
14 or before these echos?

15 A. During echocardiography I showed the pictures
16 when it was put in.

17 Q. There was actual contrast put in?

18 A. That was saline -- agitated saline contrast.
19 In echocardiogram, we don't use the fluoro contrast.
20 We use different contrast.

21 Q. I understand. But by that time fluoro contrast
22 had already been put in; is that right?

23 A. In where? I'm sorry.

24 Q. Into the pericardial space of Mr. Dibernardo.

25 A. This might have been first, this one. The

1 echocardiogram might have been first and then fluoro
2 might have been done.

3 Q. All right. So the reason -- well, let's start
4 this way: from the beginning. When you insert this
5 needle you're supposed to draw back on it, right?

6 A. Yes.

7 Q. And in this case you drew back on it and you
8 did not get frank blood. You got what turned out to
9 be normal for him pericardial fluid?

10 A. Pinkish fluid. Not normal.

11 Q. So are you saying that when you inserted this
12 needle into the space you injured something on the
13 heart that caused it to start bleeding, yet when the
14 tip of the needle was in the area that it had just
15 created where the blood was directly in contact with
16 the tip of the needle did not show up when you
17 aspirated? Is that what you're saying?

18 A. There was no frank blood on my first aspiration
19 is what I'm saying.

20 Q. Okay. So back to the question. Is it your
21 testimony that somehow you managed to insert this
22 needle, injure the heart to cause a bleed bad enough
23 to cause his blood pressure to drop, and when you
24 pulled back on the syringe there was no blood in
25 this syringe, even though the tip of that needle was

1 in the direct area of injury on the heart that had
2 just been caused?

3 A. Yes.

4 Q. Okay.

5 A. You can have bleeding and not aspirate blood
6 back.

7 Q. That -- the reason you do the aspiration is to
8 check for blood, right?

9 A. To check whether you're in the right space is
10 why you do it.

11 Q. And if you get blood you're supposed to respond
12 to it and do things, right?

13 A. Well, you can have bloody fluid and many times
14 you have to differentiate are you -- do you have
15 real blood or do you have bloody fluid? Let me tell
16 you how you do that. You actually put that fluid on
17 a disk. If it clots, it's blood. If it doesn't
18 clot, it's just bloody fluid.

19 Q. When you pulled back on this syringe --

20 A. Yes.

21 Q. -- with the needle tip in the area of injury
22 did you have any indication that that needle tip had
23 caused an injury and bleeding?

24 A. No.

25 Q. Does that not lead you to believe that it was

1 probably not the needle stick, given the fact that
2 there was no blood in that fluid when you drew it
3 back, knowing that the tip of that needle was in the
4 direct area where the injury and bleeding, you
5 think, were occurring?

6 A. I'm trying to illustrate why this can be
7 possible. Can I try and do that?

8 Q. I'm more concerned about most likely because
9 possibilities are --

10 A. No. Can I try and explain why you can injure
11 and then not get back -- can I explain that?

12 Q. Sure.

13 A. Can I try and do that please?

14 Q. Sure.

15 A. May I try and get up and do it?

16 Q. Whatever His Honor allows you to do is fine.

17 THE COURT: The witness may step down.

18 A. So this is our heart here. This is our heart
19 here.

20 Q. Okay.

21 A. We enter and we can cause injury. And you're
22 saying if there's injury from this I should
23 definitely get blood back. If I get injury and then
24 I -- my needle is not in contact with the heart
25 there's no way you'll get blood back. You can get

1 pericardial fluid back.

2 So what I'm trying to say is you can have
3 injury -- you can have this needle not touch the
4 area that it caused the injury in and not get blood
5 back. Is that fair?

6 Q. It's not really for me to decide, Doctor.

7 A. I'm asking you. You can have contact causing
8 injury. You can lose contact and you can not get
9 blood back and you can get pericardial fluid back
10 just by virtue of losing contact to the site causing
11 injury.

12 Q. What is it that you say you stuck that needle
13 in?

14 A. Pericardium.

15 Q. In the muscle?

16 A. Pericardium. You start by going in the
17 pericardium. Then you had injury.

18 Q. What part of the heart did you injure with that
19 needle when you stuck it in there?

20 A. I -- I cannot say I injured vein, artery or
21 muscle. It could be any of that. I -- I didn't
22 have view of the bleeding, where it's coming from.

23 Q. Now, when you do this, just like Dr. Schob
24 said, you hooked up an alligator clip to the needle.
25 You did the same thing, right?

1 A. I did not hook up an alligator clip.

2 Q. Well -- okay. So you said that you -- so you
3 did not use EKG guidance in this case?

4 A. I used telemetry electrocardiographic guidance,
5 not alligator clip guidance.

6 Q. Okay.

7 A. Can I read my deposition for you please?

8 Q. You did not -- did you or did you not guide
9 this needle with the EKG, knowing that if you hit it
10 the EKG would signal?

11 A. What I was trying to explain -- and I did this
12 during the day of deposition -- is I was looking at
13 telemetry monitoring on the screens, not alligator
14 clip.

15 Q. All right. So I'm going to direct you -- you
16 can have this. It's page 14. Your depo.

17 All right. So I'm looking here on page 14.
18 You with me?

19 A. Yes.

20 Q. And I asked, what approach did you use?

21 And you said, subxiphoid approach, right?

22 A. Yes.

23 Q. Then you said, okay, we then gave him some
24 sedation or usually give some sedation depending on
25 what their blood pressure is or how much awake or

1 alert they are. We then usually make a small
2 nick -- anesthetize the area, make a small nick and
3 direct our needle towards the pericardial sac under
4 mainly echocardiographic and electrocardiographic
5 guidance, which is we take a look at the monitor and
6 are looking for any premature beats or anything that
7 might signify that we might be in contact with the
8 ventricle. So we do -- we do that usually.

9 And I asked, all right. So you do echo
10 ultrasound?

11 You said, yes.

12 And then you do steady pictures too or
13 fluoroscopy?

14 You said, fluoroscopy and electrocardiographic
15 guidance.

16 Electrocardiographic is EKG, right?

17 A. ECG also.

18 Q. And we can go -- and ECG is what you said then?

19 A. (No response.)

20 Q. Then -- now, what are you looking for with the
21 ECG guidance? The ST elevation? If you were to
22 touch, you know, the ventricle or --

23 No. We just look for some premature beats --
24 premature ventricular beats.

25 Is there any kind of connection to that needle

1 to the ECG or I've heard people use -- put what they
2 call a roach clip on it?

3 That's right.

4 And you can use the rhythm changes?

5 Right.

6 Or you can look at the monitor and see what you
7 are -- you're touching the heart tissue?

8 Yes.

9 Because you're creating, kind of, a short
10 circuit of the electrical system?

11 And you go, right. You're stimulating the
12 heart and that usually leads to a premature beat, is
13 what you said, right?

14 A. Yes.

15 Q. Then I asked you, was Mr. Dibernardo dealt with
16 this way, with the ultrasound echo, the fluoro and
17 the ECG?

18 And what did you say? Line 1.

19 A. That's right, yeah.

20 Q. And the next part -- and the point of all of
21 that is to make sure the needle doesn't lacerate the
22 heart tissue?

23 You said, yes, that's right.

24 All right. So let's be clear. Are you now
25 changing your story and saying you didn't use ECG

1 guidance?

2 A. That's -- I think there's a little bit of
3 misunderstanding here. What I call this telemetry
4 and ECG guidance is what you are saying is the
5 alligator clip. Nowhere did I mention the alligator
6 clip. The ECG guidance is when you look at the
7 telemetry monitoring, which this gentleman had, and
8 you look for premature beats. In alligator clip, if
9 I had used it, I would have documented saying
10 there's alligator clip but in this case it was not
11 used. It was not part of the pericardiocentesis
12 tray. It was not used in this case, alligator clip.
13 Electrocardiographic guidance or telemetry
14 monitoring was definitely done. So I'm not
15 backtracking. I'm sorry.

16 Q. If you do all of those things properly, you
17 should not cause an injury to the heart; isn't that
18 true?

19 A. Yes, it is true.

20 Q. Okay. So what we have is a basic process, if
21 it was the needle, that if you follow the basic
22 standards of care you certainly should not tear up
23 the heart tissue when you're putting in the needle,
24 right?

25 A. You should not tear up the heart tissue.

1 Q. Okay. And there's some question as to what
2 kind of -- this wasn't an actual piercing or
3 penetration of the ventricle. You agree?

4 A. Yes.

5 Q. This was more of a scrape or an abrasion or
6 something more linear across the heart?

7 A. Yes, it was an abrasion probably. Yeah.

8 Q. Okay. So this sort of injury is exactly what
9 doing the procedure properly is meant to avoid;
10 isn't that true?

11 A. Yes, definitely.

12 Q. All right. So if you had done it right -- if
13 you had done all these things the way you're
14 supposed to, Mr. Dibernardo would not have had that
15 injury to his heart; isn't that true?

16 A. If everything is done right you can still have
17 complications. I just explained to you -- and I
18 don't know if you were paying attention or not.

19 Q. I paid very close attention.

20 A. The heart is moving there. The space between
21 the right ventricle and pericardial sac was not as
22 great as -- you know, as you had claimed yesterday
23 it was a very large pericardial effusion, 4
24 centimeters, but if you look at the details, the 4
25 centimeters was procedurally.

1 So if you have a heart in motion you can have
2 bleeding; you can have what is a known complication
3 of pericardiocentesis. Unfortunately that's what
4 happened here, sir.

5 Q. Wasn't my question though, Doctor. You made an
6 injury to the heart that is avoided by the normal,
7 everyday, standard process by which you monitor this
8 and make sure you don't do it, right?

9 A. Yes.

10 Q. And if you had done it properly, if you had
11 paid attention to these processes the way you were
12 supposed to, Mr. Dibernardo's heart would not have
13 been injured in this case; isn't that --

14 A. No. Honestly, I did this properly and it was
15 injured. I did this properly. I took all
16 precautions. In spite of that, unfortunately there
17 was injury.

18 Q. Okay. So --

19 A. I'm not denying there's injury. I am denying
20 the fact that I did not do this properly.

21 Q. And let's talk about the subxiphoid approach.
22 Now, you can approach pericardial effusions from
23 different angles and avenues, right?

24 A. Yes.

25 Q. Some xiphoid. Sometimes you go from the side.

1 You gotta go wherever it's best for the patient,
2 right?

3 A. Yes.

4 Q. All right. So he had a very large effusion
5 sort of behind the heart; is that right?

6 A. Yes.

7 Q. Was there any other way to get to it other than
8 the subxiphoid?

9 A. Subxiphoid in literature is the safest
10 approach, the most commonly used approach.

11 Q. I'm talking about Mr. Dibernardo in particular.
12 Could you have gone --

13 A. Let me explain. I have to -- I have to tell
14 you why I chose this approach.

15 Q. Let's first answer my question and then you can
16 explain all day long.

17 A. Thank you.

18 Q. Could you have done a different approach for
19 Mr. Dibernardo depending exactly the way he was?

20 A. I believe I did the safest approach for
21 Mr. Dibernardo.

22 Q. Wasn't my question, Doctor. Could you have
23 done a side approach?

24 A. The side approaches have their own
25 complications. The clinical literature supports

1 that subxiphoid is the safest approach to do it.

2 Q. I'm talking about for Mr. Dibernardo. Did you
3 -- are you telling me that -- because what I hear
4 you saying, Doctor, is that for Mr. Dibernardo the
5 effusion that was closest to the subxiphoid, the
6 breast bone was not very big --

7 A. Yes.

8 Q. -- but he had a massive one to the side?

9 A. It's very difficult to do the side one. Yes.

10 Q. Well, so --

11 A. And that's a reason he was referred to surgery,
12 because it was a difficult effusion.

13 Q. Did you know --

14 A. But the patient refused surgery, came to me,
15 and we know what happened then.

16 Q. So did you knowingly -- did you give
17 Mr. Dibernardo the choice on your approach from the
18 subxiphoid where you say it's much more dangerous or
19 the side which for him may be much safer?

20 A. Let it be stated that the subxiphoid in
21 literature is the safest way to do the
22 pericardiocentesis. The complication with the
23 apical approach in Mr. Dibernardo's case is
24 two-fold. One is he had a massively enlarged heart.
25 His anatomy was not the typical anatomy you see in

1 this picture. The apex was -- I couldn't find it.

2 Q. What do you mean you couldn't find it? You had
3 echos all over the place.

4 A. I'm just saying you can't -- you can't access
5 easily here.

6 Q. Easily?

7 A. You cannot access easily.

8 Q. All right. Did you give Mr. Dibernardo the
9 choice? Did you say, all right, Mr. Dibernardo.
10 There's two ways we can do this. We can go in here
11 or we can go in here. You got a big bunch of fluid
12 back here that makes it safer once I get the needle
13 in but it may be a little more technical for me to
14 do if I go this way. Or if I go in this way there's
15 not much room for me to work and I might screw you
16 up.

17 Did you give him that choice?

18 A. When I started off with the procedure to try
19 and do the pericardiocentesis I did not anticipate
20 that I would run into complications. I chose what I
21 believed at that time was the safest approach for
22 Mr. Dibernardo.

23 Let it be stated that the approach that you're
24 saying, the apical approach is flawed with danger.
25 It can lacerate the artery there, the left anterior

1 descending artery. You can do that.

2 Q. Wasn't my question. You did echos on the 19th?

3 A. Yes.

4 Q. Three days before this procedure. And you met
5 with Mr. Dibernardo --

6 A. Yes.

7 Q. You say you did, right?

8 A. (No response.)

9 Q. So between --

10 A. I'm sorry. My note is there so I definitely
11 did. Although yesterday you were disputing that,
12 right? That I did not meet with him.

13 Q. Between the time of your echos and notes and
14 meeting with him on the 19th to the time of the
15 procedure did you ever clear it with Mr. Dibernardo,
16 based upon what I see on the echo it's more
17 dangerous for a heart injury to go this way but it's
18 more technical for me to go with way?

19 Did you ever give him that choice and lay those
20 options out for him?

21 A. No.

22 Q. You realize Mr. Dibernardo didn't want surgery
23 and was worried about the safety of the procedure?

24 A. I am not aware of the reasons why Mr.
25 Dibernardo refused surgery.

1 Q. Were you -- were you aware that he was told the
2 pericardiocentesis is much safer than surgery?

3 MR. BEIGHLEY: I would object to the --

4 THE COURT: I'll sustain the objection.

5 BY MR. MCGOWAN:

6 Q. Would you agree that the pericardiocentesis
7 normally is much safer than an actual procedure
8 where you get cut open?

9 A. No.

10 Q. No? All right.

11 A. Can I -- can I explain?

12 Q. Do what you want, Doctor.

13 A. Can I do that, sir?

14 Q. Sure.

15 A. Okay. Here's why I say they both have equal
16 safety: If someone has a normal heart and you just
17 get pericardial effusion and they go for surgery and
18 they don't have other problems, everything else is
19 normal, they recover just as well from surgery as
20 from pericardiocentesis. So both are equally safe.
21 In fact, for complicated pericardial effusion
22 surgery is preferred as opposed to
23 pericardiocentesis.

24 Does that answer your question, sir?

25 Q. Yes, it does.

- 1 A. Thank you.
- 2 Q. All right. This is fluoro -- we've seen this
- 3 50 times. Do you agree with Dr. Schob that this
- 4 shows a catheter that arcs around toward sort of the
- 5 back, a fluid pocket in Mr. Dibernardo's chest?
- 6 A. Yes.
- 7 Q. And this is a good positioned catheter?
- 8 A. Yes.
- 9 Q. And you injected contrast into it?
- 10 A. Yes.
- 11 Q. And you would have done that shortly after it
- 12 was placed?
- 13 A. Yes.
- 14 Q. And it shows that -- you see the fog of the
- 15 contrast flowing from right to left?
- 16 A. Yes.
- 17 Q. That's good?
- 18 A. That's good.
- 19 Q. Based upon this, everything is hunky-dory,
- 20 right?
- 21 A. (Nonverbal response.)
- 22 Q. Right.
- 23 A. Then the plot thickens, right?
- 24 Well, the plot thickens. Sorry.
- 25 Q. Do you agree with us on this particular fluoro?

1 This is taken -- we have a sheath. Sheath ends
2 here. Catheter goes into here.

3 A. Yes.

4 Q. So we're totally correct about all that?

5 A. Yes.

6 Q. And then when you put dye in it what we see is
7 the tip of the catheter tethered to the heart
8 because it --

9 A. It is in contact with the heart, yes.

10 Q. It beats?

11 A. It is on contact with the heart.

12 Q. Right. Again, it's actually --

13 A. Technically, doesn't it have to be attached by
14 something? I'm sorry. My English is not as good as
15 yours.

16 Q. The tip of this catheter is in contact or
17 tethered to the heart because it pumps with the
18 heart, right?

19 A. It moves with the heart, yes.

20 Q. Moves with the heart?

21 A. Yes.

22 Q. And this staining here, just like Dr. Schob
23 said, that's staining of the myocardial tissue?

24 A. Not really dramatic in this picture. The next
25 one is more dramatic.

1 Q. Okay. But it shows it nevertheless?

2 A. It shows it and if you -- if you see it, it
3 washes away.

4 Q. Now --

5 MR. MCGOWAN: Can we get the lights out again?
6 I'm sorry.

7 Q. We see that little crescent towards the bottom
8 kind of stay still, stay stable, don't we?

9 A. Uh-huh.

10 Q. It's this little -- it's almost like the roots
11 of a tree, right? Right in here, right?

12 A. Yes.

13 Q. That's indicative of cardiac injury?

14 A. Staining. Contact with the heart and staining.

15 Q. Well, normally you don't have contrast staining
16 the heart unless the heart tissue is somehow
17 disrupted or roughened up, right?

18 A. There is contact with the heart, not enough to
19 cause penetrative injury. Probably touch the
20 surface, cause some injury there, yes.

21 Q. So --

22 A. I do agree with that.

23 Q. All right. So we have documented,
24 incontrovertible proof of a heart injury by the time
25 of fluoro number 2?

1 A. Yes. And we have it before the sheath was put
2 in also.
3 Q. And on fluoro number --
4 A. On echocardiogram.
5 Q. On fluoro number 3, same thing. This is the
6 more dramatic issue of injury, isn't it?
7 A. Yes. Yes.
8 Q. This is our sheath that's been put in?
9 A. Yes.
10 Q. Our pigtail has now been removed?
11 A. Yes.
12 Q. This is more staining of the heart tissue?
13 A. Yes.
14 Q. The way the catheter used to go, it used to
15 kind of come around in here, right?
16 A. Uh-huh, yes.
17 Q. So we have injury here and here?
18 A. (No response.)
19 Q. Here and here?
20 A. I don't see the injury down there so there's no
21 remnant staining there.
22 Q. Well, the way the catheter used to be was down
23 in this --
24 A. Right, but there's no staining there. If
25 there's staining there, then yeah, there is

1 disruption there also.

2 Q. There's clear disruption injury here?

3 A. Right.

4 Q. Yes? And on the other one it was where the end
5 of the catheter was?

6 A. End of the catheter, yes.

7 Q. So that means there's two areas of heart
8 injury?

9 A. But if -- see, that -- what I'm trying to say
10 is contact with the heart leads to staining. If you
11 don't see the contrast there, it's washed off, I'm
12 not sure if the injury is there also. So you can't
13 equate staining with 100 percent injury. If it
14 washes away and there's no residue of contrast,
15 there may not -- the injury might not have been that
16 significant.

17 Q. Okay. So no -- you've told us a number of
18 reasons why you put the sheath in. And you still
19 have your deposition up there; is that right?

20 A. Yes.

21 Q. Now, the first time I asked you why you put the
22 sheath in you told me that you were having
23 difficulty drawing back fluid -- this is on page 23
24 -- and the patient had a drop in his hemodynamics.
25 He became unstable. That's what you said, wasn't

1 it?

2 A. Yes.

3 Q. That is not a true statement, is it?

4 A. I actually disagree with that.

5 Can we go back to the cath lab log please, sir?

6 Q. Let's get you -- try to get you tied down here
7 first.

8 Page 23 you said, At this time of the sheath
9 the patient was sort of decompensating. He was
10 dropping his blood pressure --

11 A. I'm sorry. What page is that?

12 Q. 23, line 9.

13 MR. BEIGHLEY: Can we put the lights back up?

14 MR. MCGOWAN: Sure. Your Honor?

15 THE COURT: Yes.

16 A. Yes.

17 Q. So the first story you told me was that the
18 reason you put the sheath in because he was dropping
19 his blood pressure, sort of decompensating and you
20 weren't getting a good amount of draw back. That's
21 what you said, right?

22 A. That is what happened, yes.

23 Q. Now, the drop in blood pressure, we know, did
24 not happen until after the sheath was put in and
25 after the pigtail catheter that you had reinserted

1 was removed. That is a true statement, isn't it?

2 A. If you look at the log from where he started
3 out to where we started noticing things, there was a
4 drop in systolic pressure, so it can't be entirely
5 inaccurate to say that there was definitely no drop
6 in blood pressure. Let's go back to the log and
7 review that please.

8 Q. It is true, is it not, that his blood pressure
9 remained generally stable from before you got there
10 to the time after the pigtail catheter was removed?

11 A. It did -- but it did drop compared to where we
12 started baseline.

13 Q. You mean before he had fentanyl and Versed and
14 other anesthetics?

15 A. Right around that time, yes.

16 Q. Okay. Well, that's normal, right?

17 A. You can't say it's normal for this --
18 everything was not normal for him. I'm sorry.

19 Q. Wait a second, Doc. He comes in. His blood
20 pressure's a little high. You give him fentanyl --
21 you don't but the nurses or whomever give him
22 fentanyl and Versed, right?

23 A. Yes.

24 Q. Those are anesthetics?

25 A. Right.

1 Q. They're very well known to make your blood
2 pressure go down a little, right?

3 A. Yes.

4 Q. That's -- that's what happens, yes?

5 A. Something else is also very well known to cause
6 blood pressure to drop and that's called bleeding.

7 Q. When he comes in, he's awake; he's alert. He's
8 not under the influence of fentanyl and Versed,
9 right?

10 Then you give him a little medicine because
11 that's what you do, right?

12 A. (No response.)

13 Q. That tends to drop --

14 A. Do you remember how much was given? I'm sorry.
15 I don't remember.

16 Q. I'm sorry?

17 A. I don't remember how much was given -- how much
18 fentanyl or Versed was given.

19 Q. It's in the notebook.

20 A. Okay. Do you remember, sir?

21 Q. No. I mean, this case is not about fentanyl
22 and Versed.

23 A. Okay. So you give higher doses of fentanyl and
24 Versed you can get a bigger drop in blood pressure.
25 If you -- let me -- let me tell you what can happen.

1 You give them Versed and fentanyl and they're not
2 relaxed or anything, they're a little bit anxious,
3 the blood pressure can possibly go up. So not all
4 drop in blood pressure can be attributed to Versed
5 and fentanyl sedation. I'm sorry.

6 Q. Had he had any instrumentation -- anything
7 stuck in his heart cavity, any needles, anything
8 jammed in his heart that would have caused any
9 bleeding before you got there?

10 A. Before I got where?

11 Q. In the room with Mr. Dibernardo.

12 A. No, I'm not aware of that.

13 Q. Okay. And the truth is, this is real data from
14 that report, isn't it?

15 A. Can we -- can we look at the log please?

16 Q. Sure. It's in the book.

17 A. I have it over there.

18 MR. BEIGHLEY: Your Honor, can I give him the

19 --

20 THE COURT: Yes, sir. Get --

21 MR. BEIGHLEY: -- hospital records so he can --

22 THE COURT: Make sure he has the record you're
23 referring to so that we can expedite the
24 questioning.

25 MR. BEIGHLEY: Your Honor, just for the record,

1 I've handed him PMC-603 through 608.

2 THE COURT: Okay. So noted.

3 THE WITNESS: Can I show you the drop in blood
4 pressure?

5 MR. MCGOWAN: Sure.

6 A. Starting blood pressure 116 by 65 79 10:44 and
7 saturations also. Look at the saturations: 65
8 percent drop from 97 percent. Heart rate 82 beats
9 per minute, went up from 60 to 82, and the systolic
10 pressure dropped from 116 over 65 to 95 over 57.
11 This is around the time when we start noticing
12 clinical decompensation of the patient.

13 Q. At 10:40-what --

14 A. This may not be entirely accurate so let's go
15 back to the source please.

16 Q. No, I promise you this is entirely accurate.

17 A. It doesn't have systolic and diastolic. You
18 only have MAP.

19 Q. Yes, it does. See the top of the line, bottom
20 of the line? That's the value of this chart.

21 A. Okay. But the numbers -- exact numbers, I have
22 them here.

23 Q. Now, let me get this straight. Are you saying
24 that he experienced a drop in his mean -- in his
25 blood pressure from before? Where was the drop in

1 blood pressure that you're referring to?

2 A. Let's look at the blood pressure at 10:39 a.m.

3 Q. Okay.

4 A. 116 by 65.

5 Q. Got it.

6 A. To a drop to 10:44 is 95 by 57.

7 Q. What blood pressure do you claim you were

8 acting on?

9 A. Systolic blood pressure.

10 Q. Are you serious? Are you -- are you telling
11 this jury that if somebody's systolic blood pressure
12 changes that you think that patient is now
13 decompensating?

14 A. The systolic blood pressure dropped 20 points.
15 The heart rate went up 20 points. The saturations
16 dropped down. That's enough evidence for me of
17 decompensation there.

18 Q. All right. Let's assume that you're telling
19 the truth right now --

20 A. I am telling the truth, sir.

21 Q. -- why did you wait 18 minutes to do anything
22 about it then?

23 A. I was trying to -- you know, at that time
24 you're not trying to -- you want to try to stabilize
25 the patient with fluids and all that, give them

1 oxygen, and you're not 100 percent sure -- you want
2 to see if it will stabilize but then it gets worse.

3 Q. Where -- which -- what blood pressure said that
4 he's decompensating. I need to switch to a sheath?
5 Which data point did you act upon?

6 A. 10:44.

7 Q. 10:44? So you waited a full 15 minutes to put
8 in the sheath, if what you're saying here is
9 correct?

10 A. I was trying to see if it will settle down or
11 not, but the number I acted upon was 95 by 57.

12 Q. It did settle down, didn't it, based upon the
13 data?

14 A. But he kept bleeding.

15 Q.. Well, where do you get the bleeding --

16 A. The echocardiogram showed bleeding.

17 Q. Where --

18 A.. There's irrefutable evidence -- even though
19 your expert did not show it, there is irrefutable
20 evidence that there was bleeding at 10:45. Sorry.

21 Q. Where -- oh, at 10:45? So you waited -- so now
22 you say there was bleeding at 10:45 --

23 A. I'm sorry. Bleeding at whatever time the first
24 echo showed. I can't -- I have it written it down.

25 I could show it.

1 Q. If --

2 A. -- act on blood --

3 THE COURT REPORTER: They're talking at the
4 same time. I can't --

5 THE COURT: One at a time, gentlemen. She
6 can't take down what you're saying.

7 THE WITNESS: If I can?

8 BY MR. MCGOWAN:

9 Q. If what you're saying is true, Doctor --

10 A. Yes.

11 Q. -- why did you wait 10 minutes?

12 A. I was hoping that bleeding would settle down
13 and that I wouldn't have to do that. Yes.

14 Q. Okay. So you were just sort of hoping?

15 A. Yes, I was hoping the bleeding would settle
16 down but it did not. It got worse.

17 Q. All right. So let's talk about that then.
18 Your concern was you weren't able to get enough flow
19 out of the pericardium?

20 A. Yes.

21 Q. And that was through a catheter?

22 A. Yes.

23 Q. What kind of catheter did you put in?

24 A. The pigtail.

25 Q. Was it something like this? No, that's the

1 wire thing, isn't it?

2 A. The one I showed over there. If you allow me,
3 I can show it to you again.

4 Q. Oh, it's this one? It's this one?

5 A. Yes.

6 Q. This one was too small and --

7 A. Look at the holes there.

8 Q. I see it.

9 A. The holes can get clogged up if there's
10 bleeding..

11 Q. Okay.

12 A. And there wasn't enough blood coming out.

13 Q. And so you were going to put that sheath in?

14 A. Yes.

15 Q. All right. Are you -- there was a not
16 insignificant amount of time --

17 A. Yes.

18 Q. -- where you had a catheter -- that you put a
19 catheter back?

20 A. Yes.

21 Q. If you're concerned about -- was that catheter
22 that you put in about like this purple?

23 A. What catheter? I'm sorry.

24 Q. Well, when you swapped out the pigtail, wire
25 goes in; pigtail comes out, right? Introducer and

1 sheath go in, right?

2 A. Yes.

3 Q. Wire comes out? Or introducer comes out?

4 A. (No response.)

5 Q. The hard part, the metal comes out then, right?

6 A. The hard part comes out, yes.

7 Q. Then you fed another catheter down into the

8 same space?

9 A. I fed the same pigtail catheter, yes. That's

10 the second pigtail. If you look at the second

11 picture --

12 Q. So you put this thing in twice?

13 A. Yes.

14 Q. All right. And you thought that --

15 A. And can I explain why I did that?

16 Q. Let me ask a question and then you can explain

17 whatever you want.

18 A. Yes.

19 Q. It wasn't -- you thought it wasn't working

20 where you had it, right?

21 A. It was -- what was not working? The catheter?

22 Q. Well, your justification for swapping this

23 thing out --

24 A. Yes, yes.

25 Q. -- was it wasn't enough flow --

1 A. I wasn't getting enough flow, yes.

2 Q. The catheter -- you then put the same catheter,
3 back in?

4 A. Yes.

5 Q. And you were expecting to get a different flow
6 from the same catheter?

7 A. That's why I said I want to try to explain why
8 I went back in with the second catheter. I didn't
9 put the second catheter in to try and get a better
10 result with the same catheter. I put it back in
11 there to make sure I'm not in the right ventricle.

12 Q. Well, let's talk about --

13 A. I wasn't -- I wasn't trying to, you know,
14 prepare for this case and do all this. I was trying
15 to find out the source of bleeding.

16 Q. All right. So --

17 A. And I was worried about going in that
18 ventricle. When you have so much bleeding with all
19 this going on you want to try and find the cause for
20 why he's decompensating, not why did I do this,
21 think about it. No.

22 Q. Well, let's talk about that.

23 A. I'm sorry. Talk about what?

24 Q. Well, you're now saying that you thought that
25 you had actually introduced the sheath into the

1 ventricle.

2 A. I was worried about introduction, injury to the
3 ventricle. I was -- as I was saying, I was worried
4 about, why is there so much bleeding?

5 Q. So instead of just injecting contrast into the
6 sheath, you decided that you would jam this other
7 catheter back up it?

8 A. That is a safer catheter.

9 Q. Why would you do any catheter? If you're
10 worried about right ventricular injury you can shoot
11 dye through the end of this sucker just like you did
12 later, right?

13 A. Yes.

14 Q. So if you really think that you have injury to
15 that ventricle and that's why you're putting your
16 catheter in, you would never do that because if you
17 do that you know that you are very likely, if you've
18 already injured it some, to injure it more by
19 putting the catheter back in. Is that the case?

20 A. As Dr. Schob mentioned, the tip of that
21 catheter is very -- it's bent like this. It's
22 atraumatic.

23 Q. Why would you ever -- if you thought you had
24 injured him with this and this alone, why would you
25 ever shove this in after it and more after that

1 point?

2 A. Because that is a safer catheter.

3 Q. Why would you do any catheter? If what you're
4 telling us is to be believed --

5 A. I'm trying to make sure there's no injury,
6 bleeding. I can get a better picture with the
7 pigtail as opposed to a sheath.

8 Q. Well, we've seen what the sheath does. That's
9 fluoro number 3, right?

10 A. Yes, yes.

11 Q. So you could easily inject -- you could easily
12 inject contrast --

13 A. But it's safer with the second one. I wanted
14 to make sure I'm not within the ventricle.

15 Q. Well, if you're in the ventricle with the
16 sheath and you shove a catheter in there, you're
17 going to shove a catheter into the ventricle.

18 A. But I wasn't in the ventricle. Thank God. I
19 was not in the ventricle.

20 Q. If --

21 A. So this -- none of this is done to -- to try
22 and prove a point. I'm trying to find the source of
23 bleeding and that's the reason I'm doing all this.
24 Because if you had seen the first picture,
25 everything is good. I could have left -- I wouldn't

1 have been here. All this is happening because of
2 bleeding. You have to try and understand that.

3 Q. Where is it in your medical records that your
4 reasoning for the sheath to be put in appears?

5 A. I -- I didn't -- I don't document everything
6 that I did in the procedure.

7 Q. It's not.

8 A. I did not.

9 Q. It's not.

10 A. It's -- I did not -- I'm saying I did not
11 document everything that I'd done.

12 Q. And it is not -- the only basis that anybody
13 has in this case to say that the bleeding happened
14 before you put the sheath in is your word on it?

15 A. Timing of echocardiography. I'm sorry. Did
16 you miss that? Can I show it again?

17 Q. You're the only one who has said there was
18 bleeding before the sheath; isn't that true?

19 A. Yes.

20 Q. And none of that is supported by any of your
21 statements in the medical record?

22 A. It is supported by imaging evidence. A picture
23 says a thousand words. So if you're not accepting
24 that that is blood clot and the timing of the
25 echocardiogram, then you're right that I am the only

1 one saying it. You have to go with why I did that.

2 But if you're not accepting that -- now, if you
3 get an expert to say that is blood clot, then maybe
4 I'm not the only one.

5 Q. The medical records show that his blood
6 pressure dropped significantly after the pigtail
7 catheter was removed the second time, right?

8 A. Yes.

9 Q. And that would have been after the sheath was
10 put in, right?

11 A. Yes.

12 Q. And that would have been after both fluoro
13 number 2 and fluoro number 3?

14 A. Probably, yes.

15 Q. So the only thing in your mind that rules out
16 the sheath as being the cause of the injury,
17 swapping that out -- would you agree that if you put
18 the sheath in and you did it improperly, that that
19 -- the only way to get the sheath the injure
20 somebody is if you don't do that properly?

21 A. Yes.

22 Q. Okay. So --

23 A. But I'm saying something. I've done these
24 procedures a lot of times. I know how to put a
25 sheath in.

1 Q. Which makes this -- which would make it pretty
2 particularly reckless if you caused an injury in
3 this way, right?

4 MR. BEIGHLEY: Object to the form, Your Honor.

5 THE COURT: Sustained.

6 BY MR. MCGOWAN:

7 Q. All right. So let me finish up here, Doctor,
8 because this may be the primo spot. If you put this
9 sheath in properly, it's not going to injure the
10 patient, right?

11 A. If I put it in properly, yes, it's not going to
12 injure.

13 Q. Similarly, if you do what you're supposed to do
14 to insert the needle --

15 A. Haven't I answered this before? I felt like I
16 have already. I think I have already. Do you want
17 another explanation? Because I'm going to say the
18 same thing.

19 Q. That's all I want you to do, Doctor.

20 A. The same thing again?

21 Q. Yes.

22 A. Okay.

23 Q. If you put this in properly, if you followed
24 the proper techniques, you should not injure the
25 heart?

1 A. You should not.

2 Q. So it does not matter in this case if the
3 injury was due to the needle or if it was due to the
4 sheath?

5 A. The injury here was due to the needle. We have
6 evidence for that, not just my hearsay. We have
7 echocardiographic evidence of that. In spite of
8 best precautions, you can have complications because
9 of the difficulties we faced with the size of the
10 heart, with the morphology of his chest bone -- his
11 sternum, the movement. You can have complication.
12 So it was recognized early here.

13 I felt the best possible thing to do was not
14 have tamponade in him; get the blood out; get it
15 back to the patient; stabilize him; correct the
16 injury; send him for surgery. In my view that's
17 what -- that's the best thing I felt for the patient
18 and I did that.

19 Did that answer your question, sir?

20 Q. No. Whether it was done by the needle or
21 whether it was done by the sheath, either way, if
22 you do either of those or both of those procedures
23 properly, you're not going to injure the heart,
24 true?

25 A. Yes.

1 Q. So in this case it does not make a bean's worth
2 of difference if this was due to the needle or if
3 this was due to the sheath because either way you
4 would have not done the basic procedure because if
5 you had you would not have injured the heart; isn't
6 that true?

7 A. I think I did the procedure the way I was
8 taught to them and we had a complication. I'm not
9 denying the complication. I never, ever did try to
10 hide the complication. I went looking for the cause
11 for the complication, the bleeding. I recognized it
12 and I sent him for surgery.

13 But to say that all in ways of procedures are
14 fool proof 100 percent, no complications can happen,
15 I cannot ever say that to a patient that this
16 procedure is 100 percent fool proof. I can never
17 say that.

18 Q. Sometimes your --

19 A. Does that answer your question, sir?

20 Q. Sometimes your negligence is the complication
21 though, isn't it?

22 MR. BEIGHLEY: Object to the form, Your Honor.

23 THE COURT: Sustained.

24 A. Are you --

25 THE COURT: Rephrase the question.

1 BY MR. MCGOWAN:

2 Q. Doctor?

3 A. Yes?

4 Q. If you injured this man's heart by not
5 following the standard, normal procedure, would you
6 agree that that -- well, is that a complication in
7 your mind?

8 A. I did follow the standard of care here so I --
9 the first part is I disagree with I did not follow
10 standard of care. The second part, there is a
11 complication. I agree there was a complication.

12 So if you -- it is a two-part question. The
13 first part, did I follow standard of care? I
14 absolutely did.

15 Q. If you were negligent causing injury to this
16 man's heart, would you consider that injury to be a
17 complication?

18 A. I was not negligent.

19 Q. That wasn't my question. If you were negligent
20 and caused an injury to the man's heart, would you
21 consider that injury to be a complication?

22 A. All injuries are complications, sir.

23 Q. Okay. So to say it's a complication, which
24 y'all have kept saying the bleeding complication,
25 the complication, you're not saying by using that

1 word that you weren't necessarily -- that you were
2 not negligent?

3 A. I don't understand, sir. Can you rephrase?

4 MR. BEIGHLEY: I'll object. He's answered that
5 question about five times.

6 THE COURT: I sustain the objection.

7 MR. MCGOWAN: All right. I think I'm good.

8 Thank you, Doctor.

9 MR. BEIGHLEY: Briefly, Your Honor?

10 REDIRECT EXAMINATION

11 BY MR. BEIGHLEY:

12 Q. Doctor, you were asked about an interrogatory
13 answer that asked you if you had any information
14 outside the medical records that related to the care
15 and treatment, and the answer we gave was none other
16 than the medical record?

17 A. Yes.

18 Q. The imaging studies that you showed, the
19 echocardiograms, are they part of the medical
20 record?

21 A. The echocardiograms are part of the medical
22 record, yes.

23 Q. Have they been part of the medical record --

24 A. They have been for all this time, yes.

25 Q. -- since the procedure?

1 And in this case of pericardiocentesis can you
2 perform the procedure with all appropriate steps and
3 still have an injury?

4 A. Yes, you can. Yes, you can.

5 Q. Does the fact that an injury occurred mean that
6 you departed from the standard of care?

7 A. No, it doesn't mean that you've departed from
8 standard of care just because you have a
9 complication.

10 Q. And is that what you explained to the patient,
11 that even with the safe performance -- the standard
12 of care performance --

13 A. Yes, yes.

14 Q. -- you still might have a complication?

15 A. Yes.

16 MR. BEIGHLEY: Thank you, Your Honor.

17 MR. MCGOWAN: One more question.

18 RE CROSS-EXAMINATION

19 BY MR. MCGOWAN:

20 Q. Does the risk of injury to your patient go up
21 significantly if you don't follow the standard
22 procedures?

23 A. I think, yes, it does.

24 MR. MCGOWAN: Thank you.

25 THE COURT: Anything further from this witness?

1 MR. BEIGHLEY: Nothing, Your Honor.

2 THE COURT: Thank you, Doctor. You can step
3 down.

4 THE WITNESS: Thank you.

5 THE COURT: Okay. We're going to take a break.

6 Mr. Bailiff, would you take our jury to the
7 jury room please?

8 (The jury panel exits the courtroom.)

9 THE COURT: Okay. We'll be in recess for about
10 15 minutes.

11 MR. BEIGHLEY: Just so the Court knows, we have
12 one witness by video. It was taken late. We didn't
13 find out she couldn't come -- we couldn't get her
14 scheduled until Friday a week ago. You ruled as to
15 two elements of her testimony, and so what I would
16 like to do with counsel's consent is when we get to
17 that area simply stop the play and fast forward over
18 the two sentences that she read and were objected to
19 -- the part that was objected to or two sentences --

20 THE COURT: Right.

21 MR. BEIGHLEY: -- that were sustained. If we
22 run into some kind of technical problem in doing
23 that, I would request that I could just read the
24 portions that are admissible if we can't stop and
25 start it.

1 THE COURT: Any objection to that, Mr. McGowan?

2 MR. MCGOWAN: No, sir, whatever's easiest.

3 THE COURT: I think that's a feasible way of --

4 MR. BEIGHLEY: I just want to make very sure
5 that I don't violate the Court's instructions. If I
6 cut something out that was supposed to be in there,
7 I might just decide to read it and be done with it.

8 THE COURT: Okay.

9 MR. BEIGHLEY: Thank you, Your Honor. That
10 will be our last witness today. I think it will run
11 about 35 or 40 minutes.

12 THE COURT: Okay. Okay. So how many -- you've
13 got your expert coming in tomorrow?

14 MR. BEIGHLEY: Two experts tomorrow.

15 THE COURT: Okay.

16 MR. BEIGHLEY: If we can start at 9:30 we
17 should be finished easily by lunchtime. I don't
18 know how long Mr. McGowan will cross-examine but the
19 direct testimony shouldn't be -- both should fit in
20 before lunch easily, is my best estimate.

21 THE COURT: All right. Then we can just take a
22 look at that point where we are and proceed from
23 there.

24 MR. BEIGHLEY: All right. Thank you.

25 THE COURT: All right. We'll be in recess.

1 (Recess was taken.)

2 THE COURT: All right. Anything from either
3 side before we bring the jury back in?

4 MR. MCGOWAN: Nothing from the plaintiff, Your
5 Honor.

6 MR. BEIGHLEY: No, Your Honor. I just handed
7 the video to Ron. We'll see how it's appearing on
8 the screen in terms of ability to stop and start.
9 It may be when we get to the point of objection
10 we'll just tell the Court we'd like to publish the
11 response to a certain question so as to comply with
12 the Court's ruling and then restart it whether it
13 runs out to the end -- there's only one objection.

14 THE COURT: Right. The two sentences are on --
15 that would be on PMC-27.

16 MR. BEIGHLEY: Yeah, this is page 19, line 22
17 and 23 is where that -- and 24. That's the first
18 sentence that was taken out. And then page 20, line
19 2 running over to line 4.

20 THE COURT: Okay.

21 MR. BEIGHLEY: Okay. And then the exhibits
22 that were marked, we'll just obliterate that
23 language from those to comply with that rule.

24 THE COURT: Okay.

25 All right. Mr. Bailiff, if you'll get our jury

1 for us.

2 MR. BEIGHLEY: Judge, I assume you'll tell them
3 what a video depo is.

4 THE COURT: I'll just give them the deposition
5 charge again.

6 (The jury panel enters the courtroom.)

7 THE COURT: All right. Ladies and gentlemen,
8 we are getting ready to proceed with the trial. The
9 attorneys have informed me that the next witness
10 will be presented to you by way of video deposition.

11 Now, again, let me reiterate what a deposition
12 is. You've heard from me before on that and you've
13 heard some deposition questions, but a deposition is
14 the sworn, recorded answers to questions asked of a
15 witness in advance of the trial.

16 This is a deposition taken by video. Under
17 some circumstances if the witness cannot be present
18 to testify from the witness stand that witness's
19 testimony may be presented under oath in the form of
20 a deposition.

21 Deposition testimony is entitled to the same
22 consideration and is to be weighed and otherwise
23 considered by you insofar as possible in the same
24 way as if the witness had been present and had
25 testified from the witness stand in the courtroom.

1 So with that said, Mr. Beighley?

2 (Videotaped deposition of Dr. Sally Wooten
3 played for jury panel.)

4 MR. MCGOWAN: And then there was the objection.

5 (Videotaped deposition was paused.)

6 MR. BEIGHLEY: Just for convenience of the
7 Court can I just go ahead and read the paragraph
8 with excerpts and then we'll skip ahead enough so we
9 don't come down on top of those two sentences that
10 you excluded?

11 THE COURT: Any objection, Mr. McGowan?

12 MR. MCGOWAN: No, sir.

13 THE COURT: Okay. That -- do that, Mr.
14 Beighley.

15 MR. BEIGHLEY: All right.

16 Go ahead, Doctor.

17 Okay. And according to them, he'd been unable
18 to do anything. He has not been able to get out of
19 bed by himself --

20 MR. MCGOWAN: Your Honor, I thought this is
21 what we were excluding?

22 MR. BEIGHLEY: There were two sentences --

23 THE COURT: Mr. Bailiff, would you take the
24 jury to the jury room please?

25 (The jury panel exits the courtroom.)

1 THE COURT: Okay. Now, Mr. McGowan, what was
2 your objection?

3 MR. MCGOWAN: He's reading the two sentences, I
4 think just by mistake, that you had excluded. The,
5 according to them he had not been able to do
6 anything for three or four months and had not been
7 able to get out of bed.

8 THE COURT: Mr. McGowan, the two sentences that
9 I have underlined that I excluded, first one is,
10 according to them his quality of life has been
11 extremely poor for the last three to four months,
12 and then the other one was they had basically stated
13 that he has outlived his life expectancy by multiple
14 years.

15 MR. MCGOWAN: All right. I'm getting lost in,
16 according to them.

17 MR. BEIGHLEY: I just went from there to there.

18 THE COURT: The --

19 MR. MCGOWAN: Okay. So --

20 THE COURT: The two opinion -- I excluded the
21 two opinion hearsay statements.

22 MR. MCGOWAN: My problem, Your Honor, is I
23 think George read it, and according to them he had
24 been unable to do anything.

25 THE COURT: Okay. Okay.

1 MR. MCGOWAN: I thought that -- it just led to
2 some confusion on my part because I thought the
3 "according to them" part --

4 THE COURT: Okay. I see where you're confused.
5 Right.

6 MR. BEIGHLEY: But I left out that part you
7 ruled on.

8 THE COURT: Right. So just start at, he has
9 been unable to do anything. That was one of the
10 questions you were asked about that in the testimony
11 and I did not exclude that sentence. I did not
12 exclude -- the two sentences that were excluded
13 were: According to them his quality of life has
14 been extremely poor for the last three to four
15 months, and the other sentence, they basically state
16 that he has outlived his life expectancy by multiple
17 years.

18 MR. BEIGHLEY: Those two.

19 THE COURT: Those two sentences.

20 MR. BEIGHLEY: Yes, sir.

21 THE COURT: Right. That -- and I underlined
22 those two on the --

23 MR. MCGOWAN: So you're going to omit the "and
24 according to them" part?

25 MR. BEIGHLEY: Yeah.

1 MR. MCGOWAN: Okay. Great. That was my...

2 THE COURT: Okay. That clarifies that.

3 MR. BEIGHLEY: So we'll start again?

4 MR. MCGOWAN: Yeah. I know we did that but
5 let's do that. Get to a stopping point we all agree
6 and make it easier for the jury.

7 MR. BEIGHLEY: So they don't come back and then
8 have to send them out again. Let's forward it to --

9 THE COURT: Why don't you start it --
10 (Videotaped deposition was resumed briefly.)

11 THE COURT: Right there.

12 MR. BEIGHLEY: Okay. So I'll just read and
13 then hit play again.

14 THE COURT: I think that will solve our issue.
15 Okay. Mr. Bailiff, get our jury please.

16 (The jury panel enters the courtroom.)

17 THE COURT: Okay. Mr. Beighley?

18 MR. BEIGHLEY: Thank you, Your Honor.

19 He'd been unable to do anything. He has not
20 been able to get out of bed by himself without help.
21 They absolutely do not want him to go to a nursing
22 home. They do not want him to go to rehab.

23 (Videotaped deposition was resumed for the
24 jury.)

25 (Videotaped deposition was concluded.)

1 THE COURT: All right. Ladies and gentlemen of
2 the jury, that is our stopping point for today. We
3 are going to start at 9:30 in the morning so be back
4 in the jury room before 9:30. And remember your
5 three things: no discussion with third parties, no
6 independent research and no deliberation. I hope
7 everyone has a good evening and we'll see you in the
8 morning.

9 (The jury panel exits the courtroom.)

10 THE COURT: All right. Anything from either
11 party before we go off the record?

12 MR. MCGOWAN: No, sir, not from the plaintiff.

13 MR. BEIGHLEY: Your Honor, I would go ahead and
14 introduce the depo transcript just for the record.
15 I don't know if that's required or not but to avoid
16 not offering it --

17 THE COURT: That we just saw?

18 MR. BEIGHLEY: Yes. This is the transcript.
19 I've got a disk copy that I can introduce as well.

20 THE COURT: Both passages have been redacted?

21 MR. BEIGHLEY: Well, the deposition and the
22 exhibits, which I would want to mark in evidence --
23 they were identified by the witness -- will be
24 redacted as you instructed.

25 THE COURT: Okay.

1 MR. BEIGHLEY: But I do -- since these are
2 exhibits to the -- and would have been identified
3 and offered during her live testimony I want to just
4 make sure they're in the record as Wooten exhibits
5 or Defendant's Exhibit regarding Dr. Wooten.

6 THE COURT: So that would be --

7 MR. BEIGHLEY: We could just give it a number.

8 THE COURT: Number 2?

9 MR. BEIGHLEY: Defendant's 2. Put it as a
10 group and I redact and show Plaintiff's counsel,
11 make sure --

12 THE COURT: Yeah. Mr. McGowan, you look at it
13 as well. Just make sure those two sentences are
14 redacted from both the records and the -- the
15 records are exhibit and the testimony.

16 I believe you said it was page 20, was it? Am
17 I correct?

18 MR. BEIGHLEY: It starts on page 19 line 22 and
19 then on line 24 there's a sentence that's redacted.
20 And then on page 20 line 2 ending on line 4 the
21 second sentence redacted.

22 THE COURT: All right.

23 MR. BEIGHLEY: This is a marked up copy so if
24 -- for the record, I'll just eradicate that sentence
25 on what we'll put in. I guess that's just a Court's

1 exhibit, right?

2 THE COURT: I mean, you can make it a defense
3 exhibit. If you'd like it to be Court's Exhibit 1,
4 that would be --

5 MR. BEIGHLEY: Yeah. Because it won't go to
6 the jury but I just wanted to make sure I didn't
7 waive the right to --

8 THE COURT: Okay. Just make that Court's
9 Exhibit 1.

10 Mr. McGowan, just look at it, make sure that
11 you don't have any --

12 MR. MCGOWAN: If it's a Court's exhibit it may
13 be better if it's not redacted, that way they can --
14 the appellate court, if needed, can see the whole
15 thing.

16 MR. BEIGHLEY: Just make it a Court's exhibit.

17 THE COURT: Okay. That's fine.

18 MR. BEIGHLEY: And then I'll -- I'm going to
19 take -- I've got a permanent ink marker that I'll
20 try to eradicate and show -- we'll make that
21 Defendant's 2.

22 (Court's Exhibit No. 2 was marked and entered
23 into evidence.)

24 (Defendant's Exhibit No. 2 was marked and
25 entered into evidence.)

1 THE COURT: We'll go into recess. I want to
2 see Mr. Beighley and Mr. McGowan in chambers before
3 y'all leave.

4 (Court went into recess for the day.)

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THE COURT: All right. Anything from either party before we bring our jury in?

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MR. MCGOWAN: Not from the plaintiff, Your Honor.

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MR. BEIGHLEY: No, Your Honor.

7

8

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

9

THE BAILIFF: Yes, sir.

10

(The jury panel enters the courtroom.)

11

12

THE COURT: Good morning, ladies and gentlemen. Before we start you knew I was going to ask you this question: Has anyone had any third parties try to discuss the case with you; has anyone conducted independent research; or have there been any deliberations?

13

14

15

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17

18

Let the record reflect there are no positive responses.

19

Is Defense ready to proceed?

20

21

MR. BEIGHLEY: Thank you, Your Honor. At this time we call Dr. Jim Story.

22

23

Dr. Story, could you come around to be sworn please?

24

25

THE CLERK: Place your left hand on the Bible and raise your right.

1 (Witness was duly sworn.)

2 DIRECT EXAMINATION

3 BY MR. BEIGHLEY:

4 Q. Dr. Story, please introduce yourself to the
5 jury and tell us where you're from.

6 A. I'm James Story. I live in Spartanburg.

7 Q. What is your professional occupation?

8 A. I'm a cardiologist.

9 Q. How long have you practiced cardiology?

10 A. In Spartanburg for 35 years.

11 Q. Where did you receive your medical degree?

12 A. Medical College of Georgia in Augusta.

13 Q. Following your graduation from medical school,
14 what initial medical training did you receive?

15 A. I did what's called a straight medicine
16 internship at the Medical College in Georgia. I
17 spent two years in the Army in Canal Zone Panama. I
18 went back to August to do internal medicine
19 residency and following that I did a cardiology
20 fellowship.

21 Q. Did you become board-certified, and if so, in
22 what areas?

23 A. Internal medicine and then cardiology and then
24 approximately 18 years later interventional
25 cardiology. Interventional cardiology was not

1 recognized as a subspecialty board when I finished
2 my training. It only became available to take
3 boards in 1999 and I took my boards then.

4 Q. And in addition to practicing cardiology for 30
5 years, have you been involved in any cardiology
6 specialty organizations?

7 A. I'm a member of the American College of
8 Cardiology. I was -- I'm past president of the
9 South Carolina branch of the American College of
10 Cardiology.

11 MR. BEIGHLEY: Your Honor, at this time we
12 would present Dr. Story as an expert in the field of
13 cardiology and invasive cardiology.

14 MR. MCGOWAN: No objection from the plaintiff.

15 BY MR. BEIGHLEY:

16 Q. And as an invasive cardiologist --

17 THE COURT: Hold on. Dr. Story would be
18 admitted as an expert in the field of cardiology and
19 invasive cardiology without objection.

20 Okay. Thank you. You may proceed.

21 MR. BEIGHLEY: Thank you, Your Honor.

22 BY MR. BEIGHLEY:

23 Q. In your practice of invasive cardiology do you
24 perform and have you performed for many years
25 procedures where you place needles, catheters,

1 sheaths and other devices within the vasculature and
2 the actual heart of patients?

3 A. Yes.

4 Q. At my request, Dr. Story, did you review the
5 medical records from Carolina Cardiology as well as
6 Piedmont Medical Center for Mr. Dibernardo?

7 A. Yes.

8 Q. Did you review the deposition of Dr. Mori in
9 this case?

10 A. Yes.

11 Q. And based on your review of the records and the
12 deposition, were you able to form an opinion as to
13 whether or not the medical care and treatment
14 rendered by Dr. Mori complied with generally
15 accepted standards of medical care?

16 A. Yes.

17 Q. And what was your opinion? What is your
18 opinion?

19 A. My opinion is that his care was careful and
20 cautious and complied with the standard of care.

21 Q. And is that your opinion to a reasonable degree
22 of medical certainty?

23 A. Yes.

24 Q. Please give the jury a basic summary of
25 Mr. Dibernardo's underlying medical problems and

1 what his course was that led him to be admitted to
2 the hospital on July 19th.

3 A. From my review of the medical records, he had
4 Noonan's syndrome which is a genetic disorder, has
5 several manifestations including heart problems, and
6 as a manifestation of his heart problem he had
7 congestive heart failure. In his medical records
8 that congestive heart failure went back several
9 years. I found documentation of congestive --
10 history of congestive heart failure in an office
11 visit from 2007.

12 Over the years he had significant edema,
13 swelling of the lower extremities to the point that
14 he had what we call brawny edema, which means that
15 there are chronic skin changes over the legs and
16 thighs.

17 He also had ascites. Ascites is fluid buildup
18 inside the abdomen, the belly. It was thought at
19 one time this might be due to liver disease but
20 liver biopsy showed there was no cirrhosis. It
21 talked about passive congestive, which means heart
22 failure to the extent there was fluid buildup in
23 both the legs and the abdomen in the medical
24 records.

25 Even in spite of being on 80 milligrams per day

1 of Lasix furosemide which is a diuretic, a water
2 pill -- I dare say that most folks in this room
3 would have very low blood pressure and dehydration
4 if they were on that much Lasix. But in spite of
5 high doses of Lasix he continued to have heart
6 failure symptoms.

7 When he came to the doctor's office in June of
8 2013 -- I believe that's the time a note was made in
9 there that he had difficulty with shortness of
10 breath, walking around the house. I don't know if
11 that was inside the house or outside the house but
12 needless to say he had shortness of breath with
13 minimal activity. The medical record further states
14 that he had to have help getting out of bed and I go
15 by the medical records. To me that's class four.
16 heart failure. He has had echocardiography showing
17 massive enlargement of both his atria heart --

18 MR. BEIGHLEY: May I approach the witness, Your
19 Honor?

20 THE COURT: Yes, sir.

21 THE WITNESS: May I?

22 MR. BEIGHLEY: Yes, you -- can the witness come
23 down?

24 THE COURT: Yes, sir.

25 MR. BEIGHLEY: Watch your step.

1 A. As most of you know, the heart's got four
2 chambers. There are two at the top called the
3 atria -- atriums if you're from the south -- and
4 they contract in unison and then they send blood to
5 the ventricles, the bottom two chambers. The bottom
6 two chambers are kind of back to back with a common
7 wall called the septum, ideally like so. These are
8 the atria right here -- the right atrium and the
9 left atrium -- and they have an ideal size and
10 health. Both these atria had dilated massively
11 because they had already failed, and they failed as
12 a consequence of his genetic problem. And also he
13 had -- also he had significant effusion, fluid in
14 the sac around the heart or pericardium and -- so he
15 was a very sick man.

16 When he came to Dr. Shah's office on July 19th
17 or thereabouts he had not responded to interventions
18 that had been made in previous visits; therefore, he
19 was hospitalized in what I feel was class four heart
20 failure.

21 The -- the annual -- well, the five-year
22 survival for heart failure is 20 percent. We have
23 documentation in his medical records even going back
24 beyond -- before five years previous to July 13th
25 [sic] to document heart failure.

1 Q. Now, in a patient with these problems who's
2 hospitalized as Mr. Dibernardo was on July 19th
3 based on all the information that's out there was it
4 appropriate to recommend a pericardiocentesis and
5 attempt to draw off the fluid from around his heart
6 to try to give him some relief from his congestive
7 heart failure symptoms?

8 A. Yes.

9 Q. From your review of the records could you see
10 whether or not a surgery consultation had been done?

11 A. It's my impression that the patient had
12 declined any surgical procedure to either open the
13 pericardium to drain the fluid or strip the
14 pericardium if indeed there was constriction.

15 Q. And if surgery is not -- is eliminated as an
16 option, is pericardiocentesis then the next best
17 attempt to provide some relief?

18 A. Yes.

19 Q. Now, with the procedure known as
20 pericardiocentesis are there complications which are
21 known that can occur?

22 A. Yes.

23 Q. And what are these complications?

24 A. Most prominent is bleeding, injury to either
25 the heart or one of the larger vessels close to the

1 heart. Again, if I may?

2 Q. Yes, sir.

3 A. The right ventricle -- again, this chamber here
4 -- actually might be better described as the
5 anterior ventricle, the one in front, and the
6 pericardium is -- in health the pericardium is sort
7 of bound to the heart muscle, and then when you get
8 an effusion this pericardium gets pushed away by the
9 effusion.

10 So things are pretty tight in there and you put
11 the needle in to try to contact the fluid without
12 contacting other things but there are veins here --
13 these blue things -- that can be contacted. There's
14 the inferior vena cava, this big blue here. There's
15 even -- there are blood vessels on the dome of the
16 diaphragm. The diaphragm sits right here.

17 Moreover, obviously the patient's got to breath
18 so the heart's kind of going up and down a little
19 bit with respirations, and also the heart's beating
20 which gives it a twisting motion.

21 So there's lots of movement in there and any
22 doctor who's done this enough, including this
23 doctor, is going to get a problem eventually because
24 it's difficult -- it's a difficult procedure. It --
25 majority of the time things work out well but it's

1 not guaranteed to happen every time.

2 Q. Now, Doctor, the procedure that you described,
3 are there safeguards that you try to use to reduce
4 the chance of injury?

5 A. Yes.

6 Q. And even with those efforts can and do injuries
7 still occur?

8 A. Yes.

9 Q. And is bleeding one of those injuries that can
10 occur?

11 A. Yes.

12 Q. Does the fact that bleeding occurred in a
13 procedure mean that the physician has done something
14 wrong?

15 A. No.

16 Q. Now, if you would, please explain to your -- to
17 the jury your understanding of how the
18 pericardiocentesis was performed, the complications
19 that occurred and how they were dealt with.

20 A. From reading the medical records and from
21 reading the depositions, it's my opinion that the
22 approach used -- it's the same approach that I use
23 which is subxiphoid. I suppose that's been
24 demonstrated before, but the xiphoid process is this
25 little bit of bone that hangs below the sternum, the

1 breast bone. You want to go under the xiphoid and
2 direct your needle toward the -- toward the heart,
3 hopefully not straight in but at a 45-degree angle.

4 To be honest with you, sometimes the cartilage
5 and bone in there would redirect the needle a little
6 bit no matter how careful you are.

7 Q. Is that kind of a chart to kind of demonstrate
8 what you're telling us?

9 A. Yes, sir. So this says 15 degrees. I go
10 between 20 and 45. They talk about a rule of 45
11 where the patient is 45 degrees elevated; you go in
12 at 45 degrees; you go 45 degrees that way. The idea
13 -- hopefully you don't go all the way up here to the
14 shoulder, but the idea is to go here hopefully to
15 avoid the right coronary artery. But as I've just
16 showed you, there are veins everywhere.

17 Q. All right. Was the procedure as described in
18 your opinion done appropriately?

19 A. Yes.

20 Q. Now, what happened after the initial approach
21 was made?

22 A. It is my understanding that there may have been
23 more than one needle pass. I'm not sure about that
24 but it's happened to me several times. And then he
25 demonstrated he was in the pericardial space by both

1 echocontrast and by contrast injection, dye
2 injection if you will. And then apparently the
3 fluid was drawn. Apparently it was what we call
4 serosanguineous, which is mostly straw colored, a
5 little bit of blood. The blood part cleared. Fluid
6 was withdrawn.

7 And then there was more blood and instead of
8 being more straw colored than blood there was more
9 blood than straw colored. Then there was blood.
10 And my impression -- and then there were clots and
11 the catheter was clotted. And of course, he
12 couldn't tell if there was bleeding going on or not
13 at that point.

14 And it's my understanding that that catheter
15 was -- was withdrawn and flushed and then put back
16 in the pericardium and the contrast demonstrated he
17 was in the pericardium and not inside the heart.

18 And at that point he, I believe, removed the
19 catheter or used a larger sheath. The sheath is
20 still soft plastic. It's got the end hole. The
21 pigtail catheter is shaped like a pigtail -- a pig's
22 tail. It's got a hole up and down on the sides but
23 the holes in the pigtail catheter are much smaller
24 than the holes in the sheath.

25 And then with the sheath blood was drawn and --

1 and clot was demonstrated at the same time on echo.
2 Surgery was called, which was appropriate, and the
3 patient was autotransfused, which I commend the
4 doctor for.

5 Q. Tell us what autotransfusion is.

6 A. Well, blood was being withdrawn from the
7 pericardial space and the blood was then given back
8 to the patient through a sheath placed in the
9 femoral vein -- the vein in the leg. And a sheath
10 was also placed in the artery of the leg and that
11 was to monitor the patient's blood pressure
12 directly.

13 When we do catheterizations -- I would say
14 two-thirds of catheterizations are done the same
15 way, through the arteries in the leg and the veins,
16 about one-third being done through the wrist but
17 that's another story.

18 Q. Was the decision by Dr. Mori to pull out the
19 catheter and flush it when he wasn't getting good
20 return and putting it back in, was that an
21 appropriate step to take?

22 A. Yes. He had no idea whether it was still going
23 on. Most appropriate.

24 Q. Now, we have some pictures that reference the
25 various stages of the -- let me see where the

1 exhibits got to.

2 THE CLERK: Let me grab the exhibits, Judge.

3 I'm sorry.

4 MR. BEIGHLEY: I'll come back to that, Judge.

5 THE COURT: Okay.

6 MR. BEIGHLEY: I can go on.

7 THE COURT: We need to get the exhibits.

8 BY MR. BEIGHLEY:

9 Q. We're going to see the exhibits in a moment
10 that show the initial catheter placement and then
11 after it was flushed or reinserted it's put back in.
12 There's a picture taken and then there's a picture
13 just of the sheath itself. Lynn is bringing those
14 in now so I'll show those to you.

15 I'm showing you three photos that are attached
16 as Plaintiff's 11-A, B and C. And in this image
17 does that represent the initial catheter placement?

18 A. Yes.

19 Q. And that's appropriately positioned?

20 A. Yes.

21 Q. Now, I'll show you 11-B which has occurred
22 after the diagnosis of bleeding and has been
23 described by Dr. Mori as is a picture he took after
24 he had pulled the sheath, flushed it, put it back --
25 I mean the pigtail -- pulled it, flushed it, put it

1- back in over the sheath.

2 A. This demonstrates that the pigtail is still in
3 the pericardial space, not inside the heart.

4 Q. So there's no evidence that he's punctured the
5 heart?

6 A. Not on that picture.

7 Q. Now, if you look here you see some staining.
8 Can you -- is there any evidence, even with that
9 staining, that he's inside the heart?

10 A. No. I can't really tell where that is. I
11 think it's probably up under the heart, right on the
12 diaphragm. In the -- this is a still picture. In
13 the live pictures you see it still moving.

14 Q. Okay. Now I want --

15 A. Washing back and forth.

16 Q. What did you call it? Washing?

17 A. Yes.

18 Q. All right. Let me show you --

19 A. High tides in and out.. Whatever.

20 Q. Let me show you the third one, item C. Now,
21 this is the last one we have and this is showing the
22 catheter in contact with the heart and we see some
23 evidence of dye there, which on the moving picture
24 apparently indicates that there is some dye in the
25 heart muscle. Is that your understanding?

1 A. That is my understanding. Yes.

2 Q. All right. Now, the fact that in the course of
3 the efforts to get improved blood drawn out that the
4 sheath contacted the heart wall and there was some
5 staining, is that a departure from the standard of
6 care for that to happen?

7 A. No.

8 Q. Is that a known potential event when you have
9 to do these things?

10 A. Yes.

11 Q. And at the time of surgery was that area
12 specifically described by the surgeon?

13 A. Yes.

14 Q. And what intervention did he have to do where
15 the catheter contacted the heart wall?

16 A. He did not have to sew up any holes.

17 Q. Okay.

18 A. He removed -- there was clot. He removed the
19 clot and then put what's called SurgiSeal, I believe
20 the term is, on top of that. SurgiSeal is a -- it's
21 a super absorbent patch that gives blood a matrix
22 upon which to clot. It's made of cellulose.

23 Q. That -- the surgeon proved there was no hole in
24 the heart; is that right?

25 A. Yes.

1 Q. And there was no -- that the damage to the wall
2 of the heart was not enough to even require
3 stitches?

4 A. That's correct.

5 Q. Okay. Could that area as described could have
6 produced all the bleeding that Dr. Mori had
7 encountered?

8 A. I don't see how it could have.

9 Q. All right. So let's talk about the -- the
10 bleeding. You told us that the fluid began to turn
11 bloody and that's been described by Dr. Mori, but is
12 there other evidence of bleeding in the record that
13 occurred before this sheath/catheter was inserted at
14 the end after Dr. Mori was dealing with bleeding?

15 A. Well, there was a bit of a change in the vital
16 signs.

17 Q. Any evidence on imaging studies, particularly
18 the echocardiogram?

19 A. Restate your question one more time please.

20 Q. Was there in this medical record evidence of
21 bleeding before Dr. Mori placed the sheath that is
22 shown here in Image 11-B -- 11-C and 11-B?

23 MR. MCGOWAN: Judge, I'm going to have an
24 objection to this and it may need to be outside the
25 presence of the jury.

1 THE COURT: All right. Mr. Bailiff, if you'd
2 take the jury out please.

3 (The jury panel exits the courtroom.)

4 THE COURT: Okay. Mr. McGowan, state your
5 objection.

6 MR. MCGOWAN: My objection is that this is
7 essentially undisclosed expert testimony at this
8 point. I think it was prefaced yesterday by
9 Dr. Mori claiming there was some clot in the echo.
10 That was brand new as of yesterday. That's why I
11 asked all those questions.

12 What I see Mr. Beighley starting to do with
13 questioning Dr. Story is the same thing, that I saw
14 evidence of clot or evidence of bleeding on the
15 echo.

16 Now, I took his deposition and I asked him for
17 all his opinions, and I asked him for the bases of
18 all of his opinions. And I also did it in writing,
19 as is normal, what is the expert going to say. They
20 say take the deposition so I did. I took
21 Dr. Story's deposition.

22 If he's going to say that there's evidence of
23 bleeding on the echo, that is a brand new opinion
24 and that is a brand new basis for an opinion that I
25 asked him in his deposition for all of this and this

1 is all brand new. So I'm a little taken aback by --
2 this is to me, this whole clot on echò stuff is
3 completely new.

4 And I think we were entitled to know that
5 before now and he should not be allowed to talk
6 about this brand new opinion right now in light of
7 the fact that we went through this whole discovery
8 process -- in fact, I asked him, if you come up with
9 anything else, please let Mr. Beighley know so that
10 he can let me know, and he said, great, I'll do
11 that. And I'm assuming this is new stuff. That's
12 my problem.

13 THE COURT: Mr. Beighley?

14 MR. BEIGHLEY: Your Honor, I completely
15 disagree. The witness has said that he reviewed the
16 medical records and deposition and based on that
17 formed his opinions that the standard of care was
18 complied with.

19 I'm simply asking him if there's evidence in
20 the medical record -- Plaintiff's expert said that
21 the medical record showed bleeding occurred when the
22 blood pressure dropped at a certain time and that
23 there was no evidence of bleeding before, and he
24 categorically disregarded my client's testimony that
25 blood was present and that's what prompted him to do

1 traditional intervention.

2 And so I'm asking this witness from the same
3 medical record that everybody's had if there's some
4 evidence, as my client's been challenged in his
5 assertions that he's even dealing with bleeding to
6 make him do these procedures in the first place.
7 And now this witness, as Dr. Mori did, is simply
8 referring to the medical record.

9 The jury heard it. I'm simply asking him to
10 look at the same imaging study and see if he says
11 that that's evidence of bleeding at the time Dr.
12 Mori says it occurred.

13 THE COURT: Now, the echocardiogram in
14 question, that has already been put into evidence
15 with the other records?

16 MR. BEIGHLEY: Yes. That's part of the
17 Piedmont records --

18 MR. MCGOWAN: Technically not. I mean, the
19 images haven't. But that's really not my point,
20 Judge. My point is I asked him what the basis of
21 his opinions were and if he had any opinions. This
22 is an opinion whether that echo shows clot or not.
23 I -- this is brand new. This is -- I mean, this is
24 -- that's the problem I have. He can get a doctor
25 to come up and say whatever. I understand that.

1 My problem is I've asked them for their
2 opinions. I asked them for the basis of any
3 opinions. I asked them to supplement and they
4 didn't, and now we're getting a supplementation
5 right now on the stand and that's the problem. To
6 me it's just unfair.

7 MR. BEIGHLEY: Judge, it's not a
8 supplementation. It's simply -- it would be, for
9 example, if you asked a witness what his opinions
10 were and he told them to you -- and it would be
11 different if he had said, now, Doctor, you say the
12 bleeding occurred before the catheter insertion.
13 What evidence do you have -- what can you say that
14 occurred other than the doctor's testimony? Well,
15 then if he'd looked at -- it would be different.

16 He's just asking what his opinions are. It's
17 in the medical record. At no time did he make any
18 statement that would have excluded any part of any
19 medical record. For example, he could look at the
20 blood pressures, comment on that. It's the medical
21 record and what's his opinion based on.

22 I just think it would be entirely unfair to
23 take a section of the records -- these imaging
24 studies have been used, as to the three I showed the
25 doctor, in the plaintiff's case. So now to use --

1 to keep me from letting him reference
2 echocardiograms that have already been testified to
3 by the defendant, already identified to the jury
4 would be -- would be extremely unfair and improper.

5 THE COURT: All right. I'm going to allow the
6 question.

7 Mr. McGowan, certainly if you're alleging he's
8 made inconsistent statements, that's subject to your
9 cross-examination so I think that's a factual issue.
10 I'm going to allow the question and overrule your
11 objection.

12 MR. MCGOWAN: Can I have a continuing so I
13 don't have to make a nuisance of myself here?

14 THE COURT: Excuse me?

15 MR. MCGOWAN: May I have that objection be a
16 continuing one to the line of questioning so --

17 THE COURT: Yes. Yes.

18 MR. MCGOWAN: -- I don't have to --

19 THE COURT: Yes. Yes, sir. It will be noted
20 for the record.

21 MR. MCGOWAN: Thank you, Your Honor.

22 THE COURT: All right. Mr. Bailiff, if you'll
23 get our jury for us please.

24 THE BAILIFF: Yes, sir.

25 (The jury panel enters the courtroom.)

1 THE COURT: All right. Mr. Beighley.

2 MR. BEIGHLEY: Thank you, Your Honor.

3 BY MR. BEIGHLEY:

4 Q. Doctor, in addition to the record that talks
5 about blood in the fluid being withdrawn and the
6 testimony of Dr. Mori about the bleeding, is there
7 other evidence on echocardiogram that demonstrates
8 bleeding?

9 A. Yes.

10 Q. And can you come down here and -- the
11 computer's got the echocardiogram in it. If you
12 would, just sit right there -- and I believe you've
13 written down certain image numbers -- or you can
14 stand there. Whatever's easier for you. What we do
15 is see we've got the image running here and you can
16 -- if you want to just take the -- like that to
17 demonstrate what you're trying to show us.

18 A. So as I mentioned to you folks before, this is
19 an atrium and this is an atrium here, although part
20 of it is washed out just by the echo. This is the
21 left ventricle. This is the right ventricle here.
22 You don't see very much volume in the right
23 ventricle. This large area over here, here to here,
24 is the pericardial effusion, fluid.

25 Echocardiography, it's ultrasound. It's ultra

1 high frequency, way out of the frequency that our
2 human ears can hear, and what it does is it bounces
3 the ultrasound off of masses of fluids or anything.
4 If there's a change in the density it gets an
5 ultrasound.

6 And one of the amazing things about saline you
7 take -- salt water. It's in our blood. You shake
8 it up. You can agitate it and inject it safely in a
9 cardiac chamber or into a blood vessel and it will
10 pacify just as if you have dye in there. And that's
11 what we see here. This is agitated saline right
12 here.

13 Q. What time is that, Doctor?

14 A. That is at 10 -- I'm sorry.

15 Q. The top right corner.

16 A. My bad... Yeah, 10:34. I'm sorry.

17 Q. That's all right.

18 A. 10:34. And then we go to Image Number 10. You
19 notice the difference with this image. Here again
20 is the left ventricle. Here's the atrium we talked
21 about. This space right here is no longer cloudy.
22 It's clear and that's because this is after the
23 saline was injected and the area there is clear.

24 And then if we go down -- that's at 10:56 --
25 I'm sorry -- 10:49. And then at 10:56, Number 14,

1 you see a solid image here with just a very small
2 area on the outside of that solid image which is
3 clear, and that area on the outside of that solid
4 image I think is the original effusion and all this
5 solid mass right here is clot. You still have the
6 left ventricle here. The right ventricle's been
7 pushed out of the view. And that, of course, is at
8 10:56.

9 And then we go down, further down -- this is
10 just an image I picked out just to save time -- at
11 Image Number 21 11:09 you have even more
12 organization of clot. And then at 11:27 which is
13 Image Number 32 you have what I call frank cardiac
14 tamponade. The right ventricle is completely
15 collapsed here. You -- this is the septum. We
16 talked about the common wall right here. This is
17 the free wall of the right ventricle. This is the
18 wall of the left ventricle. The chamber's gotten
19 much smaller. The flow is practically occluded
20 because of this huge clot right here and this --
21 this little area right here is what's left of the
22 effusion, been pushed aside by a clot.

23 So there's -- to me that's cardiac tamponade.
24 I mean, the heart cannot fill enough to empty and
25 the blood pressure drops.

1 Q. All right. Thank you, Doctor.

2 Dr. Story, in your opinion was the bleeding
3 complication that occurred during this procedure
4 managed appropriately by Dr. Mori?

5 A. Yes.

6 Q. Did the interventions that Dr. Mori undertook
7 stabilize the patient so he could be taken to the
8 operating room for surgery?

9 A. Yes.

10 Q. In your opinion, sir, would it have been proper
11 medical care in this situation to simply leave the
12 original pigtail in, attach it to a drain and send
13 the patient to the recovery room?

14 A. I don't think so.

15 Q. Why is that?

16 A. Because you don't know what's happening inside
17 of there. Just because there's no blood coming out
18 it could be because the ports are clotted and that
19 indeed was the case. And I just think to me that's
20 somewhat of a cavalier attitude to take toward a
21 patient who you're drawing blood and you stop
22 drawing blood and I wouldn't have done that.

23 Q. Now, the patient required a ventilator to go on
24 surgery. Is that a required procedure when you have
25 open-heart surgery?

1 A. Yes.

2 Q. You told us that Mr. Dibernardo had class four
3 heart failure; is that correct?

4 A. Yes.

5 Q. And can you give us the definition of what
6 class four heart failure is?

7 A. Class four heart failure means that the patient
8 has signs and/or symptoms of heart failure at rest,
9 that the patient has difficulty conducting minimal
10 activities.

11 Q. And in a patient with this condition is there
12 statistical evidence of its effect on a patient's
13 survivability or survival rate?

14 A. Yes.

15 Q. And what is a class four patient with these
16 conditions and certainly the conditions that
17 Mr. Dibernardo had as a result of his class four
18 heart failure -- what would a patient in that
19 category have as a survival rate?

20 A. If you have someone in class four heart failure
21 already on medications and there's no intervention
22 such as a valve replacement, then the death rate is
23 50 percent annually.

24 Q. And if you add anything else to it --

25 A. Well, yeah, the range is quite wide, which is

1 understandable. The range goes from 30 percent to
2 70 percent.

3 Q. And was that something that you just made up or
4 did you look that up to verify your impression?

5 A. I found that number in Harrison's Principles of
6 Internal Medicine.

7 Q. And is that a reliable medical authority that
8 physicians might look at for information of that
9 sorts?

10 A. I believe it is.

11 Q. And even though you can't predict with -- no
12 one can predict how long somebody's going to live at
13 the end of the day. Can you give us your
14 impression, your opinion as to whether
15 Mr. Dibernardo fit in that -- where he would have
16 fallen on that one-year survival rate?

17 MR. MCGOWAN: I object.

18 THE COURT: All right. Mr. Bailiff, would you
19 take the jury out?

20 (The jury panel exits the courtroom.)

21 THE COURT: All right. Mr. McGowan, state your
22 objection.

23 MR. MCGOWAN: Yes, sir. My objection is that
24 there is no basis, science or otherwise, for this
25 witness to say Mr. Dibernardo was going to die at

1 any given time. That's clearly the intent of the
2 question and I object to it. It's inappropriate.
3 It's not subject to expert testimony.

4 THE COURT: Mr. Beighley?

5 MR. BEIGHLEY: Your Honor, I specifically
6 prefaced that by saying that there was no way anyone
7 could tell specifically when someone is going to die
8 and I was asking him when in his opinion he felt the
9 percentage range was for Mr. Dibernardo over the
10 course of the next year without any intervention.

11 THE COURT: Well, you've already asked him if
12 the patient was a class four.

13 MR. BEIGHLEY: Yes.

14 THE COURT: And he's answered that in the
15 affirmative and he's already given the
16 percentages --

17 MR. BEIGHLEY: All right.

18 THE COURT: -- for those patients that are in
19 the learned treatise that you referenced, so I'm
20 going to sustain the objection.

21 MR. BEIGHLEY: All right.

22 THE COURT: All right. Mr. Bailiff, if you'll
23 get our jury for us please, sir.

24 THE BAILIFF: Yes, sir.

25 (The jury panel enters the courtroom.)

1 THE COURT: All right. Mr. Beighley?

2 MR. BEIGHLEY: Thank you, Your Honor.

3 BY MR. BEIGHLEY:

4 Q. Doctor, did you review and appreciate from the
5 record the course of Mr. Dibernardo following his
6 emergency heart surgery?

7 A. Yes.

8 Q. And at that point in time he was under the care
9 of Dr. Wooten?

10 A. Yes.

11 Q. And I would ask you did the patient come off
12 the ventilator at some point?

13 A. Yes.

14 Q. And was he required to be put back on?

15 A. There was a request to put him back on, I
16 understand. Yes.

17 Q. And based on --

18 A. The medical recommendation.

19 Q. Based on the information reflected in the
20 medical record do you have any disagreement with the
21 family's decision not to put the patient back on the
22 ventilator?

23 A. I -- I don't disagree based on the record that
24 I read dating back to more than six years and all
25 the problems that I mentioned earlier. I don't

1 disagree with their decision.

2 Q. Now, I'm going to show you a page from the
3 record. There are two sentences here that have been
4 redacted -- this is page PMC-0027 -- so do not read
5 those. Do not read those highlighted provisions but
6 -- and you don't have to read it verbatim but just
7 summarize what the history -- about the time
8 Dr. Wooten was discussing the issue of
9 re-ventilating the patient.

10 A. It is my impression in reading this that the
11 recommendation was -- well, first of all, when he
12 came off the ventilator he had pretty good blood
13 gases -- acceptable blood gases. You measure the
14 oxygen and carbon dioxide and you should have an
15 appropriate level of each. And the blood pH --
16 excuse me. If someone's having problems with
17 ventilation the pH can give that outline.

18 Q. Look at the history. I probably should have
19 asked a better question. Look at the bracketed
20 history that the -- that the -- was related about
21 the patient's condition but exclude those two marked
22 sentences.

23 A. So the doctor talked to the patient about
24 reintubating -- with the family about reintubating
25 the patient and resting him on the ventilator for

1 five to seven days and then trying again to see if
2 we could get him off the ventilator. The family was
3 extremely hesitant to put him back on the
4 ventilator. He had been unable to do anything. He
5 has not been able to get out of bed by himself
6 without help. They absolutely do not want him to go
7 to a nursing home. They do not want him to go to
8 rehabilitation. After much discussion with them and
9 attempts to encourage them to allow us to reintubate
10 him the family requested that he not be reintubated.

11 And she apparently acquiesced to the family's
12 request.

13 Q. And is that appropriate --

14 A. And -- and pursued comfort measures. I'm
15 sorry.

16 Q. Is that an appropriate decision for the family
17 and the decision to make?

18 A. I think so.

19 Q. Doctor, throughout the course of your testimony
20 today you've been asked a number of opinions and
21 I'll ask, sir, if you gave those opinions to a
22 reasonable degree of medical certainty?

23 A. Yes.

24 Q. And do you continue to hold those opinions to
25 this day?

1 A. Yes.

2 MR. BEIGHLEY: Thank you, Doctor. Please
3 answer any questions opposing counsel may have.

4 THE COURT: Mr. McGowan, your witness.

5 MR. MCGOWAN: Thank you, Your Honor.

6 CROSS-EXAMINATION

7 BY MR. MCGOWAN:

8 Q. Dr. Story, let's get some housekeeping out of
9 the way. Your charges for being involved in this
10 case are what?

11 A. My charges? Oh, how much I charge?

12 Q. Yes, sir.

13 A. Oh, I charge \$250 an hour to review records and
14 I charge \$400 an hour if I have to be away from my
15 office.

16 Q. Okay. Like now?

17 A. Yes.

18 Q. Have you ever met Dr. Mori before today?

19 A. No.

20 Q. In fact, it was Mr. Beighley who contacted you?

21 A. Yes.

22 Q. And Mr. Beighley that you've been dealing with?

23 A. Yes.

24 Q. And part of the agreement you have is that if
25 you're going to come to court and charge \$400 an

1 hour you need to be as supportive as you can, right?

2 A. No.

3 Q. Okay.

4 A. I need to tell the truth.

5 Q. All right. Well, we'll see. Let's talk for a
6 minute about this echo. Now, I had taken your
7 deposition a couple of months ago. You remember
8 that?

9 A. Yes, sir.

10 Q. And I asked you what the basis you had for
11 there being any bleeding and you didn't mention
12 anything about this echo.

13 A. That's correct.

14 Q. And it was between then -- which I think was,
15 what, a month or two ago?

16 A. (No response.)

17 Q. Something like that?

18 A. Yeah.

19 Q. -- and now that this echo was brought to your
20 attention?

21 A. Yes.

22 Q. And in fact, was it this morning?

23 A. No.

24 Q. When was it?

25 A. Well, the echo was brought to my attention -- I

1 answered incorrectly. I reviewed those echo images
2 before I gave my deposition.

3 Q. Okay. Well, when did you start identifying
4 clot and agitated saline on these echos?

5 A. At that time. I --

6 Q. Okay. You didn't tell me about it then.

7 A. You didn't ask me about it.

8 Q. Well, let's -- let's be fair, Doctor. This is
9 what I asked you: I asked you on page 53 of your
10 deposition -- you can read along -- So the sheath
11 and the dilator are ruled out in your view as the
12 cause of the injury to the heart?

13 And you said, The sheath and the dilator to me
14 are ruled out as the cause of the bleeding.

15 I said, Why?

16 Because he had blood in the pigtail before he
17 put the sheath in.

18 And then I said, That is only based upon his
19 testimony and not based upon anything in the medical
20 record; is that right?

21 To me it would be illogical to put a sheath in
22 and then take it out and put a pigtail in, so I
23 think the pigtail had to be in before the sheath.

24 You didn't mention anything about there being
25 blood or clot or it didn't say anything on that

1 echo, right?

2 A. Okay. We're talking about pigtails or echos?

3 I'm sorry.

4 Q. I asked you why you thought the sheath wasn't
5 it and you said there was evidence of bleeding,
6 right?

7 A. Yes.

8 Q. And I asked you, the only basis you had for
9 that at that time was the testimony of Dr. Mori,
10 that he had gotten blood out before?

11 A. Yes.

12 Q. You didn't mention anything about the echo?

13 A. No.

14 Q. This morning you met with the defense attorneys
15 and Dr. Mori in this little room back here; is that
16 right?

17 A. Yes.

18 Q. And you looked at that echo, didn't you?

19 A. Yes.

20 Q. You didn't have a lot of time to study up on it
21 though, did you?

22 A. (No response.)

23 Q. Did you?

24 A. No, I didn't.

25 Q. Okay. And in fact, this is the one where you

- 1 said this is agitated saline?
- 2 A. That's my impression, yes.
- 3 Q. Okay. What time is that?
- 4 A. I can't see that. I'm sorry.
- 5 Q. 10:34. You think this is agitated saline at
- 6 10:34?
- 7 A. I thought it was, yes.
- 8 Q. Tell me how it is you got -- in order for it to
- 9 be agitated saline you have to have a needle in the
- 10 chest?
- 11 A. That's correct.
- 12 Q. According to this timeline -- here's 10:34 --
- 13 he didn't even have the lidocaine administered to
- 14 his chest yet, did he?
- 15 A. I can't -- I can't see that.
- 16 Q. I'll give you a copy up there. We're referring
- 17 to Exhibit No. 4.
- 18 10:35 he had the lidocaine administered to his
- 19 chest, right?
- 20 A. Yes.
- 21 Q. That means no needle yet?
- 22 A. If we go by these timelines, yes.
- 23 Q. It's the only one we've got, right?
- 24 A. Yes.
- 25 Q. And then we have it being noted the echo tech

1 arrives, and then at 10:42 we have the puncture to
2 the chest wall?

3 A. That's correct.

4 Q. There is no way you have agitated saline inside
5 the man's chest before you put a needle in?

6 A. I was mistaken about that. That apparently was
7 not contrast.

8 Q. So that apparently is not agitated saline?

9 A. On which view now?

10 Q. The one at 10:34 that you told this jury was
11 agitated saline.

12 A. Apparently it's not agitated saline.

13 Q. Okay. With that sort of thing going on you
14 think what you're telling this jury is reliable?

15 A. Yes, it's my best intention.

16 Q. Okay.

17 A. I -- sir, I actually saw those and I did not
18 realize the time. I looked at those pictures -- I
19 don't know -- six months ago.

20 Q. Okay.

21 A. Did not realize the time.

22 Q. All right.

23 A. I recognized the clot.

24 Q. So you're just wrong about that being agitated
25 saline?

1 A. I -- maybe the time sequence is right. I don't
2 know -- is wrong. We have several documentations of
3 the time sequence being incorrect so...

4 Q. Okay.

5 A. I mean, all I can do is go by the records and
6 what I saw.

7 Q. You have no basis --

8 A. It looks to me like that's agitated saline. I
9 personally think that the time is more incorrect
10 than the agitated saline. I can't explain, if
11 that's not agitated saline, why it's more clear
12 later.

13 On Image Number -- whatever it was -- 10 or so
14 there's clearly a difference and I think it's more
15 likely the time is off than that I was incorrect
16 about it being agitated saline. I wasn't there. I
17 just look at the records.

18 Q. All right. You gave some testimony about
19 Mr. Dibernardo and the life expectancy of patients
20 like him; is that correct?

21 A. I'm not sure how much I was allowed to give,
22 sir.

23 Would you ask the question again please?

24 Q. Yes. You have -- you cannot with any degree of
25 certainty whatsoever say when Mr. Dibernardo was

1 going to die?

2 A. No. Well, you mean before the family refused
3 to put him back on the ventilator?

4 Q. Doctor, are you here -- you have no scientific
5 or professional basis to say Mr. Dibernardo in
6 particular would be dead at any particular time;
7 isn't that true?

8 A. No.

9 Q. Now, is it acceptable in the medical community
10 -- is it okay for doctors to cut short the life of
11 someone who has medical problems?

12 A. Is it acceptable to cut short -- you talking
13 about euthanasia? Is that what you're asking me?

14 Q. Well, I'm asking you why were -- well, I mean,
15 let's get to fundamental gist of it, Doctor.
16 Doctors treat sick people, right?

17 A. Yes.

18 Q. And it's not an excuse for the cause of
19 someone's death to say, well, they were sick, right?
20 That's not an excuse, is it?

21 A. No.

22 Q. And in fact, that's pretty morally
23 reprehensible, isn't it?

24 A. I -- yes. Yes.

25 Q. Well --

1 A. It's, again, cavalier. I don't -- I would have
2 to have more specific examples but generally we
3 don't like to do that.

4 Q. Right. But that's what's happened in this
5 courtroom, hasn't it?

6 A. No.

7 Q. No? Was the loss to his family any less with
8 him being with various medical issues or being
9 treated by doctors?

10 A. No.

11 Q. Let's talk for a minute about complications
12 versus breaches from the standard of care. Now, a
13 complication is an injury that's not expected; is
14 that fair?

15 A. Yes.

16 Q. Some of those injuries can be caused by the
17 doctor who falls below the standard of care, right?

18 A. Yes.

19 Q. So just saying it's a complication does not
20 answer the question we're here about, does it?
21 Which is whether Dr. Mori fell below the standard of
22 care, right?

23 A. Agree.

24 Q. Okay. Would you agree with me that no patient
25 consents to a doctor being below the standard of

1 care?

2 A. I would hope not.

3 Q. So whether he consented to the procedure or not

4 is not relevant to the question of whether

5 Mr. Dibernardo consented to Dr. Mori not performing

6 to the standard of care, right?

7 A. We're going around in circles here. I'm not

8 sure I can follow you. I don't believe that the

9 patient expected to be treated below the standard of

10 care when he consented.

11 Q. And that is not part of the consent process? A

12 doctor never goes to the patient and says, All

13 right. Here's your problem: I may really screw

14 this up. I may be below the standard of care and

15 you're okay with that?

16 That's not the way it works, right?

17 A. I don't believe it should work that way. I

18 don't think it does.

19 Q. Okay. So let's talk about the fluoro videos

20 that we've seen. I don't want to go over them too

21 much but -- we've seen it a million times. This is

22 Fluoro Number 1. The catheter's in a good spot. It

23 arcs nicely, goes behind. You've seen the video

24 too, right, where the contrast flows nicely?

25 A. Yes, sir.

1 Q. That's a well placed catheter. It's good to
2 go.

3 A. I think it's fine, yes.

4 Q. All right. Fluoro Number 2, this is one with
5 both the sheath and the catheter. You've seen this
6 one also, video?

7 A. Yes.

8 Q. And what we see is we see it comes up to the
9 sheath up here; catheter comes out sort of tethered
10 to the heart?

11 A. Tethered to it?

12 Q. Well, it's in contact with it. It beats with
13 the heart.

14 A. Well, yeah, but -- I mean, you can feel your
15 heart beat from the abdomen. You can feel your
16 heart beat from the chest. Not tethered to it but
17 the moving of the heart affects the catheter. I'll
18 give you that.

19 Q. The tip of this catheter is in contact with the
20 heart?

21 A. I'm not sure about that.

22 Q. What do you need to be sure?

23 A. Well, I need -- it's beside it, yes. I don't
24 see -- on the fluoro image -- the moving image I
25 didn't see any staining of the heart muscle in that

1 picture.

2 Q. Well --

3 MR. MCGOWAN: Can we turn these lights down a
4 little bit?

5 Q. Everybody else has said this is staining of the
6 heart tissue. Do you agree or no?

7 A. Excuse me, sir?

8 Q. It looks like the root of a tree almost right
9 here. You agree that that's staining?

10 A. I'm not clear what that is. That -- no. This
11 is the diaphragm.

12 Q. Heart's in front of it.

13 A. Heart's up there, not down here.

14 Q. In this fellow?

15 A. (No response.)

16 Q. We've been told for the last two days that he
17 had a very large heart.

18 A. He did.

19 Q. Okay. Well, let's watch the -- let's look at
20 -- let me switch over to the video.

21 Is the tip of that catheter moving in rhythm
22 with the heart?

23 A. Yes, it is.

24 Q. And not --

25 A. But tethered to it, I can't say it's tethered

1 to it.

2 Q. The tip of that catheter is in contact with the
3 heart.

4 A. It's moving with the heart. I'm not sure it's
5 in contact with it.

6 Q. Okay. And this -- this material down here that
7 we've seen come out, you don't think that's staining
8 in the heart tissue?

9 A. I -- I'm not sure what it is. I'm not sure. I
10 really don't know.

11 Q. I'll run it again so you can --

12 A. Sir?

13 MR. BEIGHLEY: He's running it again so you can
14 see it.

15 THE WITNESS: It's in contact with something.
16 Maybe base of the pericardium itself. I don't know.

17 Q. Okay. Fair enough.

18 Then you've seen this video. This one, of
19 course, also -- this is just the sheath --

20 A. In contact with the heart.

21 Q. And then it's got -- this is staining which
22 indicates some cardiac damage.

23 A. If you'll recall from the last view, the sheath
24 went up and the catheter went back down so I don't
25 know about the other --

- 1 Q. That's --
- 2 A. We're through talking about that. We're
- 3 talking about this one now. Okay.
- 4 Q. It went around and back and into this here?
- 5 A. Yeah.
- 6 Q. And this is without the catheter. The
- 7 catheter's been removed, right?
- 8 A. Yes, sir.
- 9 Q. Sheath is in. Dye goes in. Staining of the
- 10 heart. Heart injury.
- 11 A. Yes.
- 12 Q. Okay. So we agree on that?
- 13 A. Yes.
- 14 Q. We also agree that the medical information
- 15 that's in the timeline that the hospital kept is
- 16 this: We have the puncture at around 10:44. We
- 17 have the pigtail catheter was inserted around that
- 18 time. We have contrast injected, which is Fluoro
- 19 Number 1, right?
- 20 A. Yes.
- 21 Q. We saw that. It looked good. It was in a good
- 22 position, right?
- 23 A. Yes.
- 24 Q. We then have a sheath inserted at 10:59, right?
- 25 A. Again, if we believe -- there -- yes.

- 1 Q. Contrast injected which had to be because the
2 pigtail was in there. That was Fluoro Number 2.
- 3 A. May I see this?
- 4 Q. Sure. Exhibit 4.
- 5 A. Where do we look? I don't know where to look.
- 6 Q. Exhibit Number 4. Tab Number 4.
- 7 A. And your time --
- 8 Q. We're at 11:11. 10:59 is when it says the
9 sheath was inserted. That's true, isn't it?
- 10 A. At 10:59 I see the 6 French long sheath.
- 11 Q. Right.
- 12 A. Yes. Yes.
- 13 Q. Then we have --
- 14 A. -- some pull down when inserted. If we look
15 back at that -- if we look back at 8:30, 8:36, 8:40
16 we see all kinds of equipment being pulled.
- 17 Q. That means it's available. It's on the table.
- 18 A. Correct. But I don't -- and that's my point
19 about the sheath as well. I know it was pulled at
20 that time -- pulled from its shelf.
- 21 Q. All right. Let's assume Dr. Mori's correct on
22 that because I asked him that.
- 23 A. Okay.
- 24 Q. And we ended at about 11 o'clock, fair enough?
- 25 A. Okay.

1 Q. Then we had some more contrast being injected,
2 right?

3 A. Yes.

4 Q. And then we have a notation of a pigtail
5 catheter being removed?

6 A. Yes.

7 Q. All right. And then we start having -- these
8 are our blood pressures. So you know how to read
9 this, this is the top number of the blood pressure,
10 this is the bottom number and this is the MAP. The
11 dots --

12 A. It's hard to get my attention off of brain
13 damage here. All right. I'm with you. Okay.

14 Q. Well, that's kind of important, don't you
15 think? I mean, you have to have a MAP above a
16 certain level to profuse your brain.

17 A. Yes.

18 Q. All right. And that's generally accepted, 60
19 to 65?

20 A. No, not really. Not to me. If someone faints,
21 the MAP is below 60 but they don't have brain
22 damage.

23 Q. Well, being down there for 10 minutes is a
24 problem.

25 A. Being -- I can give you that.

1 Q. All right. So our dots are our MAPs. This is
2 -- this is true and this is accurate, right?

3 A. I don't really know based on all these -- we
4 have some inconsistencies in time.

5 I don't know the answer to your question.

6 Q. Okay. Now, you would agree with me that in
7 this case the injury to the heart was either caused
8 by the needle or the sheath?

9 A. Yes.

10 Q. And you believe it to be more the needle than
11 the sheath?

12 A. Yes.

13 Q. Did --

14 A. Based on all the blood that came out.

15 Q. Fair enough.

16 A. And the patient -- and the clot that formed.

17 Q. Okay. Were you made aware of what Dr. Mori
18 testified to yesterday?

19 A. I -- I think I saw it but you'll have to be
20 more specific please.

21 Q. All right. This is a transcript of what he
22 said yesterday. I'm going to hand this to you. I'm
23 looking at page 16.

24 MR. BEIGHLEY: Your Honor, I would object to
25 using a transcript of a witness's testimony at the

1 trial now --

2 THE COURT: All right. Mr. Bailiff, let's take
3 the jury out please.

4 (The jury panel exits the courtroom.)

5 THE COURT: All right. Mr. Beighley, state
6 your objection.

7 MR. BEIGHLEY: Your Honor, the plaintiff has
8 obtained a portion of the defendant's trial
9 testimony, and it is now being introduced and shown
10 to the jury taken out of context without the full
11 benefit of hearing the whole thing and it's being
12 used to cross-examine this witness.

13 And you simply have no evidentiary right to
14 pull part of a witness's testimony and then use it
15 to cross-examine someone else. You can say what
16 they said, but it's for the jury to remember how it
17 was given and what context it was in.

18 If you pull out two or three lines or two or
19 three questions out of context, it unduly emphasizes
20 that and destroys the jury's duty to hear everything
21 in context, so I think it's improper to do that.
22 There's no opportunity for them to take -- it's like
23 taking notes. I mean, you're only showing one page
24 or one paragraph of an hour or the whole testimony.
25 I think it's very unfair for admission.

1 THE COURT: Mr. McGowan?

2 MR. MCGOWAN: I think there's two issues here,
3 Judge. One is whether I'm allowed to cross-examine
4 this expert based upon testimony given in court, and
5 I believe I'm clearly allowed to do that.

6 The second question is the method by which I do
7 that. If the objection is to the method, then I'm
8 happy to paraphrase it or I'll ask the question and
9 say, if Dr. Mori testified to the following would
10 you agree to it. From my perspective it's the same
11 thing.

12 If using the transcript is the issue, fine,
13 I'll do it another way. If me asking this expert
14 questions about testimony given in court and if it
15 would change his opinion, I think that's totally
16 fair game.

17 THE COURT: All right. I'm going to sustain
18 the objection for the purposes of the transcript. I
19 think Mr. Beighley is correct that portions of the
20 transcript should not be used in this matter.
21 However, that will not limit your ability to
22 question this witness about assertions made by the
23 defense in the case.

24 MR. MCGOWAN: Yes, sir. May I retrieve that
25 transcript?

1 THE COURT: You don't want to use the
2 transcript.

3 Mr. Bailiff, get our jury for us please, sir.

4 (The jury panel enters the courtroom.)

5 THE COURT: All right. Mr. McGowan?

6 MR. MCGOWAN: Thank you, Your Honor.

7 BY MR. MCGOWAN:

8 Q. Were you made aware of what Dr. Mori testified
9 to yesterday relative to putting in the sheath and
10 relative to putting in the needle?

11 A. You -- I don't recall. I'm sorry.

12 Q. Did anybody before right this minute talk to
13 you about what happened in court yesterday when
14 Dr. Mori was testifying?

15 A. Yes. We all had a discussion, yes.

16 Q. Okay. I want you to assume for the purpose of
17 my question that I asked him, if he put in the
18 sheath properly it's not going to injure the
19 patient; is that right?

20 And his answer -- assume this to be true -- if
21 I put it in properly, yes, it's not going to injure
22 the patient.

23 Do you agree with Dr. Mori where he says that
24 if you follow proper procedure in putting in the
25 sheath it will not cause an injury?

1 A. Putting in the sheath only? So you're not
2 talking about the entire procedure? You're talking
3 about just placing the sheath in --

4 Q. The insertion of that sheath. If you do that
5 the way you're supposed to, if you follow the
6 standards widely accepted, you're not going to cause
7 an injury to the heart.

8 A. Yes.

9 Q. Okay. Similarly with the needle, if you put
10 the needle in properly, if you follow the proper
11 techniques, you should not injure the heart when you
12 do that.

13 Do you agree with Dr. Mori on that point?

14 A. It's undesirable, should not -- you don't --
15 you don't intend to injure the patient. Yeah,
16 should not. Yes.

17 Q. So if you follow the proper standard procedures
18 for inserting this needle you should not cause an
19 injury to the patient's heart, right?

20 A. I guess we get semantic here but should -- you
21 know, we should not have an automobile accident.
22 Sometimes we do. We should not -- the complication
23 of a heart catheterization is one out of a thousand
24 but I don't think that thousandth patient should
25 have a complication. So I think the intention is

1 that we don't do it.

2 Q. And that's all fine and good, Doctor.

3 My question though is, if you follow the normal
4 procedures putting a needle in you should not cause
5 an injury to the patient's heart, right?

6 A. We should not cause -- we should not do
7 something that would injure the patient as intending
8 to do it. That's correct.

9 Q. Well, I -- you understand if you thought
10 somebody intended to hurt Mr. Dibernardo this would
11 be criminal court? You understand that?

12 A. Yes.

13 Q. Intent doesn't have anything to do with it.
14 You understand that?

15 A. Yes.

16 Q. Okay. So if one -- if a doctor puts this
17 needle in using the normal standard procedures, it
18 should not injure that patient's heart. That's
19 true, right?

20 A. If that's what you want and insist upon then
21 yes, that's -- but it doesn't work that way.

22 Q. Well --

23 A. We do the best we can do and sometimes we get
24 complications.

25 Q. Well, again, you keep running to the -- to the

1 -- to what you believe to be a complication but the
2 truth is, Doctor, is it not that a complication can
3 be caused by the doctor not doing standard, everyday
4 procedure which causes the injury, right?

5 A. That's correct.

6 Q. Okay. So if you put this needle in the way
7 you're taught to, you won't cause a complication,
8 true?

9 A. No.

10 Q. Okay. So you disagree with Dr. Mori?

11 A. I -- I will not cause -- to say if I do it the
12 way I'm taught I will absolutely not cause a
13 complication, that's saying that every cardiologist
14 who has ever had a complication with this was
15 negligent.

16 Q. Well, what do you understand the injury to this
17 man's heart to be?

18 A. I under -- I suspect probably a vein was
19 encountered when the needle went in, possibly the
20 inferior vena cava, possibly a small artery. I
21 think -- I think it bled a little bit and then it
22 clotted and then rebled.

23 Q. All right. And you'd agree with me that
24 according to Dr. Savage's report there was no
25 indication of any vessel being involved?

1 A. He didn't see any.

2 Q. And you also understand that Dr. Mori said that
3 when he pushed this --

4 A. Please understand, sir, that some of these
5 vessels are half a millimeter in diameter. The
6 surgeon is not going to see those -- you can laugh
7 at me if you want to but the truth is the truth,
8 sir.

9 Q. Well --

10 A. The surgeon is not going to see those in a
11 gross inspection when he's taking blood out and
12 trying to find an active bleeding spot. He's not
13 going to start probing each vessel to see if he can
14 get it to bleed again, sir.

15 Q. You understand that Dr. Mori says that he
16 inserted this needle and then pulled back on the
17 syringe like you do, like -- put suction on it?

18 A. Yes.

19 Q. And there was no frank blood in the fluid at
20 that point?

21 A. I don't recall specifically that. I know that
22 when they began to withdraw blood and fluid, they --
23 it was bloody to begin with -- slightly bloody and
24 then it cleared.

25 Is that what you're asking me?

1 Q. Do you know what Dr. Mori reported, what he
2 said about the results of his -- and I guess y'all
3 call it aspiration and that's when you stick the
4 needle in before you put a catheter in and you pull
5 back on the syringe. You put suction on the syringe
6 so that when you enter the space you get fluid.
7 drawback, right?

8 A. Yes.

9 Q. Are you aware at all of what Dr. Mori testified
10 to and --

11 A. You mean --

12 Q. -- told us --

13 A. -- yesterday?

14 Q. Anytime before this second, Doctor. Are you
15 aware of what he said the drawback was when he did
16 it?

17 A. I'll be glad to review the records, if you'd
18 like. We can do it right now to look. But I don't
19 recall.

20 Q. If this was --

21 A. I didn't memorize it, sir.

22 Q. If this was not blood, would you agree that it
23 makes it highly unlikely that this needle tip, which
24 would have been in the position of the injury,
25 caused an injury at that time?

1 A. No, I don't agree.

2 Q. So if you have the tip of this needle in the
3 area it's -- the point that he would have done
4 drawback on it would have been where he injured --

5 A. If --

6 Q. -- the heart, right?

7 A. -- you enter a small vessel on the dome of the
8 diaphragm or in the pericardium or even in the --
9 even on the surface of the heart that doesn't mean
10 you're -- that you're going to -- that you're going
11 to get blood, that -- I don't know if a stylus was
12 used in the needle or whether it was aspirated the
13 entire time but sometimes you -- the vessel will
14 collapse on itself and you don't get blood because
15 the suction just pulls the walls together but later
16 they might bleed. I don't know the answer to that
17 question.

18 Q. What do you understand the nature of the injury
19 to this man's heart to be? You don't know, do you?

20 A. I --

21 Q. You think it might be --

22 A. I think it's probably the needle.

23 Q. Okay. So whether this was done by the needle
24 or whether this was done by the sheath insertion,
25 you would agree with me that if Dr. Mori had

1 followed the normal standard procedures that all
2 cardiologists do, that injury, whether by needle or
3 sheath, would not have happened?

4 A. No, I don't agree.

5 MR. MCGOWAN: All right. Thank you, Doctor.

6 THE COURT: Any redirect?

7 REDIRECT EXAMINATION

8 BY MR. BEIGHLEY:

9 Q. Doctor, let me show you on the images -- if
10 you'd come down for a minute. You were asked about
11 the first image that you showed. If you can just
12 come down --

13 A. Yes, sir.

14 Q. If you would, sir, go to Images 4 and 5. I
15 think you looked -- I think you started with
16 Number 1.

17 A. I started with Number 1, yes.

18 Q. All right. Let's go to Number 4.

19 A. Okay.

20 Q. All right. So now, I will tell you that the
21 image -- the time on there is 10:40; is that right?

22 A. Yes, sir.

23 Q. And what time was the saline injected?

24 A. (No response.)

25 Q. Go to the one -- go to Number 5.

- 1 A. (Witness complies.)
- 2 Q. Now, do you see a difference in the imaging
- 3 there in the upper right quadrant?
- 4 A. Yes.
- 5 Q. All right. What is that in that image?
- 6 A. You're talking about right here?
- 7 Q. Yeah. Let me put --
- 8 A. I'm sorry. I should have --
- 9 Q. This.
- 10 A. My bad. Yeah.
- 11 Q. Do the first one on there.
- 12 A. That looks like agitated saline to me.
- 13 Q. All right, sir. And after that did that
- 14 change?
- 15 A. Yes.
- 16 Q. And did blood clot appear --
- 17 A. This one right here is after that and the
- 18 saline's gone away, and you have just the effusion
- 19 left -- the fluid.
- 20 Q. All right. And then blood clot appears --
- 21 A. Yes.
- 22 Q. -- before the sheath goes in?
- 23 A. According to the time that I saw, yes.
- 24 Q. All right. And does that prove there was
- 25 bleeding before the sheath was inserted?

1 A. I think it does, yes.

2 Q. All right. You were asked, Dr. Story, if a
3 medical procedure's done properly you shouldn't have
4 injury, and you agreed with that general statement.
5 But does it mean that every time you do one properly
6 and have a procedure [sic] you've committed
7 malpractice?

8 MR. MCGOWAN: Object to the leading, Your
9 Honor.

10 THE COURT: Rephrase your question.

11 BY MR. BEIGHLEY:

12 Q. Does the fact that a procedure is done
13 correctly and complication still occurs mean that
14 the physician has fallen below the standard of care?

15 A. No.

16 Q. What would it mean in medicine, sir, if every
17 procedure that was done properly and had a
18 complication without and departure from the standard
19 of care and that was determined to be a liability?

20 MR. MCGOWAN: Objection, Judge. That's not a
21 relevant question to anything in this trial, Your
22 Honor.

23 THE COURT: I'm going to sustain the objection.

24 MR. BEIGHLEY: All right.

25 BY MR. BEIGHLEY:

1 Q. Let me try it this way, Doctor: In medicine is
2 it an exact science?

3 A. No.

4 Q. When you are using all your training and
5 experience, you're using techniques that you've been
6 taught and you take a sharp object and place it near
7 a beating heart, doing everything correctly can you
8 still have an injury?

9 A. Yes.

10 Q. And is the fact that an injury occurred
11 evidence of malpractice?

12 A. No.

13 Q. Based on all the questions Plaintiff's counsel
14 has asked you, what is your opinion as to whether or
15 not Dr. Mori complied with generally accepted
16 standards of care?

17 A. I thought his treatment of the patient was
18 exemplary and cautious, and he complied with the
19 standard of care.

20 Q. Is that your opinion to a reasonable degree of
21 medical certainty?

22 A. Yes.

23 MR. BEIGHLEY: Thank you.

24 THE COURT: Mr. McGowan?

25

1 RE CROSS-EXAMINATION

2 BY MR. MCGOWAN:

3 Q. I'm sorry. What if you're right about that
4 agitated saline being at 10:34? What if that is
5 agitated saline at 10:34?

6 We know from the timeline that the echo tech
7 didn't arrive and it's not noted as being arrived
8 until 10:40. Give them a minute to put the thing
9 together. So what if that first video is actually
10 seven minutes later, that there was a seven-minute
11 time gap between the echo and the timeline in the
12 cath lab?

13 A. (No response.)

14 Q. That could be -- that could be the explanation,
15 right?

16 A. I -- I don't follow you. I'm sorry. The
17 pictures that I saw there's a clear difference after
18 what I thought was agitated saline when it clears up
19 completely. I don't know about timing. I feel that
20 the timing in these records aren't exactly right.

21 Q. And -- well, let's give you the benefit of the
22 doubt, Doctor. Because if that first video was --
23 in fact, you need an echo tech in order to make
24 echos?

25 A. Most probably, yes.

1 Q. Okay. So that first video you saw was an echo,
2 right? It was timed at 10:34.

3 A. Yes.

4 Q. The echo tech is not noted to arrive until
5 10:40, six or seven minutes later, right?

6 A. According to a different timeline, yes.

7 Q. Okay. So there's some disparity between the
8 echos --

9 A. We have a timeline with the echo machine itself
10 produced.

11 Q. There's timestamps?

12 A. Yes.

13 Q. And then we have the one in the lab?

14 A. Yes.

15 Q. So is it fair for me to conclude that the
16 timings of the echos versus the cath lab are off?

17 A. I think they probably are but I don't know for
18 certain. Yes.

19 Q. Okay. Well, at least in one instance, right?

20 A. Yes.

21 Q. Because you can't make an echo without a tech?

22 A. Yes, yes.

23 Q. That would give us a seven- or eight-minute
24 difference, right?

25 A. Yes.

1 Q. Okay. So what -- what we see and what you're
2 relying upon as being blood clot, the only reason
3 that's important in this case is because of the
4 timing of it, right?

5 A. I think that's correct, yes.

6 Q. And we know the timing is suspect?

7 A. Yes.

8 MR. MCGOWAN: Okay. Thank you.

9 FURTHER EXAMINATION

10 BY MR. BEIGHLEY:

11 Q. If the evidence, Dr. Story, even with the fact
12 you've got an echo tech documented as arriving at
13 10:40, chest wall puncture 10:42, if this is off by
14 a few minutes, is there any question in your mind
15 that you still have clot appearing on the echo
16 before the insertion of the sheath?

17 A. There's no question.

18 MR. BEIGHLEY: Thank you. No further
19 questions, Your Honor.

20 THE COURT: Anything further from this witness?

21 MR. MCGOWAN: No, sir.

22 THE COURT: All right. Thank you, Doctor. You
23 can step down.

24 We're going to take a break now. Mr. Bailiff,
25 if you'll take our jury to the jury room. We're