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S.C. SUPREME COURT

**THE STATE OF SOUTH CAROLINA
In the Supreme**

**APPEAL FROM YORK COUNTY
Court of Common Pleas**

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 II of II

Richardson, Plowden, & Robinson, PA

George C. Beighley
Carmen V. Ganjehsani
1900 Barnwell Street (29201)
Post Office Drawer 7788
Columbia, South Carolina 29202
Phone: (803) 771-4400

ATTORNEYS FOR RESPONDENTS

McGowan, Hood & Felder, LLC

Whitney B. Harrison
1517 Hampton Street
Columbia, South Carolina 29201
Phone: (803) 779-0100

Chad McGowan
1539 Health Care Drive
Rock Hill, South Carolina 29732

**ATTORNEYS FOR
PETITIONER**

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1 going to take about a 15-minute break.

2 (The jury panel exits the courtroom.)

3 THE COURT: We'll be in recess.

4 (Recess was taken.)

5 THE BAILIFF: All rise.

6 THE COURT: Thank you. Y'all be seated please.

7 All right. Anything before we bring our jury

8 back?

9 MR. MCGOWAN: No, sir.

10 MR. BEIGHLEY: Nothing, Your Honor.

11 THE COURT: All right. Mr. Bailiff, get our

12 jury for us please.

13 (The jury panel enters the courtroom.)

14 THE COURT: All right. Mr. Beighley?

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

16 Honor. Defendants call Dr. Mike Foster.

17 Dr. Foster, will you come around to be sworn in

18 please?

19 THE CLERK: Place your left hand on the Bible

20 and raise your right.

21 (Witness was duly sworn.)

22 DIRECT EXAMINATION

23 BY MR. BEIGHLEY:

24 Q. Dr. Foster, please introduce yourself to the

25 jury and tell us where you're from.

1 A. Michael Foster. Columbia, South Carolina.

2 Q. And Doctor, how do you earn your professional
3 livelihood?

4 A. I'm an interventional cardiologist.

5 Q. Tell us about your educational background and
6 training please.

7 A. I went to college and medical school at Indiana
8 University, graduated about 1980. Did an internship
9 here in Brockton, Massachusetts. Did two years of
10 internal medicine following that and one year at
11 Indiana University Medical Center, one year in
12 Boston.

13 Following that I did a year of research in
14 cardiac pathology as well as echocardiography. And
15 then following that two years of a fellowship in
16 cardiology at the Boston VA Hospital and New England
17 Medical Center Boston.

18 Q. And how long have you been engaged in the
19 practice of cardiology?

20 A. I've been practicing in Columbia since August
21 of 1986 so I guess I'm on my 31st year.

22 Q. All right. And following your completion of
23 your training in the various specialties that you
24 described, have you been board-certified?

25 A. Yes, I was. I've been boarded in internal

1 medicine and general cardiology. And as Dr. Story
2 mentioned, interventional cardiology was not a
3 recognized subspecialty until 1999. At that time I
4 was admitted to the board exam and passed my boards
5 in 1999 and have recertified one time since in
6 interventional cardiology.

7 Q. In addition to your training and your practice,
8 have you been involved in activities or associations
9 related to your specialty?

10 A. Yes. I was a volunteer for many years for the
11 American Heart Association of South Carolina
12 affiliate, served as president of the South Carolina
13 affiliate in the early 1990s. I'm a fellow in the
14 American College of Cardiology. I'm on the Board of
15 Governors for the state chapter of the American
16 College of Cardiology. I'm a fellow in the Society
17 of Coronary Angiography and Intervention.

18 MR. BEIGHLEY: Your Honor, at this time we
19 present Dr. Foster as an expert in the field of
20 cardiology and invasive cardiology.

21 MR. MCGOWAN: No objection, Your Honor.

22 THE COURT: All right. Dr. Foster will be
23 admitted as an expert in cardiology and invasive
24 cardiology.

25 BY MR. BEIGHLEY:

1 Q. Doctor, at my request did you review the
2 medical records from Carolina Cardiology and
3 Piedmont Medical Center for Mr. Dibernardo?

4 A. Yes, I did.

5 Q. Did you also review the deposition of Dr. Mori
6 taken in this case?

7 A. Yes, I did.

8 Q. Based on your review of the medical records and
9 the depositions were you able to form an opinion as
10 to whether or not the medical care rendered by
11 Dr. Mori in this case complied with generally
12 accepted standards of care?

13 A. I -- yes, I did reach an opinion.

14 Q. And what is your opinion?

15 A. I think his care was within the highest
16 standards, in many ways exemplary, in many ways
17 inventive.

18 Q. Doctor, can you give the jury just a basic
19 summary -- you were here earlier during Dr. Story's
20 testimony so if you'd, in the interest of time, just
21 give them a summary as you saw it of this man's
22 condition, his history which led him to the hospital
23 on July 19th.

24 A. Yes. As Dr. Story mentioned, he had a genetic
25 condition, a longstanding history of heart issues,

1 of chronic atrial fibrillation for decades,
2 enlargement of the heart or what's called
3 cardiomegaly and also what's called cardiomyopathy
4 or a pathologic over-thickening of the heart muscle,
5 all of which led to this condition of progressive
6 heart failure which had been dealt with for many
7 years.

8 It appeared that his symptoms markedly worsened
9 over a month or two before he was admitted to the
10 hospital that July 19th, and this worsening of his
11 condition was the indication to bring him into the
12 hospital and try to do something about this large
13 amount of fluid around the heart which was felt to
14 be contributory to his decline.

15 And I would agree that -- I would classify him
16 as having class four congestive heart failure, which
17 is a uniformly recognized very morbid condition.

18 Q. What is congestive heart failure? I don't know
19 if anyone has actually ever said that. We've used
20 the term, but what does it mean in layman's terms?

21 A. It's often misunderstood and misapplied, the
22 term, but it means literally the heart is failing to
23 do its job as a pump. Our hearts are in essence a
24 pump to circulate our blood in the bodies, and when
25 the disease process alters its ability to pump

1 properly then there's a series of maladaptions by
2 the body which results in the body clinging to salt
3 or sodium.

4 Anywhere sodium goes a proportional amount of
5 fluid has to go to maintain the proper homeostasis
6 in the body or balanced condition you might say. So
7 as the body retains sodium and fluid the patient
8 swells and therefore -- the edema or swelling in the
9 feet and ankles is the initial place most people
10 notice, but actually that swelling is occurring
11 throughout the body so it's affecting the vital
12 organs -- the kidneys, the liver, the intestines.

13 Loss of appetite is common in advanced heart
14 failure. Advanced heart failure patients often
15 don't lose weight despite not eating because they're
16 -- the muscle and fat mass they're losing is
17 counterbalanced by the retention of fluid.

18 That's why I have my patients with heart
19 failure weigh themselves every day so medicines can
20 be adjusted based on fluid -- fluid retention --
21 someone's baseline on weight as fluid is retained.

22 So it's this maladaptation and this swelling in
23 the body that's what we commonly refer to as
24 congestive heart failure. And one of the places we
25 see the fluid accumulate is in the lungs which makes

1 people short of breath and -- so that's sort of the
2 longwinded answer to -- it sounds like a simple
3 question but it's actually a complicated problem.

4 Q. Thank you, Doctor. Doctor, in this case -- in
5 Mr. Dibernardo's case with his congestive heart
6 failure and his pericardial effusion was it
7 appropriate to recommend a pericardiocentesis to
8 attempt to drain off the fluid around his heart and
9 give him some relief from the symptoms he was
10 suffering from?

11 A. Well, if he were my patient I would have
12 recommended that he have it done surgically due to
13 the large amount of fluid on the heart by opening a
14 window in the pericardium allowing more of the fluid
15 to exit that cavity or that sac around the heart and
16 into a more benign area which would be the larger
17 chest cavity. But in a situation where the patient
18 would decline that advice I would very much offer
19 that patient a pericardiocentesis, as was done in
20 this case.

21 Q. Now, even with the proper performance of a
22 pericardiocentesis can complications occur?

23 A. They can. Bleeding being the foremost
24 complication. Depending on the approach, a lung can
25 be punctured which can lead to a condition called

1 pneumothorax or collapse of a lung. And of course,
2 infection is always a potential risk introducing
3 inadvertently staphylococcus from the skin into the
4 -- in the sac of the pericardium. It could be a
5 deadly complication.

6 Of course, generally patients have to be
7 sedated. They have to be put into the supine or
8 slightly elevated position and that's often very
9 difficult for patients in these advanced states of
10 disease. I've seen patients literally go into
11 cardiac arrest just simply lying flat on the cardiac
12 catheterization table. I've seen them go into
13 cardiac arrest with sedation.

14 So death is a potential complication of this
15 procedure as well.

16 Q. Is the fact that bleeding occurs during this
17 procedure by itself evidence that the physician's
18 committed malpractice?

19 A. No, sir.

20 Q. Can you do everything the way you're trained
21 and still have a bleeding complication?

22 A. I've personally had it happen many times and I
23 believe I do every procedure to the highest --
24 within the highest standards and with the way we
25 were all taught. It just happens.

1 If you've -- you show me a physician who hasn't
2 had a major complication from a pericardicentesis
3 and I probably would be looking at a physician who's
4 done very few of them or is extraordinarily lucky.

5 Q. Please explain to the jury your understanding
6 of the procedure that was done in this case and the
7 actions that were taken when the bleeding
8 complication occurred.

9 A. Well, in general terms I would say that the
10 patient was -- first of all, when he was admitted to
11 the hospital he was on a blood thinner -- Coumadin
12 or Warfarin -- and his blood was very thin at the
13 time he was brought into the hospital.

14 So it was very appropriate that the procedure
15 was delayed to allow the blood thinner to get out of
16 the system, for the blood to start clotting
17 normally.

18 Obviously that's a concern when you're putting
19 a needle in someone's chest near the heart that the
20 blood not be overly thin.

21 So that was done. It looked like informed
22 consent was obtained. He was taken to the cardiac
23 catheterization laboratory sometime that morning.
24 Typically the chest is -- it's prepped sterilely,
25 drapes applied. The patient's IVs are started. The

1 area of entry is prepped carefully and injected with
2 a local anesthetic like lidocaine.

3 Once that occurs then you put the pericardial
4 needle -- there's a variety of approaches -- four or
5 five different approaches. I would say 99 percent
6 of pericardiocenteses that I've done or witnessed
7 have been done through that approach, which as
8 Dr. Story said would be right underneath the
9 sternum.

10 The needle has to be directed at an angle to
11 clear the ribcage then generally up towards the left
12 shoulder. Generally the patient is sat up to a 30-
13 to 45-degree angle which allows much of the fluid to
14 dependently go down to that lower portion of the
15 heart.

16 And there's a number of techniques described
17 for entering the needle. What I believe Dr. Mori
18 did was go in at the standard angle with a
19 pericardial needle. It was a hollow needle with a
20 syringe attached, aspirating as he went in so he
21 would know when he reached the pericardial effusion.

22 It looked like that was done. He described
23 watching the EKG to be sure there are not any
24 premature beats that might indicate contact with the
25 heart itself.

1 Once the needle was placed in what he thought
2 was a satisfactory spot, some agitated saline was
3 injected, and I think that was described by
4 Dr. Story. And that's to be sure that you're in the
5 right spot because you really can't tell going in.
6 Entering the needle is more or less a blind process.

7 We can't tell by x-ray exactly where the
8 needle's going. X-ray is a two-dimensional imaging
9 technique. The heart is three-dimensional. So it's
10 of really no value. In my experience zero value.

11 So it's really a stick that you go by
12 landmarks; you go by your experience; and you go by
13 feel. There's a certain feel you get when the
14 needle goes through the outer sac of the
15 pericardium. I describe it as a popping sensation.

16 And so once he ascertained he was in that area
17 in the pericardium -- so that's the space between
18 the heart itself and the outer sac -- he inserted a
19 flexible Jay wire, which was described. It's a thin
20 wire that serves as a guide for whatever catheter
21 you intend to put ultimately in the pericardium. So
22 that wire goes through the center of the needle.

23 And once he placed that wire he initially
24 placed what's described as a pigtail catheter, so
25 it's a relatively small catheter with a little loop

1 on the end and a series of very small, tiny holes.

2 And it really -- for people familiar with
3 construction or drainage, it sort of is like a
4 French drain in someone's house or a golf course.
5 It allows the fluid to filter into the catheter and
6 be aspirated out through that catheter.

7 Q. Now, during that initial process of the
8 pericardiocentesis was this done in accordance with
9 the standards of care in your opinion?

10 A. In my opinion, yes.

11 Q. Now, at some point bleeding was encountered.
12 Can you tell us about that?

13 A. So what's -- what I could ascertain from the
14 notes and Dr. Mori's deposition was that initially
15 the fluid was clear, straw colored, maybe a tinge of
16 blood here and there but a clear fluid, and that was
17 what I would expect to encounter in this type of
18 effusion. Although, you never know for sure going
19 in.

20 At some point he noticed a change in the
21 patient's vital signs and a drop in the blood
22 pressure, drop in the oxygen levels and the blood --
23 the aspirant or the fluid coming out to be
24 increasingly bloody and very importantly scant. So
25 he had difficulty getting anything out at all.

1 At some point, given this conglomeration of
2 findings, I think he concluded that maybe these
3 holes were just clotted off. For some reason the
4 pigtail catheter was not working properly, so he put
5 a wire back through that pigtail catheter leaving
6 his -- leaving sort of a rail or a guide back into
7 the pericardium.

8 He removed that pigtail catheter, flushed it
9 out in order to try to get any clot or debris out of
10 these little holes -- and that's a pretty standard
11 thing -- and then reinserted it.

12 And my sense is on this occasion he initially
13 put a sheath in over the wire. Sheath would be a
14 plastic, hollow catheter that can serve as an entry
15 point for devices. And he lead with a sheath over
16 the wire, then inserted the pigtail through this
17 sheath.

18 At some point the patient continued to
19 deteriorate. He did not get the amount of volume
20 out that he felt like he needed to prevent a further
21 decline in this patient's status. He then removed
22 the pigtail and aspirated what was now seemingly
23 pure blood through this sheath because it has a very
24 large hole. It has a single large hole in the end
25 of the sheath.

1 Q. All right, sir. Was the complication of
2 bleeding managed appropriately in your opinion?

3 A. I think so. Because simultaneously with this
4 it appeared more or less to me or quite soon after
5 this he called for a surgeon, which is what I would
6 do, when the patient is literally dying under your
7 eyes during the procedure.

8 There appeared to be some delay before the
9 surgeon could get to the room and that's not unusual
10 so then he -- he did something that I personally
11 have never done but I've spoken to others who have
12 done it and I've seen it described is that he had a
13 large sheath in the patient's femoral vein. I'm not
14 quite sure the time sequence of when that sheath
15 went in.

16 So he aspirated the blood from the sheath
17 around the heart and then transferred that blood
18 back into the body through this sheath in the vein.
19 So that's what we would call an autotransfusion.

20 And it's a technique surgeons do all the time
21 during surgery when they're aspirating blood out
22 through a suction device, spinning it down and
23 reinserting it into the patient. It's a way
24 surgeons use to minimize the need for transfused
25 blood from another source.

1 So he did that. He gave boluses or quick
2 infusions of fluids, saline to help increase the
3 vascular space, which is very important when you
4 have this situation we call tamponade. So the
5 heart's being strained by the external fluid in the
6 sac. By expanding the volume of blood in the
7 bloodstream that provides a counterforce to this
8 external fluid.

9 And so expanding the blood volume with saline
10 is a very important consideration -- often
11 overlooked consideration in managing tamponade. And
12 he also administered what we would call pressors,
13 medicines which are designed to temporarily raise
14 the blood pressure.

15 So it appeared to me between these
16 interventions that the blood pressure, after it had
17 sort of what we might say crashed, came back pretty
18 promptly. After perhaps a five-, six-, seven-minute
19 period of low blood pressure these moves worked and
20 it appeared to me that the patient's blood pressure
21 after that brief period of time was acceptable all
22 the way into the operating room.

23 Q. Now, Dr. Foster, have you formed an opinion as
24 to how the bleeding started in this patient in the
25 first place?

1 A. My opinion is that the bleeding occurred
2 because of the needle stick. That would be the most
3 -- most common reason we get bleeding during these
4 procedures. It's the only sharp instrument
5 utilized.

6 And as I said, the needle stick is really a
7 blind stick. You're going in the area you think
8 will get you to the heart. There's all sorts of
9 structures that can get in the way, even at times
10 the -- Dr. Story mentioned the diaphragm. I've even
11 seen structures from the liver and spleen get in the
12 way. Sometimes these organs are grossly enlarged
13 because of the patient's condition.

14 So that would be the most common way to get
15 this kind of bleeding. Also, the location described
16 by the surgeon, which was the acute -- he described
17 an oozing of the acute margin of the heart which
18 would be typically the first area one might
19 encounter in the cardiac structure as one proceeded
20 from that subxiphoid approach.

21 Q. Dr. Foster, the needle causing the injury
22 initially, can you tell the jury why -- if the
23 needle goes in and causes the bleeding why you
24 wouldn't be able to get bleeding back on your needle
25 when you pull back on the syringe?

1 A. They're not instantaneous events, number one.
2 Number two is the needle is traveling. So you may
3 briefly go through a very, very tiny structure which
4 maybe takes a few milliseconds to go through and
5 then end up an inch or two away from that structure
6 and into where you intended.

7 So really the aspirant just tells you where the
8 needle ends up. It doesn't tell you where that
9 needle's been on its journey through.

10 And in addition, he used a hollow needle, which
11 many people do. Nothing wrong with that. But as
12 it's going through, past bone and typically you bump
13 into bone as you're going through, rib bones. You
14 have to work your way off the ribcage underneath as
15 you go in. You're going through fat. You're going
16 through fascia.

17 So this -- you know, these needles act as a
18 mini knife and this material can get in and clog the
19 needle. And so one may not know they're in a
20 vascular structure as they're going in. Once you
21 get into a fluid-filled space, often that fluid will
22 then kind of clear out the needle and you can
23 aspirate back.

24 I would say it would not be surprising at all
25 not to initially see blood, even if you've been

1 through a small vein or artery or whatever space
2 might bleed.

3 Q. Doctor, it's been shown to the jury many times
4 by most witnesses about how his mean arterial
5 pressure doesn't drop until about 11 -- goes below
6 the line at about 11:26. It gets down below 40 at
7 11:29, then starts back up at 11:35.

8 Can you explain to the jury if you have an
9 injury and bleeding how long it can take before that
10 injury produces a change in your blood pressure?

11 A. You mind if I step down?

12 Q. No, please. Please feel free to do it.

13 A. I haven't seen it yet.

14 So are these black dots the mean pressure, I
15 take it?

16 Q. That's right.

17 A. Okay. So the original puncture on this
18 timeline is 10:41. Am I correct there?

19 Q. Yes, sir.

20 A. Okay. And the pressure, you know, perhaps
21 trends down a little bit in this time zone, about
22 11:14, but clearly drops in the 11:26 to 11:29 time
23 frame.

24 So this time course for me was the primary
25 factor that I used to form my opinion about what

1 caused the bleeding. Because in my 31 years of
2 practice I've never seen tamponade physiology --

3 Q. Let me hold this up here so everybody can see.

4 A. So if this is the time of the alleged injury
5 here -- and we know there was some injury here by
6 the staining. This is only 15, 16 minutes time
7 course and I've just never seen -- it takes time --
8 think of it this way: This patient had documented
9 fluid in his pericardium for years. We know that by
10 echocardiograms for years. He's already had some of
11 this fluid removed.

12 So by this time he's already in a better state
13 in terms of the amount of fluid in his sac, if we're
14 to believe this time course, and yet within 10, 15
15 minutes of bleeding through a structure no one can
16 see when they do go to surgery -- it doesn't make
17 any sense at all. I've never seen tamponade occur
18 that quickly.

19 And the textbooks and my own personal
20 experience with many, many patients -- I've seen
21 well over 100 patients I've dealt with in my career
22 with tamponade. Often times after an injury I've
23 created during a stint procedure or whatever the
24 time course is -- even for grave injuries -- is
25 usually 30 minutes and for most injuries it's hours..

1 I've seen tamponade occur up to 24 hours after an
2 injury. So this, to me, is an unrealistic scenario.

3 Now, if the injury occurred here, as I suspect
4 when the needle first went in, we have our
5 approximately 45-minute time frame, and that's a
6 much more realistic scenario to me.

7 Q. All right. Thank you, Doctor. And following
8 up on this, if I might show you what's been marked
9 as Plaintiff's 1 PMC. This is the source of the
10 information on that demonstrative aid.

11 But if you will look, the last blood pressure
12 shown is 11:35 and at that point it's -- you can sit
13 down.

14 But just looking at the blood pressures after
15 11:35 what happens to the blood pressures in
16 response to the efforts of Dr. Mori?

17 A. So at 11:34 I see dopamine started. The -- at
18 the time the pressure was the lowest of 44 over 31
19 and it progressively goes up after that. At 11:36
20 it's -- the mean arterial pressure is up roughly 20
21 points. By 11:38 we have mean of 62 systolic
22 reading and a diastolic reading of 50.

23 So it went up quite rapidly after these
24 efforts. By 11:41 we have a systolic reading of 90.
25 Wavered around a little bit for the next five or ten

1 minutes but generally the mean pressures were fine.

2 We had a systolic reading of over 100 by 11:49.

3 Q. So did the efforts of resuscitation that
4 Dr. Mori instituted serve to stabilize the patient?

5 A. I think clearly, yeah.

6 Q. And were those efforts within the standard of
7 care?

8 A. I think so.

9 Q. Now, you told us about the -- your opinions as
10 to the injury being caused by the needle stick and
11 the blood pressure sequence in support of that
12 opinion; also the testimony of Dr. Mori that he was
13 getting blood out.

14 In addition to that, have you looked at the
15 echocardiogram?

16 A. Yes, I have.

17 Q. And tell us if you had identified blood clot
18 before the time of the sheath insertion.

19 A. Based on the echocardiogram sequence we saw
20 earlier today and I reviewed earlier today I said it
21 appears we do have visible blood clot on
22 echocardiogram. I would agree that clot is visible
23 on this echocardiogram, and I believe the time
24 sequence on here would support that this happened
25 before the sheath was inserted.

1 Q. Do I need to run this again for you, or can you
2 just come down and show us, if you don't mind, just
3 to make sure there's no confusion?

4 A. I'll have to come down because I am slightly
5 nearsighted.

6 Q. We'll turn the light down a little bit and
7 we'll...

8 A. It appears here we've jumped to sequence 12.
9 At this point I see a clear area above this cursor,
10 see a clear area to the right after the patient's
11 left of this cursor, clear area over here. So this
12 looks like -- 13 is the final structure here.

13 Fluids in the world of ultrasound appear black.
14 That's why the inside of the heart here is black.
15 That's why this heart muscle here appears almost
16 white. It's a solid structure. And you see an
17 intermediate structure -- an intermediate density
18 between these two. So this is fluid density. This
19 is a solid structure density. This is an
20 intermediate density, which is quite consistent with
21 a thrombus.

22 Now, a tumor or mass could -- a soft one could
23 have that appearance but we didn't see that before.
24 So a sudden appearance like this would be very
25 consistent in my view with a thrombus or forming

1 blood clot.

2 Q. All right. Thank you.

3 Dr. Foster, there's been testimony in the
4 courtroom from Plaintiff's expert that the
5 appropriate step to have taken when the bleeding
6 complication occurred and was first recognized would
7 have been to simply attach the pigtail catheter to a
8 drain and send the recovery -- send the patient to
9 the recovery room.

10 MR. MCGOWAN: I object to that because that is
11 not what Dr. Schob said in any manner. That is not
12 his testimony.

13 THE COURT: Mr. Bailiff, would you take the
14 jury to the jury room please?

15 (The jury panel exits the courtroom.)

16 THE COURT: All right. What is your objection
17 again, Mr. McGowan?

18 MR. MCGOWAN: My objection is that Mr. Beighley
19 is misrepresenting the testimony of Dr. Schob. He
20 says -- in this question he says, well, the
21 plaintiff's expert testified that after the, quote,
22 bleeding complication arose that he should have been
23 put in the ICU. That's -- without further
24 intervention. That is not what he said.

25 He said the bleeding didn't happen until the

1 sheath was put in. If he had left the catheter in
2 its good spot where it was, what should have
3 happened at that point -- there was no injury.
4 There was no bleeding. He should have gone to the
5 ICU. Everything would have been fine. He never
6 said that if once the bleeding started that he
7 should just go to the ICU and wait it out. That was
8 never his testimony and it's improper.

9 THE COURT: Mr. Beighley?

10 MR. BEIGHLEY: Judge, the witness testified and
11 I asked him -- he says that Dr. Mori should have let
12 the catheter drain and sent the patient to the ICU
13 without further intervention, and he says that for
14 whatever reason -- the procedure was done correctly
15 -- that Dr. Mori decided to make some manipulations
16 that resulted in injury and none were necessary.

17 And my question is, that basically it's your
18 opinion he should have continued to utilize the
19 existing pigtail catheter to withdraw the bleeding
20 that was encountered? I would say that there
21 probably wasn't active bleeding going on.

22 In his deposition he attributed bleeding to a
23 needle stick. It's extremely unlikely that a needle
24 stick would cause that kind of bleeding. It's
25 almost impossible. Needle sticks usually clot by

1 themselves and the bleeding stops.

2 The only way you could encounter -- only way
3 you could encounter that kind of bleeding with a
4 needle stick is by lacerating a vein or an artery.
5 Again, very unusual.

6 THE COURT: It's my recollection of Dr. Schob's
7 testimony that he was challenging whether there was
8 bleeding after the needle stick. My recollection of
9 his testimony was that he saw no indication of blood
10 after the needle was put in and is challenging the
11 assertion there was bleeding.

12 So I'm going to allow you to ask the question
13 but do not reference bleeding in the question. I'll
14 sustain the objection for the statement of the
15 bleeding.

16 You can ask the question whether it's this
17 expert's opinion if it would have been proper simply
18 to send the patient to recovery and put on an IV
19 drip.

20 MR. BEIGHLEY: All right.

21 THE COURT: Mr. Bailiff, would you get our jury
22 please.

23 (The jury panel enters the courtroom.)

24 THE COURT: Mr. Beighley?

25

1 BY MR. BEIGHLEY:

2 Q. Dr. Foster, when a physician encounters
3 bleeding during a pericardiocentesis -- when
4 Dr. Mori in this case became concerned about
5 bleeding, would it have been appropriate for him to
6 simply put a drain on the existing pigtail and send
7 the patient to the recovery room.

8 A. I personally would not have -- would not
9 recommend that. One could argue that the pressure
10 would begin to respond, normalize and one could
11 consider that option. But I don't think that would
12 have been successful because we evidence of a large
13 blood clot forming in the sac. Those generally have
14 to be evacuated because the clot itself is applying
15 pressure on the chambers of the heart, impeding the
16 filling of the heart.

17 We see this -- the most frequent situation we
18 see this scenario in is after open-heart surgeries
19 and for most surgeons -- I don't know the exact
20 figures but I'd say 10 to 20 percent of the time
21 these patients have to go back to the operating room
22 to have bleeding looked at in the pericardium
23 because they get into the same problem.

24 And when these patients become hemodynamically
25 stable in the surgical recovery area that's very

1 common. They'll take them into the OR and
2 evacuating that clot promptly stabilizes the patient
3 hemodynamically.

4 So I personally would -- don't think going to
5 the ICU with a -- that catheter to drainage bag, I
6 don't think that would have been the appropriate
7 action. It would not have evacuated that clot. It
8 was too big.

9 Q. Dr. Foster, based on all of the evidence that's
10 been before you in this case is it your -- still
11 your opinion that Dr. Mori complied with generally
12 accepted standards of care in the treatment he
13 rendered?

14 A. Yes, it is. That is my opinion.

15 Q. And is that your opinion to a reasonable degree
16 of medical certainty?

17 A. Yes, it is.

18 MR. BEIGHLEY: Thank you.

19 THE COURT: Mr. McGowan, your witness.

20 MR. MCGOWAN: Thank you, Your Honor.

21 CROSS-EXAMINATION

22 BY MR. MCGOWAN:

23 Q. Dr. Foster, tell me what your charges are in
24 this case.

25 A. \$500 per hour for reviewing records; \$750 an

1 hour for reviewing testimony.

2 Q. So would you prefer I go slow or go fast?

3 Either way?

4 All right. The echos in this case are useful

5 for not only what they show but when they show it.

6 Would you agree?

7 A. Certainly useful for what they show. I don't

8 know, you know, that there's an exact correlation

9 between this time frame here and the echo machine.

10 I think earlier you established there may have been

11 a six-minute lag.

12 Q. Actually can you please answer my question?

13 They're important for what they show, right?

14 A. Probably.

15 Q. And there's no question there was blood and

16 there was a clot in this man's chest, right?

17 A. Yes.

18 Q. That's undisputed, right?

19 A. Undisputed.

20 Q. You understand that Dr. Mori started talking

21 about these echos yesterday to tell the jury that

22 that clot or that blood had been there before the

23 sheath was put in? You understand that?

24 A. I was not present yesterday but --

25 Q. Well, I can tell you --

- 1 A. -- I'll take your word for it.
- 2 Q. And in fact, Dr. Story -- there he is -- did
- 3 the same thing, right?
- 4 A. (No response.)
- 5 Q. Tried to show that blood was there before the
- 6 sheath was put in, right?
- 7 A. I would agree with that.
- 8 Q. So in this case what's really important about
- 9 the echos is not what they show -- because we agree
- 10 they show blood, right?
- 11 A. We do, yes.
- 12 Q. What's important here is when they show it.
- 13 Yes?
- 14 A. (No response.)
- 15 Q. That's the only reason we're talking about it?
- 16 A. Medically I don't know if it's important we all
- 17 agree there's a clot. Maybe in a legal sense. I'm
- 18 not a legal expert so...
- 19 Q. Well, these echo machines -- and this is for
- 20 people that are in this line of work --
- 21 cardiologists that do invasive procedures. The use
- 22 of the echo machine is very common during some
- 23 procedures?
- 24 A. Yes.
- 25 Q. And in fact, there's an echo tech whose job it

1 is to run this machine, right?

2 A. Yes.

3 Q. And this machine comes in on a little cart and
4 it's got its own separate terminal and its own
5 operator, right?

6 A. Yes.

7 Q. It is an independent machine from any other
8 machine in the room?

9 A. Yes.

10 Q. In the cath lab there's a person who is behind
11 the glass or in a separate area whose job is to make
12 that timeline that we see as Exhibit Number 4,
13 correct?

14 A. Certainly that's the case in our cath lab. I
15 assume that's the case in this cath lab too.

16 Q. Commonly done?

17 A. Commonly done, yes.

18 Q. There is no connection between the echo machine
19 and the cath lab computer that's making the cath lab
20 timeline?

21 A. I'd say they're separate timing mechanisms,
22 yes.

23 Q. Separate timing? And it is extremely well
24 known to cardiologists in the field that if you're
25 going to use your echo for a timing standpoint you

1 got to make sure your echo times synchronize with
2 your cath lab times, right?

3 A. I've never used an echo for a timing
4 standpoint. I use an echo to look at structures. I
5 don't use an echo to tell time.

6 Q. Well, in this case the echo is trying to be
7 used to show the timing of the blood. You
8 understand that?

9 A. In the legal sense, yes.

10 Q. Okay.

11 A. But not in the medical sense.

12 Q. Okay.

13 A. That's the point I'm making.

14 Q. In order to do that fairly we have to
15 synchronize the clot on the echo with the clot in
16 the cath lab. If we're going to compare when it
17 happened relative to what we've got to get those on
18 the same time, right?

19 A. If you're using that for a legal argument,
20 which I was not, but if you are then I would say
21 that would be important.

22 Q. Yes. In fact, to be fair and to be truthful
23 about what you're doing, if you're going to say X
24 happened before Y, you got to make sure we're all
25 using the same clock, right?

1 A. I think in a legal sense, yes.

2 Q. No. In any sense.

3 A. Well, I'm not the one making that argument.

4 You're asking me to analyze Dr. Mori's testimony,

5 which I did not witness, and you're asking me to

6 analyze Dr. Story's testimony. That's their

7 argument. It wasn't mine.

8 Q. Fair enough.

9 A. What I said was, the time course from the

10 hemodynamic standpoint makes no sense, other than a

11 needle stick.

12 Q. Now, the echo tech wheels in the machine. How

13 long does it take fairly to get that thing set up

14 and ready to go? A minute? Two minutes?

15 A. Longer. Our machines, seems like an eternity

16 sometimes.

17 Q. How about --

18 A. It depends on the age of the machine. I would

19 say two to five minutes.

20 Q. Let's go with two. So two minutes would be the

21 low side of fair?

22 A. Well, I personally did a case last week with

23 tamponade and it took over five minutes for the

24 machine to warm up so --

25 Q. Well, we can use two to five.

1 A. That's what I said, two to five.

2 Q. Okay. So in this case would you agree with me
3 that the echo cannot be produced until the tech
4 arrives?

5 A. Well, I can do an echocardiogram myself and I
6 have but --

7 Q. Is there any evidence --

8 A. I would disagree with that answer, that in the
9 real world most of the time the echo doesn't get
10 done until the echo -- the machine is there
11 obviously with the technician.

12 Q. And then one or two minutes -- two to five
13 minutes to get them set up and ready to roll?

14 A. I think so.

15 Q. Okay. So in this particular case what we know,
16 do we not, is that based upon Exhibit Number 4 in
17 that book -- I want you to read along for me -- we
18 know that the echo tech is having noted as arriving
19 at 10:42. Is that true?

20 A. I'm looking at Exhibit 4, a picture of a heart.

21 Q. Yes, sir. It's actually one of those pages in
22 there. It's page 9 of 15 in that particular
23 exhibit, Doctor.

24 A. Okay. I'm on page 9 of 15.

25 Q. You see 10:42?

1 A. Echo tech arrived to case, I do.

2 Q. So the first time an echo could be taken as a
3 practical matter is going to be 10:42 to 10:45?
4 Let's just say 10:42. That's the soonest you expect
5 it, right?

6 A. That's making the assumption that this entry at
7 10:40 that the echo tech arrives is correct. It may
8 be; it may not be. I've seen --

9 Q. That's all we've got.

10 A. I've seen many incorrectly entered data in
11 these logs. They're not the gospel.

12 Q. It's all we've got.

13 A. For the sake of your argument, that's what it
14 says.

15 Q. Okay. And we know that the first echo -- Echo
16 Number 1 was at 10:34. You know that because you've
17 seen the echos, right? It's right up here if you
18 want to see it. You see it? 10:34, Echo Number 1.

19 A. Okay.

20 Q. So if we were to synchronize our watches, echo
21 time 10:34 fairly would echo cath time 10:42.

22 A. Okay.

23 Q. Fair?

24 A. Okay. Without argument, yes.

25 Q. An eight-minute difference? 10:34 minus 10:42

1 is eight minutes, right?

2 A. That's -- you're adding the two minutes to turn
3 on the machine?

4 Q. Yes, sir.

5 A. Okay.

6 Q. The first echo you saw indication of blood or
7 consolidating blood, clotting blood was Echo Number
8 12; isn't that correct?

9 A. (No response.)

10 Q. Is that correct, Doctor?

11 A. I think that's correct.

12 Q. Okay. This is Echo Number 12. That one is
13 time packed at 10:53:31, right?

14 A. I can't see this far away but I'll take your
15 word for it.

16 Q. If we adjust echo time to cath lab timeline
17 time, we have to add eight minutes, right?

18 A. I understand.

19 Q. Yes? So that takes us to, what, 11:01:30,
20 right?

21 A. (No response.)

22 Q. If our watches are synchronized? The sheath is
23 noted as having gone in at what time?

24 A. (No response.)

25 Q. It's on the other page, Doctor. It's right

1 down here.

2 MR. BEIGHLEY: I would object to the question
3 to the extent it's noted as going in. It notes
4 there's a sheath there.

5 THE COURT: All right. Rephrase -- rephrase
6 your question, Mr. McGowan.

7 BY MR. MCGOWAN:

8 Q. The record shows a long sheath at 11:00:14,
9 right?

10 A. Says a long sheath. It does not say it was
11 inserted.

12 Q. Now, you understand that Dr. Mori has agreed
13 that that's when it was put in?

14 A. Okay. I wasn't there for his testimony but...

15 Q. All right. Well, if it was put in at that time
16 -- let's assume for the purpose of my question that
17 this says 11:00:14 is when it was put in. Okay?

18 A. So this is a hypothetical.

19 Q. Well, that ultrasound or the echo which first
20 showed the blood synchronized to cath lab time was
21 at 11:01:30, a minute and 15 seconds later, right?

22 A. I agree with your math, yes.

23 Q. So if we synchronize cath lab to echo time,
24 what was before is now after, isn't it?

25 A. Here's the problem with that argument --

1 Q. Please answer the question first and then you
2 can tell me about all my problems.

3 A. Okay. What's the question?

4 Q. The question is, if we synchronize cath lab
5 timeline time to echo time, we add that eight
6 minutes to account for the synchronization, that
7 means that this Echo Number 12, which first showed
8 blood, was actually after the sheath was noted;
9 isn't that true?

10 A. If one accepts all of your hypotheticals, that
11 -- you are correct. But I'm not saying I accept all
12 your hypotheticals.

13 Q. It would be a big problem if you did, wouldn't
14 it?

15 MR. BEIGHLEY: Object to the form, Your Honor.

16 THE COURT: Sustained.

17 THE WITNESS: It's not a problem with me, Your
18 Honor.

19 BY MR. MCGOWAN:

20 Q. Now, doctors in this line of work like Dr. Mori
21 and Dr. Story know that in order to make timing
22 meaningful you have to synchronize the times;
23 otherwise, your clocks just may be off, right?

24 A. I would suspect they know that.

25 Q. Do you know why in their testimony -- and I'll

1 tell you there's testimony there's been no effort to
2 synchronize times until right now.

3 A. (No response.)

4 Q. And you saw Dr. Story. He didn't try to
5 synchronize the times, did he?

6 A. It didn't appear to me.

7 Q. So if a cardiologist knows that in order for
8 this timing to be meaningful, do you know why --
9 knows that in order for the timing to be meaningful
10 you have to synchronize the clocks. Do you know why
11 Dr. Story and Dr. Mori would have not synchronized
12 the timing when talking about these echos before
13 today?

14 A. Well, I think --

15 MR. BEIGHLEY: I'll object to the --

16 THE COURT: All right. Mr. Bailiff, would you
17 take our jury to the jury room please?

18 (The jury panel exits the courtroom.)

19 THE COURT: Okay. Mr. Beighley?

20 MR. BEIGHLEY: Your Honor, I would object to
21 the question. He's asking this witness why my
22 client and another witness wouldn't have
23 synchronized clocks. Number one, he doesn't know
24 what they did or didn't do or what was their state
25 of mind. Number two, there's no evidence here about

1 any clocks being synchronized or unsynchronized.

2 There's been two different times pointed out
3 and then speculation on top of that, so I think that
4 question's clearly improper. There's no evidence
5 that there was some requirement for synchronization
6 and certainly not what my client is doing or another
7 witness was doing in that regard.

8 THE COURT: All right. Mr. McGowan, I think
9 you would have to lay some foundation. You would
10 have to have from the witness some indication that
11 he was aware of what the defendant did or intended
12 to do before you could ask that question.

13 MR. MCGOWAN: Fair enough.

14 THE COURT: So I'll sustain the objection.

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

16 THE COURT: Mr. Bailiff?

17 (The jury panel enters the courtroom.)

18 BY MR. MCGOWAN:

19 Q. Doctor, I'll try a new question. The upshot to
20 all this is if you synchronize the clocks between
21 the echo and the cath timeline, this echo is
22 actually a minute and change after the sheath; isn't
23 that true?

24 A. That would be true by your math, yes.

25 Q. Now, is it true also that if you put a sheath

1 in properly, protect the end of it with the wire the
2 way you're supposed to, that this -- that you put it
3 in properly you should never cause an injury to the
4 patient's heart with the sheath if you do it right?

5 A. What did I say earlier?

6 Q. You got to work pretty hard to injure
7 somebody's heart if you are following all the
8 standard procedures with a sheath and a dilator;
9 isn't that true?

10 A. I've seen dilators injure structures before but
11 I think the risk is minimal. These are relatively
12 soft, relatively atraumatic but not complete.

13 Q. And if you do it right, you advance it over the
14 guide wire which is this floppy wire -- this floppy
15 wire helps to protect the open end of this dilator,
16 right?

17 A. That's right.

18 Q. And if you do that properly you're not going to
19 -- you're going to keep the wire where it needs to
20 be as you're inserting the sheath and the dilator,
21 you're not going to expose the sharp type of the end
22 of the dilator, right?

23 A. That's right.

24 Q. And it makes it extremely unlikely to cause
25 injury when you're putting in a sheath and a dilator

1 in the proper manner?

2 A. Makes it unlikely but not impossible, and that
3 dilator can scrape structures or rub structures as
4 it goes by.

5 Q. Do you agree that putting the sheath in
6 properly it's not going to injure the patient?

7 A. I disagree with that statement.

8 Q. All right. Are you aware of Dr. Mori's
9 testimony yesterday?

10 A. No.

11 Q. Would you agree that if you put the needle in
12 properly, if you follow the proper techniques, you
13 should not injure the heart?

14 A. I would not agree with that.

15 Q. And are you aware of Dr. Mori's testimony
16 yesterday on that very question?

17 A. Only the allusions you made to Dr. Story, but I
18 was not present for his testimony and I've not read
19 the transcript. And I'm also not aware of the
20 context of the questions. I know that you-all are
21 very good at getting physicians to say things they
22 don't want to say.

23 Q. Hold on. Are you saying that I am capable of
24 manipulating a cardiologist in the field of
25 medicine?

1 A. I think cardiologists who sit in this position
2 are a fish out of water, just like you might be a
3 fish out of water if you were suddenly sat in a
4 pilot's seat of an airliner with no engines that
5 somebody was flying, or if you got put in a cath lab
6 you would be a fish out of water. I think a
7 cardiologist is typically a fish out of water in a
8 courtroom.

9 Q. So do they --

10 A. Probably misstate -- now, maybe he meant to say
11 that. I don't know if he did. I would disagree
12 with that statement.

13 MR. MCGOWAN: Okay. Thank you, Doctor.

14 THE COURT: Any redirect?

15 REDIRECT EXAMINATION

16 BY MR. BEIGHLEY:

17 Q. In -- just have a couple questions. Do you
18 know the cath lab recordkeeping is coordinated? You
19 ever been in that cath lab?

20 A. I never have.

21 Q. And how would you compare with images that the
22 machine is printing the time on when they're taken?
23 Do you know how that coordinates?

24 A. There are two -- those would be two separate
25 time pieces.

1 Q. Would it be speculation in your opinion to try
2 to do that?

3 A. I think that's -- as I said to him, I think
4 some of that is speculative. Yes.

5 Q. All right, sir. And if -- if there was this
6 time gap, and as I heard his question that if you
7 take his math and you disregard a time on an image
8 or if you add one to the other, assume one's right
9 and one's wrong, that the clot has formed and is
10 demonstrated in a minute and a half after the sheath
11 is inserted, in your opinion would it be likely that
12 a clot could have formed in a minute and a half
13 after the sheath was inserted?

14 A. Extremely un -- almost impossible. The reason
15 for that is that image that we looked at that
16 occurred -- if we accept that time frame -- that
17 time course -- that image we looked at is not blood
18 in the pericardium. It's clot.

19 Q. Yes, sir.

20 A. So once blood gets into the pericardium there
21 is a time delay before it can become clot. We
22 measure clotting times in medicine all the time.
23 Surgeons often measure clotting times before they do
24 surgery. A very fast clotting time can be three to
25 five minutes.

1 This is a patient who has been on Warfarin or
2 Coumadin for years and would probably have a delayed
3 clotting time. So even if we took those -- that
4 time resynchronization as correct, medically it's
5 impossible for that clot of that size to form in a
6 minute and a half. It cannot happen. It's
7 impossible.

8 MR. BEIGHLEY: Thank you, Doctor.

9 RE CROSS-EXAMINATION

10 BY MR. MCGOWAN:

11 Q. The echo made immediately before that one at
12 10:53 was at 10:50, right?

13 A. I don't know.

14 Q. Did you see it?

15 A. I can't see it from here.

16 Q. Was the 10:53 -- Echo Number 12, the one at
17 10:53 the first one you saw blood in?

18 A. When you say blood, I'm saying thrombus.

19 Q. Well, you said it was an intermediate --

20 A. Blood would be black. Okay? The inside of the
21 heart is black. It's full of blood. It's black.
22 Okay? Pericardial effusion is black because it's
23 liquid. So looking at a pericardial effusion you
24 can't tell the difference between blood and clear,
25 straw-colored fluid. They look the same by

1 ultrasound.

2 When we see that structure forming, that
3 intermediate appearance, that's clot. That means
4 there's proteins and it's forming an organized mass.

5 Q. And the one at 10:53 is the first one that you
6 saw evidence of clot?

7 A. That was the one I was asked to look at. I'd
8 have to go back through all of them to know if
9 that's the very first time.

10 MR. MCGOWAN: Okay. Fair enough. Thanks.

11 THE COURT: Anything further from this witness?

12 MR. BEIGHLEY: None, Your Honor. We ask he be
13 excused.

14 THE COURT: Any objection?

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

16 THE COURT: Thank you, Doctor. You're excused.

17 MR. BEIGHLEY: Nothing further from the
18 defense, Your Honor.

19 THE COURT: Any reply testimony from the
20 plaintiff?

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

22 THE COURT: All right. Mr. Bailiff, would you
23 take our jury to the jury room just for a moment and
24 then I'm going to bring them right back in?

25 (The jury panel exits the courtroom.)

1 THE COURT: All right. Gentlemen, it appears
2 that we are -- it's almost one o'clock and I know we
3 discussed this in chambers yesterday about timing.
4 They haven't had lunch ordered for them. I mean, we
5 -- they weren't in deliberation so the clerk
6 wouldn't have had any way of doing that. So if I
7 let them take lunch, we're looking at 2:00, 2:15 is
8 the earliest that we could start back.

9 Based on my conversations with counsel
10 yesterday, I'm not certain that that would give us
11 enough time to get this to the jury by four o'clock,
12 and that's sort of my -- I have sent cases out later
13 than that but that's not something I like to do,
14 especially with a case with as many records and
15 things that have been admitted into evidence as each
16 side has admitted in this case.

17 So I want to hear from counsel. My impression
18 is for us to just send them home and do closing and
19 charge tomorrow. Is there any objection to that?

20 MR. MCGOWAN: No, sir. I'd rather go home and
21 do my homework before, to be honest.

22 THE COURT: And Mr. Beighley?

23 MR. BEIGHLEY: No objection, Your Honor.

24 THE COURT: Okay. I think that would -- that
25 would allow them to decide this case when they're

1 rested rather than after 5:00 and after hours
2 tonight, so that's what we'll do.

3 Mr. Bailiff, if you'll get our jury.

4 (The jury panel enters the courtroom.)

5 THE COURT: Now, ladies and gentlemen of the
6 jury, the testimony has concluded in the case. Each
7 side has rested. Now, that brings us to a point in
8 the trial where what we have left to do are what are
9 called closing arguments and then me charging you on
10 the law. These are lengthy things that take a
11 significant amount of time.

12 We haven't -- it's almost one o'clock. You
13 haven't been to lunch yet. I'm looking at the
14 calendar. We have the rest of the week. Looking to
15 the clock and speaking with the attorneys I'm going
16 to let you go for the day.

17 Because if I send you to lunch and bring you
18 back we're really not going to have time to finish
19 what we need to finish without you getting the case
20 late in the evening and I don't -- I want to be as
21 little invasive into your personal time as I -- not
22 anymore than I need to be and I realize anything
23 after 5:00 really puts a hardship on a lot of
24 people.

25 So I'm going to let you go for the day. We'll

1 reconvene and conclude the case tomorrow at 9:30.

2 So be in the jury room shortly before 9:30.

3 Now, remember my instructions: no third-party
4 discussions, no independent investigation and no
5 deliberation amongst yourselves. I hope everyone
6 has a good evening.

7 (The jury panel exits the courtroom.)

8 THE COURT: Gentlemen, we will -- we'll convene
9 shortly before 9:30 and just have a conference on
10 the charges and the verdict form. My clerk and I
11 are going to work on that this afternoon and I'll
12 get with y'all in the morning on that. We'll go
13 into recess.

14 (Court was adjourned for the day.)

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THE BAILIFF: All rise.

THE COURT: Thank you. Thank you. You can be seated please. All right. Gentlemen, before we bring the jury in for closing arguments are there any motions or any matters we need to take up?

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

MR. BEIGHLEY: Your Honor, the defendant would renew the verdict for directed verdict in favor of the defendants on the grounds that the evidence taken in its entirety in a light most favorable to the plaintiff failed to show that the defendants fell below generally accepted standards of care which was the proximate cause of the deceased's death.

Secondarily, we would renew our motion for a directed verdict on allegations of the punitive damages on the grounds that the evidence before the Court in a light most favorable to the plaintiff fails to show evidence of willful, reckless, grossly negligent or wanton conduct to a level of clear and convincing evidence.

Additionally, we would move to strike the allegation of the misrepresentation of the complaint

1 on the grounds that there is no evidence in a light
2 most favorable to the plaintiff which would support
3 a claim that the defendants misrepresented -- made
4 misrepresentations in reference to the claim.

5 The allegations are the medical records at the
6 time were incomplete but there's no allegation that
7 there was any false, fraudulent or alteration of the
8 medical records. And as a matter of law
9 incompleteness of a medical records can't constitute
10 a misrepresentation.

11 Thank you, Your Honor.

12 THE COURT: Okay. Mr. Beighley, I've reviewed
13 the records. I find there is sufficient evidence
14 when considering that in the light most favorable to
15 the plaintiff to deny your motions, but they are
16 noted for the record.

17 MR. BEIGHLEY: Is it possible to indulge me for
18 just three minutes to run down the hall before we
19 bring in the jury?

20 THE COURT: That's -- yes, sir.

21 MR. BEIGHLEY: I'll be right back.

22 THE COURT: Yes, sir.

23 MR. BEIGHLEY: Your Honor, if I could mention
24 one other thing. I don't want to have to object to
25 counsel's argument, but I would inquire if counsel

1 is planning to display excerpts of Dr. Mori's trial
2 testimony during his closing argument I would like
3 have my objection on the record and you rule on that
4 so I don't have to interrupt. Mr. McGowan may not
5 plan to do that but I don't want to jump up during
6 the argument and interfere with his argument.

7 THE COURT: I ruled on that yesterday.

8 MR. BEIGHLEY: Yes, sir.

9 THE COURT: Mr. McGowan certainly is free to
10 refer to what was said in testimony, just as you
11 will be in your closing argument, but the actual
12 transcript will not be displayed.

13 MR. BEIGHLEY: I just hate to interrupt
14 somebody's --

15 THE COURT: Well -- and that -- I ruled on that
16 yesterday that the transcript would not be
17 displayed.

18 All right. Anything further? Mr. McGowan?

19 MR. MCGOWAN: Yes, sir. We would also elect to
20 move forward on the wrongful death claim and not the
21 loss of consortium because we believe they're
22 duplicative in this case.

23 THE COURT: Okay. And that -- we will modify
24 the verdict form to remove the loss of consortium
25 claim accordingly.

1 All right. Mr. Bailiff, if you'll get our jury
2 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 PANEL: Good morning (in unison.)

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

14 JURY PANEL: (No response.)

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

18 Mr. McGowan?

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

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

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

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

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

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

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

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

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

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

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

25 And we know what the standard procedures are.

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

3 THE BAILIFF: Yes, sir.

4 (The jury panel enters the courtroom.)

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22 inserting a needle, you will not injure the heart.
23 If you follow the standard procedure for inserting a
24 sheath, you will not injure the heart.

25 And we know what the standard procedures are.

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

8 Particularly, one thing that -- remember the
9 game of Operation? I think that came out in like
10 1979 or something. But if you hook your arterial
11 clip to, which he said originally that he did, and
12 you're inserting this needle with pressure and you
13 feel that pop of the pericardium, you stop and you
14 pull your fluid back and see that it's in the right
15 spot. And that's what he said he did.

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

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

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

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22 -- you would have known that you were in contact
23 with heart tissue before you ever broke it up,
24 abraded it and lacerated it the way they did.

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

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

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

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

1 catheter.

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

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

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

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

25 So he never put in the medical records he made

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 sort of situation.

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

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

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

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

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

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

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

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

22 And in fact, we very well recognize that. In
23 1991 the South Carolina Department of Corrections
24 put to death Pee Wee Gaskins and he was convicted of
25 murdering another fellow on death row. We take it

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

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

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

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

1 below the standard of care, standards of medicine?

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

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

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

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

25 The third question is, what amount of actual

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 from the first day.

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

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

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

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

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

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

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

1 you another time. Thank you.

2 THE COURT: All right. Mr. Beighley?

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

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

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

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

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

1 first concern about bleeding.

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

6 What you will see -- and Dr. Mori testified to
7 this -- this patient's blood pressure dropped from
8 116 over 65 to 95 over 57; his oxygen dropped from
9 97 to 65; his heart rate went up from 60 to 82. And
10 that was noted at 10:44, shortly after the needle
11 went in. That was a concern. That made him worry.

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

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

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

1 evidence of bleeding.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 clot.

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

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

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

25 And did that -- did the catheter contact the

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

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

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

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

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

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

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

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

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

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

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

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

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

1 in the treatment of my condition. He acknowledges
2 it.

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

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

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

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

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

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

15 And even after¹ now the patient has passed away
16 Dr. Mori does his final note. I won't read the
17 whole thing to you. Plan was to perform left and
18 right heart cath; however, this could not be done
19 because of complications from the
20 pericardiocentesis. During pericardiocentesis
21 patient had expressed hemorrhagic pericardial fluid.
22 Likely consideration: At this time there's injury
23 to the myocardium as a result of the needle injuring
24 the myocardium.

25 How more direct and honest can you be? You put

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 THE COURT: Mr. McGowan?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (Sidebar discussion.)

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

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

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

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

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

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

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

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

1 that have been entered into evidence.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Just because another doctor may have used

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 reasonable compensation is left to your sound
2 discretion and judgment.

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

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

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

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

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

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

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

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

25 Recklessness is the knowing failure to exercise

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

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

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

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

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

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

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

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

1 probable but that it is highly probable.

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

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

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

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

1 properly awarded to the plaintiff.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (The jury panel exits the courtroom.)

6 THE COURT: Okay. Any exceptions from the
7 plaintiff?

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

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

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

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

20 MR. MCGOWAN: Yes, sir.

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

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

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

12 MR. MCGOWAN: Yes, sir.

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

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

18 THE COURT: That will be Number 3.

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

21 THE COURT: All right. Any exceptions?

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

1 plaintiff exists to support those jury charges.

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

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

10 (Discussion off the record.)

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

13 MR. BEIGHLEY: Form and exhibits going back.

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

19 THE BAILIFF: Yes, sir.

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

1 welcome to stay.

2 Just tell him where to go to get his lunch.

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

8 We'll now go into recess.

9 (Court is in recess.)

10 THE COURT: Let's go on the record.

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

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

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

21 MR. MCGOWAN: I agree with you, Judge.

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

24 (The jury panel enters the courtroom.)

25 THE COURT: Mr. Foreman, I have received your

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

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

8 (The jury panel exits the courtroom.)

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

10 (Court is in recess.)

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

14 Tell the bailiff to bring the jury in.

15 (The jury panel enters the courtroom.)

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

18 MR. FOREMAN: Yes, sir.

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

21 MR. FOREMAN: (Complies.)

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

24 THE CLERK: Yes, sir.

25 In the State of South Carolina, County of York,

1 Civil Action Number 2015-CP-46882, in the matter of
2 Lorrie Dibernardo, Individually and Personal
3 Representative of the Estate of Anthony Dibernardo
4 versus Carolina Cardiology Associates, PA and Naresh
5 Mori, MD. As to the allegations of wrongful death,
6 did Dr. Mori violate generally accepted standards of
7 medical care in his treatment of Mr. Dibernardo, the
8 answer to this is no. Signed this day September 15,
9 2016, Foreperson Kevin Cabrera.

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

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

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

17 MR. MCGOWAN: No, sir.

18 THE COURT: Anything from the defense?

19 MR. BEIGHLEY: No, Your Honor.

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

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

3 (The jury panel exits the courtroom.)

4 THE COURT: Okay. Anything further from the
5 plaintiff?

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

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

11 MR. MCGOWAN: Thank you.

12 THE COURT: We'll close the record.

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

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

16

17

18

19

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22

23

24

25

CERTIFICATE OF REPORTER

STATE OF SOUTH CAROLINA)

COUNTY OF YORK)

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

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

January 7, 2017

/S/ Dana New _____

Dana New

Official Court Reporter

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] years/Male

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

History and Physical Reports

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

History and Physical
Patient Name: DIBERNARDO, ANTHONY R
DOB: [REDACTED]
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

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

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

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

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

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

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

IMPRESSION:

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



Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000585

PMC 006

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MORRIS, [REDACTED] SHAH MD, J
K

History and Physical Reports

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

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

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

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

SHAH MD, J K

Consultation Reports

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

Consultation

Patient Name: DIBERNARDO, ANTHONY R
DOB: [REDACTED]
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF CONSULTATION: 7/22/2013

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000586

PMC 007

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

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

History and Physical Reports

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

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

History and Physical
Patient Name: DIBERNARDO, ANTHONY R
DOB: [REDACTED]
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

AGE: 50

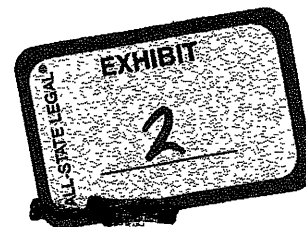
CARDIOLOGIST: J. K. Shah, M.D.

PROBLEM LIST:

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

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

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



Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation
Chart Request ID: 16959967 3 of 172 Print Date/Time: 02/24/2014 09:46:04 CST
Printed By: Larsen, Susan

Appendix 000587

PMC 003

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MORI [REDACTED] SHAH MD, J
K

History and Physical Reports

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

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

ALLERGIES: He has no known drug allergies.

PAST SURGICAL HISTORY: Unremarkable.

FAMILY HISTORY: Unremarkable.

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

REVIEW OF SYSTEMS: Per HPI.

PHYSICAL EXAMINATION:

VITAL SIGNS: BP 118/68, pulse is 78.

GENERAL: This is a diminutive statured white male, appears to be in no acute distress.

HEENT: Normocephalic. There is significant exophthalmus noted. Oropharynx is clear.

NECK: Supple without bruits.

CARDIOVASCULAR: He has an irregularly irregular rate with an audible systolic murmur.

LUNGS: Clear.

ABDOMEN: Markedly distended with positive shifting dullness to percussion.

EXTREMITIES: Have 1-2+ pitting edema bilaterally.

LABORATORY DATA: All labs are currently pending. Most recent labs from 6/17 showed a hemoglobin of 8.9 with a hematocrit of 28.3, MCV of 66.4, MCH 20.9. The sodium at that time was 133 and the potassium was 6.7, BUN was 94 and creatinine is 3.1. EKG has not yet been performed.

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

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

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

History and Physical Reports

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

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

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

BOULWARE PA, RICHARD B

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

MORI MD, NARESH A

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000589

PMC 005

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MOR [REDACTED] SHAH MD, J
K

EKG/Rhythm

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



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

Cath Lab

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

Cardiac Catheterization Report
Patient Name: DIBERNARDO, ANTHONY R
DOB: [REDACTED]
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

PROCEDURES PERFORMED:

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

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

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

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000590

PMC 0043

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] /Male

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

Cath Lab

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

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

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

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

MORI MD, NARESH A

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference: c = corrected, i = interpretation

Chart Request ID: 16959967

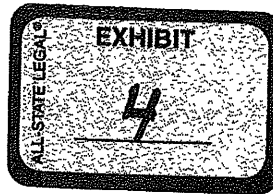
44 of 172

Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000591

PMC 0044



Piedmont Medical Center



CARDIAC CATH - POST-PROCEDURE NOTE

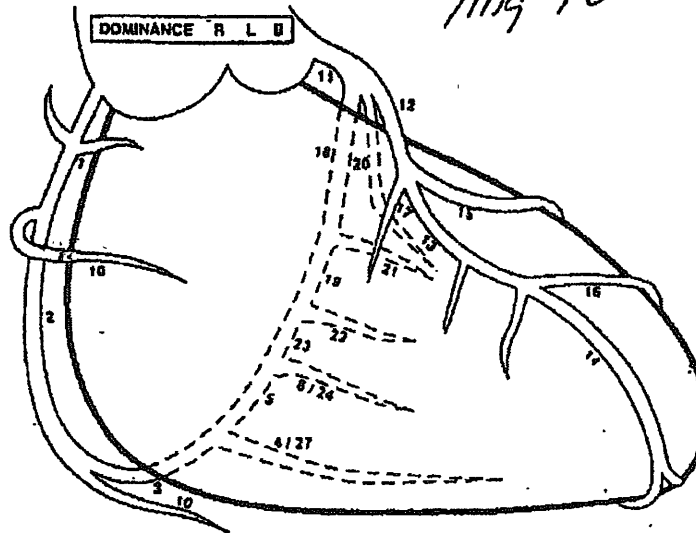
Physician: N. Mori

Pre-Procedure Diagnosis: _____

Post-Procedure Diagnosis: _____

Right Coronary Artery

1. Prox RCA
2. Mid RCA
3. Dist RCA
4. RPOA
5. RPLS
6. 1st RPL
10. AC Marg.



Left Coronary Artery

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

Access

RFA 6 Fr
LFA 5 Fr
RFV 4 Fr
LFV Fr
Rt. Radial Art. Fr
Lt. Radial Art. Fr

Rhythm: A FIB HR 90 EF _____

LHC Aorta 1 Mean _____
LV _____ LVEDP _____

RHC RA _____ A _____ V _____
RV _____ RVEDP _____
PA _____ Mean _____
PCWP _____ A _____ V _____

O₂SAT IVC _____ RV _____ FA _____
SVC _____ PA _____ AO _____
RA _____ LV _____

ACT: _____ Sedation/Anesthesia: _____

PROCEDURE:

Pericardiocentesis done

Complications: _____

SPECIMEN: N/A

ESTIMATED BLOOD LOSS: ☐ minimal or ☐ _____ ml

FINDINGS/ PLAN:

pericardiocentesis done
① heart cath could not be done

Immediate post-procedure pt. condition: because of hemodynamic instability

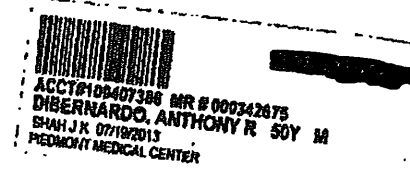
PHYSICIAN SIGNATURE: N. Mori Time: _____ Date: _____

PHYSICIAN NAME: (Printed) N. MORI T/22/13

DICTION # _____

Cardiac Cath-
Post-Procedure Note

4/3/2013 11:39:00 AM EZ-8502



Piedmont Medical Center



Cardiac Cath Lab Report

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

Staff

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

Cath Lab Assessment

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

OutPatient Assessment

System Assessment 1

System Assessment 2

Patient's Plan of Care

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

Patient Name: DIBERNARDO, ANTHONY
MRN: 000342675

Study Date: 7/22/2013
Admission ID: 100407386

Piedmont Medical Center



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

Patient's Plan of Care #2

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

Procedures

Time	Procedure	Code 1	Code 2	Code 3	Code 4	Comment
12:19 PM	Pericardiocentesis	4613010 0				
12:19 PM	QR - Art Access - R femoral artery*					

Patient Name: DIBERNARDO, ANTHONY
MRN: 000342675

Study Date: 7/22/2013
Admission ID: 100407386

Piedmont Medical Center



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

Radiology Summary

	Diagnostic	Interventional	Total
Fluoro Time (minutes)	6.3		6.3

Contrast

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

FFR

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

Complications

Time	Complication	Comment
12:19 PM	Emergency vascular surgery	

Pressures Used in Calculation (mmHg)

Baseline

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

Medication Events-M

Pre-Case - Arun Kundra

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

Other - Naresh Mori

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

Patient Name: DIBERNARDO, ANTHONY
MRN: 000342675

Study Date: 7/22/2013
Admission ID: 100407386

Piedmont Medical Center



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

Vital Signs

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

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

Intervention Summary

Conscious Sedation

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

Recovery Aldrete Score Pre Procedure Pulses

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

Post Procedure Pulses Transfer/Discharge Form Event Log

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

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

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

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

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

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

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Supplies Summary

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

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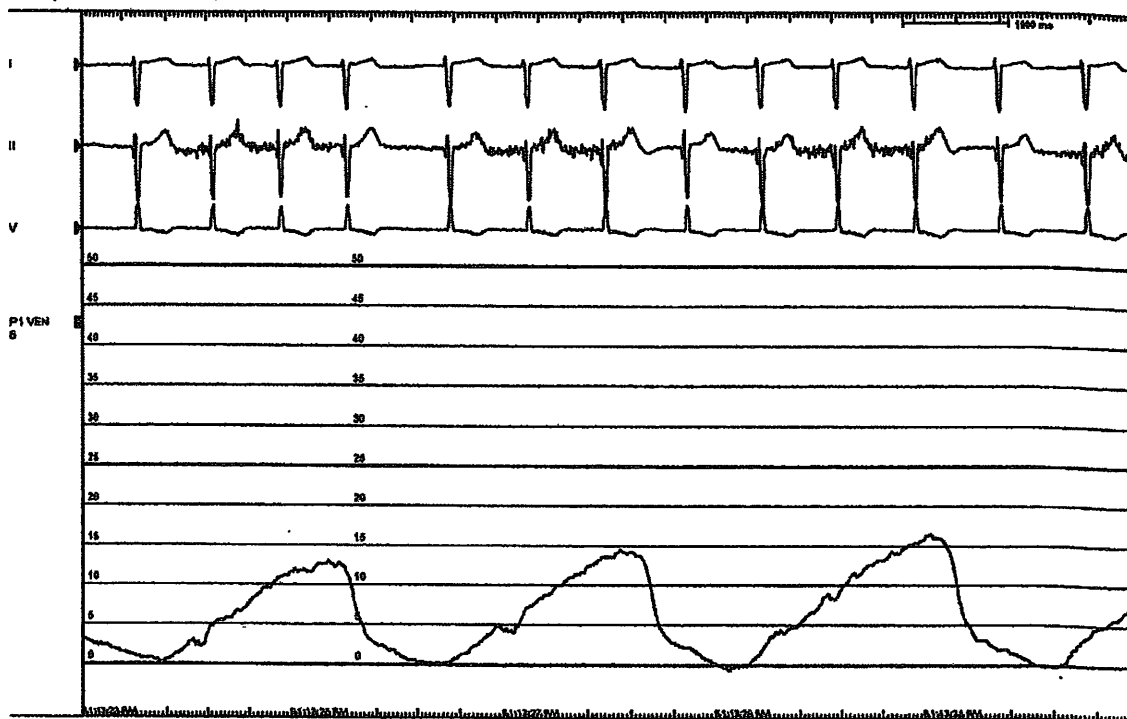
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Snapshots

Snapshot: VEN : 6, HR = 80



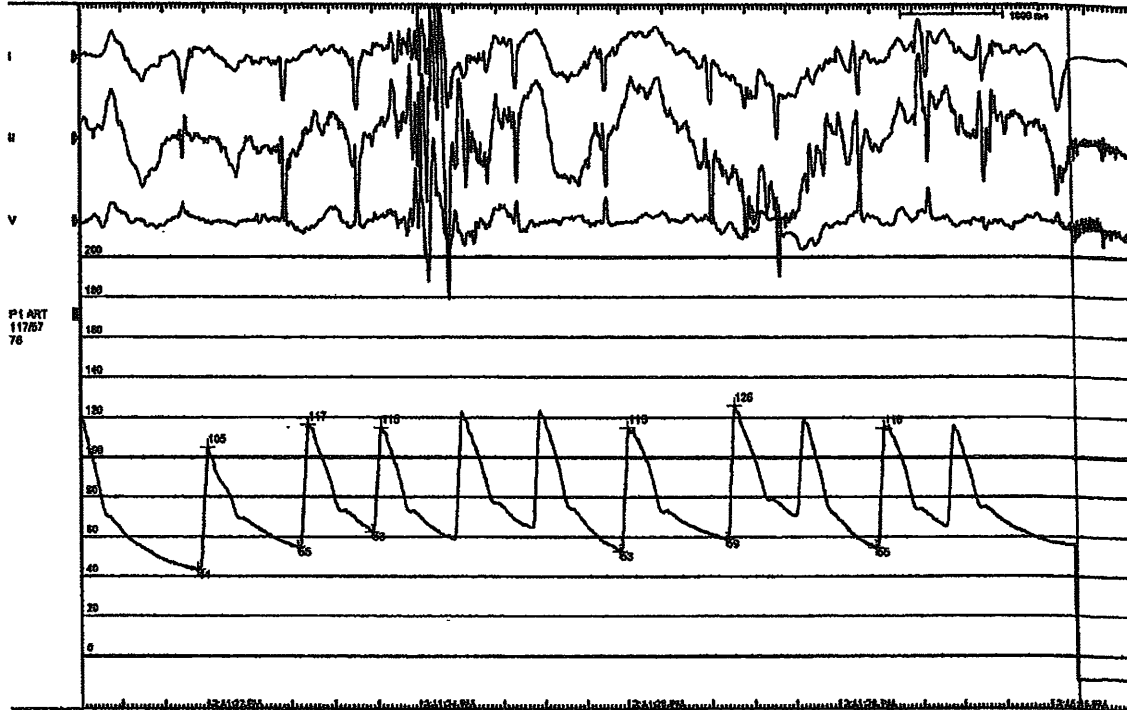
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Snapshot: ART : 117/57/76



Contrast Form # 1

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

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TENET
South Carolina

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Appendix 000607

PMC 00608

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MORI [REDACTED] SHAH MD, J
K

Physician Progress Notes

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

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

WOOTEN MD, SALLY M



Operative/Procedure Reports

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

Procedure Note
Patient Name: DIBERNARDO, ANTHONY R
DOB: [REDACTED]
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF PROCEDURE: 7/22/2013

PREOPERATIVE DIAGNOSES: Cardiac tamponade status post pericardial drainage.

POSTOPERATIVE DIAGNOSES: Cardiac tamponade status post pericardial drainage.

PROCEDURE: Emergency subxiphoid pericardial window.

SURGEON: David Savage, M.D.

ASSISTANT: Judy Carlton.

ANESTHESIA: General by Dr. Richter.

BIOPSY: Pericardial tissue to pathology.

COMPLICATIONS: None.

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000608

PMC 0033

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MORI [REDACTED] SHAH MD, J
K

Operative/Procedure Reports

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

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

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

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

SAVAGE MD, DAVID H

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000609

PMC 0034

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MORI [REDACTED] SHAH MD, J
K

Operative/Procedure Reports

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

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000610

PMC 0035

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MOR [REDACTED] SHAH MD, J
K

Consultation Reports

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

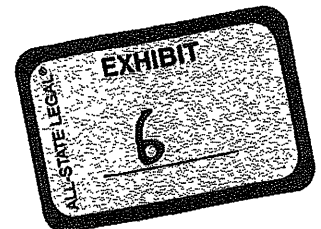
REFERRING PHYSICIAN: David Savage, M.D.

REASON FOR CONSULTATION: Critical care management.

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

PAST MEDICAL HISTORY:

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



PAST SURGICAL HISTORY: Positive for the current pericardial window.

ALLERGIES: None.

FAMILY HISTORY: Noncontributory to the current illness.

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

REVIEW OF SYSTEMS: Unobtainable due to his condition.

PHYSICAL EXAMINATION:

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000611

PMC 008

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

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

Consultation Reports

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

RECOMMENDATIONS:

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

Critical care time has been 45 minutes.

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

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

WOOTEN MD, SALLY M

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000613

PMC 0010

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

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

Consultation Reports

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

VITAL SIGNS: His blood pressure is 102/49, pulse is 72, his O2 sats are 100%.

He is currently off of Levophed, on normal saline at 100 and Versed at 4 mg an hour. His current vent settings are assist control of 16, tidal volume 500, FiO2 of 50% and PEEP of 5.

HEENT: He has evidence for exophthalmos. Both of his sclerae are erythematous and appear to be dry. His pupils do react. He is orally intubated.

NECK: Thick neck. I do not appreciate any thyroidomegaly.

CHEST: His breath sounds are equal although diminished. There are a few rales, no rhonchi, no wheezing.

HEART: Slightly irregular. Heart sounds are distant. There is a systolic murmur.

ABDOMEN: Distended and rotund. There is evidence for ascites. I do not appreciate any hepatosplenomegaly.

EXTREMITIES: He has brawny changes bilaterally, left more so than right.

Left is more edematous than the right with 2+ pitting edema.

NEUROLOGIC: The patient is currently sedated, although he is moving extremities.

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

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

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

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000612

PMC 009

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

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

Consultation Reports

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

Consultation

Patient Name: DIBERNARDO, ANTHONY R
DOB: [REDACTED]
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF CONSULTATION: 7/19

TIME: 3:45 p.m.

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

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

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

PAST MEDICAL HISTORY:

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

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

SOCIAL HISTORY: No alcohol or tobacco.

FAMILY HISTORY: Denies family history of renal disease.



Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000614

PMC 0011

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

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

Consultation Reports

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

PHYSICAL EXAMINATION:

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

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

Thank you for asking us to see Mr. Dibernardo.

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

ERB MD, BRIAN C

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

12 of 172

Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000615

PMC 0012

Piedmont Medical Center



Progress Notes

DATE	NOTES
7/14/13	Critical Care - 2nd note
7/15/13	4141633
7/24/13	DEATH NOTE
7/15	Pt 3 pulse spent respiration No carotid pulse, pronounced deced @ 1745

PROGRESS NOTES

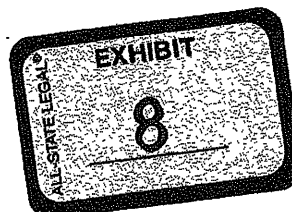
7/23/2013 8:09:00 AM

EZ-2050



07/19/2013

ACCT#: 100407386 MR#: 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J K DOB: [REDACTED]



Piedmont Medical Center



EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
7-24-13	(428) Resp Care notes AM. Hx on 14/470/15/40 -- 7-24/35/112/23/4/99.8
	Can
7/24/13	Sniff on ventilator Ausc. low grade hum (Sney vs 16) Stable vital good urine output. decreased output for 1 hr Echo: good LV LAF: 52-71(+) EKG
	M: 7/14 R: 35 CR: 1.2 BUN: 24 Mg: 1.5 gl: 98 Hb: 7.4/93 WBC: 11.2 Plate: 115.0
	kg: Improving
7/24/13	ABG on CPAP+5/PSt10 1030 40% as follows: on 7.59/PCO2 36.2/PO2 107/HCO3 22.3/BD-1/Sat 98% N. Winter called with results — J. Kye BRT
7/24/13	7.37/40.9/98 50% BiPAP 14/7

PROGRESS NOTES

7/25/2013 8:09:00 AM

EZ-2050



07/19/2013

ACCT#:100407386 MR#:000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH JK DOB

Piedmont Medical Center



EZ-2050 PRO NOT R2/04

Progress Notes

DATE	NOTES
July 23, 13 0443	AM ABH drawn with patient on AC 14/500/40/15. Results: pH 7.446 CO ₂ 32.4 PO ₂ 84 HCO ₃ 25.1 BE 2 SO ₂ 97%. — J. Bragdon, MD
7/23/13 1130	CCM for breathing trial today. Sp pericardial window SPO ₂ 116 870 T-tube: A+13 Sp pericardiocentesis is pericardial tamponade well follow. — J. Bragdon, MD
7/23/13 1220	Echo completed by Cori DeLeon, ROCs Catheterology Ph
7/23/13 4:50 PM	one dia PR parents. Expected procedure & complication, - prognosis guarded. NO N.M.W.R.I.

PROGRESS NOTES

7/27/2013 7:08:00 AM

EZ-2050



ACCT#108407386 MR # 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAN J K 07/19/2013
PIEDMONT MEDICAL CENTER

Piedmont Medical Center



Progress Notes

DATE	NOTES
7/13/13	ICU on call
0135	1) evaluated in crash cart 2) acute p/q cry failure 3) motor deficit 4) p/q pericardial drainage for pericardial tamponade 5) p/q Hgb: RUCB 37 mm Hg; LVEF 55-60% 6) central CRT v. noncardiogenic pulmonary edema 7) Noonan syndrome 8) acute oliguric renal failure 9) chills apix 10) acutely (acute) CE edema 11) Noonan's syndrome 12) full workup ordered: w/ CT 13) no/ consider echo 14) optimize (fully) pericardial (CUP) 15) ? need for echo by 7/18/13 also 16) present (note 7/18/13) 17) likely drug to convert to normal 18) renal echo for CUP (H) 19) R/L lab 20) y/hao plan 21) regimen ordered 22) CUP 16. ① blood counts ② blood ③ acutely / CE edema ④ chills 23) most remained w/ in L. Paced for CRT

PROGRESS NOTES

7/17/2013 7:08:00 AM

EZ-2050



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

Facility: PMC
FIN: 100407386

EZ-2050 PRO NOT R2/D

DATE	NOTES
7.22.13	Various Duplex complete.
16 ³⁶	1) Negative Dvs B/L Lower Extremities.
	PRELIMINARY FINDINGS Final Report to follow

1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

2. Next, it is important to gather relevant information and resources. This may include conducting research, consulting experts, or reviewing existing data.

3. Once the information is gathered, the next step is to analyze it and identify the key factors that influence the outcome. This often involves breaking down the problem into smaller, more manageable parts.

4. After analysis, a plan or strategy should be developed to address the problem. This plan should outline the steps to be taken and the resources needed to implement them.

5. The final step is to execute the plan and monitor the progress. This involves implementing the strategy and making adjustments as needed based on the results.

6. Finally, it is important to evaluate the outcome and determine if the problem has been successfully resolved. This may involve comparing the results to the original goals and objectives.

ACCT#:100407386 MR#:000342676
DIBERNARDO, ANTHONY R 60Y M
SHAH JK DOB

7/22/2013 3:08:05 PM EZ-2050

Piedmont Medical Center



Progress Notes

DATE	NOTES
7/2/13	Critical Care
1485	50 yo male - followup
	1) Acute Respiratory failure
	2) Pericardial Tamponade
	3) Noonan Syndrome
	4) Chronic atrial fibrillation
	5) Pulm HTN / RIGHT HEART failure
	6) Mild Hypoalbuminemia
	7) Anemia
	8) Ch. Anticoagulation
	Consent obtained
	4041274
	<i>[Signature]</i>
	<u>CNA</u>
7/13/13	on respiratory with very mild
	hyper-
HR: 60	cardiac MR - Rpt D 9-110 systolic
BP: 110/70	on respiratory to 500
CR: 1.2	

PROGRESS NOTES

7/22/2013 1:02:50 PM EZ-2050

07/19/2013
ACCT#: 100407386 MR#: 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH JK DOB: [REDACTED]

Progress Note - Printed

Piedmont Medical Center

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

DIBERNARDO, ANTHONY R RM: 2007, PMC - CT 58 Y (DOB: [REDACTED]) M ACCT#: 100407386
Attending: SHAH MD, J K Code Status: None Specified Reason for Admission: PERICARDIAL EFFUSION CHF
Service: 42 - IP - Telemetry MRN: 342675
Allergies: NKA
Diagnosis: No diagnoses recorded
Isolation: None Specified

Vitals	Temp	BP	Pulse	RR	SpO2	FIO2	Date	kg	lb	Recorded	Input	Output	Balance	
07/21 08:44	98.2	101/64	84	20	98	—	Current Wt	07/21	60.9	134	07/21 07:00-11:07	690	200	490
07/21 04:10	98.3	116/68	69	20	93	—	Previous Wt	07/21	60.9	134				
07/20 23:45	98.2	111/58	59	18	99	—	Admit Wt	07/19	62.6	138	07/20 7a - 3p	560	550	10
24 Hr Tmax: 98.4 at 07/20 16:19							BMI	07/21	26		3p - 11p	80	600	-520
48 Hr Tmax: 98.4 at 07/20 16:19											11p - 7a	50	400	-350
											24Hr Total	690	1550	-860

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

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

Reviewed Personally: ☐ Radiology ☐ Tele-findings ☐ Path ☐ PT note ☐ OT note ☐ ST note ☐ Other: _____
Case discussed with: _____ Time Spent: _____

SOAP Note

RR 20s Rate controlled A. fib.
8 complaints.
Still tense ascites. Edema.
Planned: L+R Hctn + Pericardio
contents in AM.
will ↑ Lungs to 15 m/h.
replace CP.

Active Inpatient Medications:

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

Active PRN Medications:

Al hydroxide/Mg hydroxide/simethicone (Mylanta (with simethicone) II Maximum Strength) 30mL
acetaminophen (Tylenol) 650mg = 2tab Oral Q4hr
alprazolam (Xanax) 0.25mg = 1tab Oral Q6hr
aspirin 300mg = 1suppos Rectal Daily
bisacodyl (Dulcolax Laxative) 10mg = 2tab Oral Daily
bisacodyl (Dulcolax Laxative) 10mg = 1suppos Rectal Daily
magnesium hydroxide (Milk of Magnesia) 30mL Oral Daily
morphine 2mg = 0.5mL Injection As Directed
nalbuphine (Nubain) 5mg = 0.5mL Injection Q4hr
nitroglycerin (Nitrostat) 0.4mg = 1tab Sublingual As Directed
sodium chloride (NS flush) 10mL Flush As Directed
zolpidem (Ambien) 5mg = 1tab Oral Q Bedtime
One Time Medications in the Past 36 hours:
Continuous Infusions:
furosemide 100 mg + Sodium Chloride 0.9% 100 mL 100mL IV 10 mL/hr ✓

Provider Signature

Pg 1

Staff #

Date/Time

(REPORT CONT)

Piedmont Medical Center



Progress Notes

DATE	NOTES
7/16/13	Reul: for CKD
6/15/13	Based on recent labs there seems no evidence of CKD (Scr x2 2.4mg creat, in N.I.O). With this and the fact that the patient is not a diabetic, there seems little/minimal risk of elevated ATN.
	Please contact us if we can assist further.
	Bill Peterson Nephrologist
	Ca ²⁺
	* Periodic elevation / S.C.R
7/12/13	* CM / 10.5
	* Curc on rxn
	* S.C.R
	* hypokalemia
	feels slightly better
	7/12 - med
	ca-will med on rxn
	Pr N med
	re at / 14 cardiac cath + Periodic cath.
	07/13 05 H.A.
	or. of med open-lab

PROGRESS NOTES

8/20/2013 1:05:00 AM

EZ-2050



ACCT8100407386 MRN # 000342675
DIBERNARDO, ANTHONY R 50Y M
SHAH J.K. 07/19/2013
PIEDMONT MEDICAL CENTER

Progress Note - Printed

Piedmont Medical Center

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

DIBERNARDO, ANTHONY R

RM: 2807, PMC - CT

58 Y (DOB: 01/11/55)

M

ACCT#: 100407386

Attending: SHAH MD, J K

Code Status: None Specified

Reason for Admission: PERICARDIAL EFFUSION CHF

Service: 42 - IP - Telemetry

MRN: 342675

Allergies: NKA

Diagnosis: No diagnoses recorded

Isolation: None Specified

Vitals	Temp	BP	Pulse	RR	SpO2	FIO2	Date	kg	lb	Recorded	Input	Output	Balance	
07/20 08:02	98.4	✓ 106/74	✓ 67	20	97	—	Current Wt	07/20	61.0	134	07/20 07:00-11:36	290	200	90
07/20 04:36	98.4	123/71	67	18	97	—	Previous Wt	07/20	61.0	134				
07/19 23:53	98.3	97/47	66	20	98	—	Admit Wt	07/19	62.6	138	07/19 7a - 3p	5.3333	0	5.3333
24 Hr Tmax: 98.4 at 07/20 08:02							BMI	07/20	26		3p - 11p	80	1025	-945
48 Hr Tmax: 98.4 at 07/20 08:02											11p - 7a	60	450	-390
											24Hr Total	145.3333	1475	-1329.6667

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

07/20 08:10				Pro-BNP	28200		Hgb	9.0	L	Creatinine Lvl	1.0	
PT	24.0	H		Total Protein	6.6		Hct	29.1	L	Glucose Level	183.0	H
INR	2.0			Albumin Lvl	3.3	L	MCV	69.7	L	BUN/Creat	30	H
Chol Trig Ratio	1			Alk Phos	104		Platelet Count	171		Osmolality Calc	272	L
Chol/HDL	5.0			ALT	✓ 11	L	D Dimer	744		AGAP	10.0	
Chol	90	L		AST	✓ 22		PT	79.6	H	CK Total	26	L
Trig Lvl	74			Bili Total	1.1		INR	6.3	C	GFR African Am	>60	
HDL	18	L		Globulin	3.3		PTT	>400.0	C	GFR Non African Am	>60	
LDL Calc	57			Bili Direct	0.3		Sodium Lvl	135.0		CKMB	0.84	
07/19 19:45				A/G Ratio	1.00	L	Potassium Lvl	3.20	L	Troponin I	0.033	
CK Total	30	L		Bili Indirect	0.8		Chloride Lvl	93	L	T4 Total	8.690	
CKMB	0.91			07/19 11:10			CO2	32.0		T3 Uptake	55.9	H
Troponin I	0.035	H		WBC	9.1		Calcium Lvl	8.90		Hgb Alc	5.7	
07/19 17:40				RBC	4.18	L	BUN	30	H			

Reviewed Personally: ☐ Radiology ☐ Tele-findings ☐ Path ☐ PT note ☐ OT note ☐ ST note ☐ Other:

Case discussed with:

Time Spent:

SOAP Note

Vitals stable. Rate controlled
on lasix @ 10 mg/hr drip.
A. fib.

Asymptomatic heart failure, pericardial
effusion. Cx A-fib.
Continue diuretics, P/L Heart cath &
pericardiocentesis Monday.
Keep Warfarin

Active Inpatient Medications:

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

Active PRN Medications:

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

Provider Signature

Staff #

Date/Time

7/20/13 11:55 AM

Pg 1

(REPORT CONT)

Piedmont Medical Center



Progress Notes

DATE	NOTES
7/19/13	Cardiology
4:30 PM	50 yr old → PM
	Admitted 2 weeks LE edema & abd distension. Dyspnea on exertion.
	Nocturnal syndrome (occasional to pt). diagnosed by pediatrician in Albany, NY
	BP 97/43 P 68 L
	JVD; chest - hr insp. crackles.
	only - S ₂ : irregular.
	No murmurs.
	Abd - distended; Ext 2+ edema
	Cx → cardiomegaly.
	Echo today
	RV & LV function mild LVN.
	Bicathal enlargement - severe.
	Mean gradient of 10 mm across MV, although MV appears normal with no 20% mitral stenosis.
	large pericardial effusion. No echo to tamponade.
	(INR 6.3) (H/H 9/29):
	K 3.2 BUN/Cr 30/1
	liver biopsy → S/S →
	predominantly ① heart
	① failure symptoms
	② LE edema; distended abd.
	③ INR

PROGRESS NOTES

Dissect

① heart can

to Rb constrictive physiology.

② pericardiocentesis.



ACCT#100407386 MR #006342675
DIBERNARDO, ANTHONY R 50Y M
SHAH JK 07/19/2013
PIEDMONT MEDICAL CENTER

N. MORI

Piedmont Medical Center



Progress Notes

DATE	NOTES
7-19-13	Renal 4/20/25 Initiated
3:45 P	(1) Hypokalemia sK 3.2
	(2) sCr 1.0 ✓ urinalysis
	(3) chronic A-fib
	(4) chronic pericardial effusion
	(5) hypothyroidism
	(6) Anemia
	(7) congenital heart dz with MV stenosis
	(8) Jima 17 th - sCr 3.1 ✓
	ERB

PROGRESS NOTES

6/30/2013 1:05:00 AM

EZ-2050



ACCT#100407386 MR #000342875
DIBERNARDO, ANTHONY R 50Y M
SHAN J K 07/19/2013
PIEDMONT MEDICAL CENTER

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MORRIS, J. SHAH MD, J
K

Physician Progress Notes

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

Progress Note

Patient Name: DIBERNARDO, ANTHONY R
DOB: [REDACTED]
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF SECOND PROGRESS NOTE: 7/24/2013

TIME: 5:30

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

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

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

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

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000628

PMC 0027

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MOR [REDACTED] SHAH MD, J
K

Physician Progress Notes

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

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

WOOTEN MD, SALLY M

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000629

PMC 0028

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MORRIS, [REDACTED], SHAH MD, J
K

Physician Progress Notes

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

Progress Note
Patient Name: DIBERNARDO, ANTHONY R
DOB: [REDACTED]
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF PROGRESS NOTE: 7/24/2013

PROBLEMS: Respiratory failure.

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

PHYSICAL EXAMINATION:

VITAL SIGNS: His current blood pressure is 117/54, pulse is 84. His O2 sat on the ventilator was 100%. His vent settings were assist control of 14, tidal volume 470, PEEP of 5 and FiO2 of 40%. His I's and O's; he had 5177 in, 1906 out.

HEENT: He has severe exophthalmus. He is orally intubated.

NECK: He has a webbed neck.

CHEST: His breath sounds are equal although diminished bilaterally. They are short and shallow.

HEART: Regular rhythm. He has S3, S4, systolic murmur.

ABDOMEN: Rotund, soft. Bowel sounds are positive.

EXTREMITIES: He has brawny changes.

NEUROLOGIC: He is moving all extremities.

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

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

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000630

PMC 0029

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MOK [REDACTED] SHAH MD, J
K

Physician Progress Notes

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

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

PLAN:

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

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

Critical care time has been greater than 40 minutes.

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

WOOTEN MD, SALLY M

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference, c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000631

PMC 0030

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MOR [REDACTED] SHAH MD, J
K

Physician Progress Notes

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

Progress Note

Patient Name: DIBERNARDO, ANTHONY R
DOB: [REDACTED]
ACCT: 100407386PMC
ADM: 07/19/2013
DIS:

DATE OF PROGRESS NOTE: 7/23/2013

PROBLEMS: Respiratory failure.

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

PHYSICAL EXAMINATION:

VITAL SIGNS: His current heart rate 79-82, temperature is 99.2, blood pressure currently is 123/57. His O2 sats 100%. His CVP pressure is 20. His I's and O's, he had 5022 in and 1015 out. His pericardial drain is approximately 10-20 mL per hour. His vent settings, he has assist control with FiO2 of 40%, rate is 14, tidal volume 500, PEEP is 5.

HEENT: He has severe exophthalmus. We do have his eyes patched. He is orally intubated.

NECK: Thick ____.

CHEST: His breath sounds are equal. He has got a pectus excavatum. He has rales in both bases. No wheezing.

HEART: Irregularly irregular.

ABDOMEN: Slightly distended, but soft, slightly tympanic. I don't appreciate bowel sounds.

EXTREMITIES: He has brawny changes bilaterally.

NEUROLOGIC: He is answering questions. He is moving his extremities.

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Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

Admission Date: 07/19/2013
Discharge Date: 07/24/2013
Attending Provider: MORRIS, PARESH K, SHAH MD, J
K

Physician Progress Notes

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

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

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

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

PLAN:

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

Critical care time has been greater than 40 minutes.

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000633

PMC 0032

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

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

Discharge Summary Reports

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

Discharge Summary

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

Patient Name: DIBERNARDO, ANTHONY R
MRN: 342675PMC
DOB: [REDACTED]
ACCT: 100407386PMC
ADM: 07/19/2013
DIS: 07/24/2013

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

Cause of death likely was cardiopulmonary arrest.

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



Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000634

PMC 0013

Piedmont Medical Center
222 S Herlong Ave-Rock Hill, SC 29732

Patient: DIBERNARDO, ANTHONY R
MRN #: 342675
Account #: 100407386
DOB/Age/Sex: [REDACTED] Male

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

Discharge Summary Reports

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

JOB:10745132/4400456

DS-**-Discharge Summary-**-20131114212406

Electronically Signed on 11/21/2013 12:54 EST

MORI MD, NARESH A

Physician Progress Notes

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

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Chart Request ID: 16959967

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Print Date/Time: 02/24/2014 09:46:04 CST

Printed By: Larsen, Susan

Appendix 000635

PMC 0014

STATE OF SOUTH CAROLINA

CERTIFICATION OF VITAL RECORD

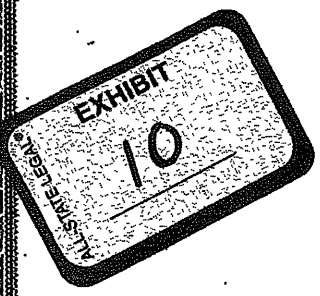
State of South Carolina
Department of Health and Environmental Control
CERTIFICATE OF DEATH

State Birth Number _____ State File Number **13 026018**

1. DECEDENT'S LEGAL NAME (Please AKA's, if any) (First, Middle, Last) Anthony Robert DiBernardo				2. SEX Male		3. SOCIAL SECURITY NUMBER [REDACTED]	
4a. AGE-Last Birthday (Please)		4b. UNDER 1 YEAR Months _____ Days _____		4c. UNDER 1 DAY Hours _____ Minutes _____		5. DATE OF BIRTH (MM/DD/YYYY) [REDACTED]	
6. BIRTH PLACE (City and State or Foreign Country) Albany, NY				7. CITY OR TOWN Clover			
7a. RESIDENCE-STATE South Carolina		7b. COUNTY York		7c. CITY OR TOWN Clover		7d. RESIDE CITY LIMITS? ☐ Yes ☒ No	
7e. STREET AND NUMBER [REDACTED]		7f. APT. NO. [REDACTED]		7g. ZIP CODE [REDACTED]		7h. RESIDE CITY LIMITS? ☐ Yes ☒ No	
8. EVER IN U.S. ARMED FORCES? ☒ Yes ☐ No		9. MARITAL STATUS AT TIME OF DEATH ☒ Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown		10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage) Lorrie Moss			
11. FATHER'S NAME (First, Middle, Last) Anthony P DiBernardo				12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Marie Dellino			
13a. INFORMANT'S NAME Lorrie DiBernardo		13b. RELATIONSHIP TO DECEDENT Family Member		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 1010 Cloninger Street Clover, South Carolina 29710			
14. PLACE OF DEATH (Check only one box) ☒ Hospital ☐ Emergency Room ☐ Dead on Arrival ☐ Nursing home ☐ Home ☐ Decedent's home ☐ Other (Specify) _____							
15. FACILITY NAME (If not hospital, give street and number) Piedmont Medical Center				16. CITY OR TOWN, STATE AND ZIP CODE Rock Hill, South Carolina 29732			
17. METHOD OF DISPOSITION ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) _____				18. PLACE OF DISPOSITION (Name of Cemetery, crematory, other place) Mountain Cemetery			
19. LOCATION (City, Town and State) State Island, New York				20. NAME AND ADDRESS OF FUNERAL FACILITY Bratton Funeral Home, Inc.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT Kenneth L. Bratton (Electronically Verified)				22. LICENSE NUMBER (Of Licensee) 1000		23. LICENSE NUMBER (Of Facility) 502	
24. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable) J Henry Owen III				25. DATE PRONOUNCED DEAD (MM/DD/YYYY) 7/24/2013		26. TIME PRONOUNCED DEAD 1745	
27. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)				28. LICENSE NUMBER 1745		29. DATE SIGNED (MM/DD/YYYY)	
30. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) July 24 2013				31. ACTUAL OR PRESUMED TIME OF DEATH 1745		32. WAS CORONER OR MEDICAL EXAMINER CONTACTED? ☒ Yes ☐ No	
33. PART I. Enter the chain of events - disease, injuries, or complications - that directly caused the death. DO NOT enter terminal events (cardiac arrest, respiratory arrest, or ventricular fibrillation) without showing the etiology. DO NOT abbreviate. Enter only one cause on a line. Add additional lines if necessary. Respiratory failure Pneumonia due to (or as a consequence of) due to (or as a consequence of) due to (or as a consequence of) due to (or as a consequence of)							
34. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause shown in PART I. [REDACTED]							
35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☒ No ☐ Unknown				36. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to one year before death ☐ Unknown if pregnant within the past year		37. MANNER OF DEATH ☒ Natural ☐ Homicide ☐ Accident ☐ Pending investigation ☐ Suicide ☐ Could not be determined	
38. DATE OF INJURY (MM/DD/YYYY)		39. TIME OF INJURY		40. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) ☒ Yes ☐ No		41. INJURY AT WORK? ☐ Yes ☒ No	
42. LOCATION OF INJURY: State: _____ City or Town: _____ County: _____				43. DESCRIBE HOW INJURY OCCURRED: [REDACTED]			
44. CERTIFIER (Check only one) ☒ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated. ☐ Prosecuting and Certifying physician-To the best of my knowledge, death occurred in this time, date, and place, and due to the cause(s) and manner stated. ☐ Coroner/Medical Examiner-On the basis of information under my supervision, death occurred at the time, date, and place, and due to the cause(s) and manner stated.				45. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify) _____			
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Form 521) Juanita Smith 1916 Cardiology Dr. Rock Hill SC 29732				47. NAME OF ATTENDING PHYSICIAN (If other than certifier) [REDACTED]			
48. TYPE OF CERTIFIER MD		49. LICENSE NUMBER 10867		50. DATE CERTIFIED (MM/DD/YYYY) 8/13/13		51. FOR REGISTRAR ONLY. DATE FILED (MM/DD/YYYY) August 13 2013	

NAME OF DECEDENT
Anthony Robert DiBernardo
For use by physician or investigator

Items 1-22 To Be Completed/Verified By FUNERAL DIRECTOR
Items 23-29 To Be Completed By MEDICAL CERTIFIER
Items 30-43 To Be Completed By MEDICAL CERTIFIER



SC03007679

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

Catherine Templeton
Catherine Templeton
Director and State Registrar

Guang Zhao
Guang Zhao
Assistant State Registrar

This copy is not valid unless prepared on an engraved border displaying the state seal and issuing agency logo.
Revision Date: 03/21/2012

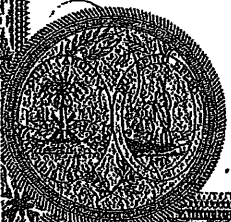


Exhibit 11—Fluoroscopy Readings

Please see flash drive

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

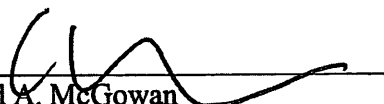
[REDACTED]

Exhibit 13—Pictures of:
Dilator, Introducer, Sheath and J. Wire
Please see flash drive

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

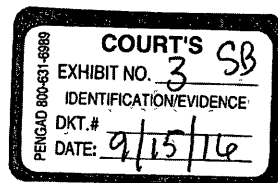
“When a thing which causes injury is shown to be under the management of the defendant, and the accident is such as in the ordinary course of things does not happen if those who have management use proper care, it affords a reasonable evidence, in the absence of explanation by the defendant, that the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

Childers v. Gas Lines, Inc., 248 S.E.2d 316 at 323-324.


Chad A. McGowan
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800
cmcgowan@mcgowanhood.com

W. Jones Andrews, Jr.
McGowan, Hood & Felder, LLC
1517 Hampton Street
Columbia, South Carolina 29201
(803) 779-0100
(803) 787-0750 Facsimile
jandrews@mcgowanhood.com

9-8
June 9, 2016
Rock Hill, SC



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

RECEIVED

SEP 01 2017

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.

Appellant's Brief

McGowan, Hood & Felder, LLC

Whitney B. Harrison
1517 Hampton Street
Columbia, South Carolina 29201
Phone: (803) 779-0100

Chad McGowan
1539 Health Care Drive
Rock Hill, South Carolina 29732

ATTORNEYS FOR APPELLANT

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STATEMENT OF ISSUE ON APPEAL

Appellant was prejudiced by the trial court's error in declining to give the requested charge and is therefore entitled to a new trial.

STATEMENT OF THE CASE

Appellant Lorrie Dibernardo, individually and as the Personal Representative of the Estate of Anthony Dibernardo, filed a medical malpractice action against Respondents Carolina Cardiology Associates, PA and Naresh Mori, MD alleging Mr. Dibernardo suffered a fatal heart injury during a pericardiocentesis. (R. 4, 29, 180-81). Respondents answered, denying allegations of medical malpractice. (R.50). The case proceeded to a jury trial before the Honorable R. Scott Sprouse in September 2016. (R.54). After a four-day trial, the jury returned a verdict in favor of Respondents. Appellant timely filed a notice of appeal.

STATEMENT OF FACTS

Mr. Dibernardo was a long-time patient of Respondent Carolina Cardiology Associates. (R.85). He was born with Noonan syndrome, a genetic condition that caused him to have a larger than normal heart. (R.85, 241). Because of his larger heart, Mr. Dibernardo had regular cardiac appointments, and over the course of eight years had been a patient of Dr. Jay K. Shah, a doctor at Respondent Carolina Cardiology Associates. (R.85, 125, 130, 179, 219, 242). During that time, Dr. Shah monitored Mr. Dibernardo's heart and adjusted medications accordingly.

Around 2009, Dr. Shah diagnosed Mr. Dibernardo with a large pericardial effusion. A pericardial effusion occurs when there is a build-up of fluid between the heart and pericardium, an area commonly known as the heart sac. (R.84, 169, 174, 550-53). For Mr. Dibernardo, this build up occurred chronically, and was something that Dr. Shah kept an eye on. (R.174, 550-53). If left unmonitored and untreated, extensive fluid build-up can compress the heart and prevent it from functioning normally. (R.169). Thus, Mr. Dibernardo kept regular appointments with Dr. Shah to avoid an emergency or fatal situation. (R.174).

In July 2013, Mr. Dibernardo began experiencing some swelling in his legs and shortness of breath when walking. (R.85, 550-53). These problems had presented in years prior and were not unexpected given Mr. Dibernardo's large pericardial effusion, despite the fact the fluid levels had been closely monitored for years. (R.84-85, 112, 130, 174, 176). At this time, Mr. Dibernardo was maintaining his normal lifestyle and routine, and Dr. Shah and Mr. Dibernardo recognized in order for him to continue doing so, the fluid around his heart needed to be removed. (R.251-52, 551).

Dr. Shah admitted Mr. Dibernardo to Piedmont Medical Center on July 19, 2013, for two scheduled procedures. (R.29, 242, 251, 550-52, 548-59). First, Mr. Dibernardo needed the fluid around his heart to be drained, by a surgeon within the practice group—Respondent Mori. Second,

Dr. Shah recommended a left and right heart catheterization to confirm the overall health of Mr. Dibernardo's heart to determine if there was any blockage. (R.553).

By way of background and for context, during a pericardiocentesis—which is the process of aspirating fluid from the pericardial space¹—a hollow needle is inserted in the lower part of the sternum and is positioned towards the shoulder. (R.175, 370, 434). The needle is directed to the fluid in the sac, not the heart itself. An echocardiogram and a fluoroscopy (a video x-ray) are used so the doctor can have a visual of where the fluid and the instrument are located within the patient's pericardial sac throughout the procedure. (R.88, 177-79).

Prior to insertion of the needle, an EKG² clip (connected to an EKG machine³) is attached to the needle as a safeguard. The EKG creates a short circuit so that if the needle touches the heart it will alarm before any damage can be done to the heart.⁴ (R.89, 176, 178). The needle is then placed in the patient while a syringe, placed in the hollow portion of the needle, is used to extract the fluid—this act is known as aspiration. (R.179-80). During this initial aspiration, the fluid color can appear clear, tan, yellow, or a pinkish color; however concern only arises if there is bright red blood in the syringe.⁵ (R.180). Assuming blood is not detected, the surgeon removes the syringe from the needle and uses the needle to insert saline into the patient. (R.90, 180). Saline is visible with the echocardiogram, and allows confirmation that the needle is correctly

¹ For visual purposes, the heart is covered by a sac—known as the pericardial sac. The sac is made up of two layers of tissue, the pericardium (outer and inner), and is surrounded by pericardial fluid that is used to cushion the heart as it expands and contracts. The pericardial space targeted in this procedure is comprised of the pericardium and pericardial sac. In Mr. Dibernardo's case too much fluid had gathered around the pericardium layers around the heart, which is why the fluid needed to be removed. (R.114).

³ An EKG machine operates the test that checks for problems with the electrical activity of the heart. An EKG shows the heart's electrical activity as line tracings on paper.

⁴ Practically, this short circuit can be likened to the game Operation. (R.89). The doctor will be alerted if the needle is misplaced. (R.89).

⁵ If that were to occur, it would signify that the heart had been damaged. (R.180).

placed in the pericardial sac by the fluid. (R.90, 180). After determining proper placement, a guide wire, known as a J wire, is inserted through the needle. (Flash drive—Picture of J-wire). The guide wire is essentially a soft, pliable spring that cannot hurt any tissue. (R.180-82). This wire protects the pericardial space throughout the procedure to ensure nothing harms the heart. Once the wire is in, the needle is removed. (R.183).

Following the insertion of the wire, the doctor confirms the wire is placed deep enough into the pericardial space to adequately protect the heart from any other device⁶ that may be employed throughout the procedure.

Once the doctor has confirmed the correct placement, a dilator/introducer is placed over the wire and it is slid down to the patient's pericardium. (R.90, 181, 183, 186; Flash drive—Picture of dilator/introducer). The purpose of the dilator/introducer is to create the necessary space in the tissue to advance a catheter, sheath, or other tube that will be used in draining the fluid out of the pericardium sac. (R.182, 185). Unlike the wire, the dilator and the sheath (which may be inserted later on) are very sharp. (R. 183; Flash drive—Picture of dilator and sheath). The only way to protect the heart from being harmed by a dilator or sheath during the procedure is for the doctor to maintain a good wire position. (R. 183, 185, 190).

Once the dilator has created the space, it is removed so a catheter/sheath/other tube can be inserted over the wire. The wire is then removed and the chosen drainage device remains in the pericardium. The doctor verifies placement using a fluoroscopy. (R.185-86). The doctor inserts a dye and confirms the device is properly placed within the pericardial sac by observing the dye

⁶ As a point of reference the other devices that may be inserted are a dilator (a sharp device that creates space for the draining devices), a catheter (a mechanism that drains the fluid), and a sheath (a hard/sharp plastic tube). Practically, the wire needs to extend a further distance within the pericardial space than any other device used in the procedure to protect the heart.

circulating around the heart. (R. 91, 183, 186). Following that confirmation, the doctor begins draining the desired amount of fluid. (R. 91, 186, 436).

Returning to the specifics of this case, on July 22, 2013, Mr. Dibernardo was taken to the cardiac cath lab around 8:00 a.m. to begin heart monitoring and to receive sedation drugs for the procedure. (R. 93, 245, 433, 597). Around 10:30 a.m., Respondent Mori arrived and was later joined by the echocardiogram technician, who operates the EKG equipment. (R.93, 563). At the time of the procedure, Mr. Dibernardo had about an inch and half of thick fluid around his heart. (R.88). The procedure went according to plan with the insertion of the needle, then the wire through the hollow needle, then the placement of the dilator, then the insertion of the catheter with confirmation of correct placement by inserting dye by 10:50 a.m. with a fluoroscopy (hereinafter "Fluro #1"). (R.206, 213, 307, 371, 434; Flash drive- Fluro #1). Around 11:00 a.m., Respondent Mori began draining the fluid from Mr. Dibernardo's pericardium space. (R.95, 564-65). Mr. Dibernardo's vital signs, including blood pressure, were stable and during the next fifteen minutes, a quarter of the fluid, more than a liter to be exact, was removed. (R. 95, 186-95, 603).

Respondent Mori then decided, with no stated reason in the medical records, to change the equipment in Mr. Dibernardo's heart and switch from the catheter to a sheath.⁷ (R. 95-96, 335-337, 603). As noted *supra* a catheter is a mechanism that drains the fluid and a sheath is a hard/sharp plastic tube. (R. 187). To make the switch from the catheter to the sheath, the J-wire had to be re-inserted to withdraw the catheter, leaving just the wire in the pericardial space.

⁷ Respondent Mori's reasoning for removing the catheter was highly debated over the course of trial. At various points during litigation and trial Respondent Mori's reason ranged from the speed of the fluid, the coloring of the fluid, finding a clot, and arguable concerns about proper placement of the first catheter. For the purposes of the issue on appeal, Respondent Mori's reason is of no consequence.

(R.190-91, 603). However, the J-wire was not inserted far enough into the pericardium, leaving it unable to perform its function of protecting the heart. (R. 194).

Respondent Mori fed a dilator/introducer down the wire into the pericardium space, and then added the sheath. (R. 195). Once those items were in place, Respondent Mori fed the same catheter into the sheath. (R. 191, 195). To confirm its placement, a visual was done using a fluoroscopy (hereinafter "Fluro #2"). (Flash drive-Fluro # 2; R.603-04). During Fluro #2 it became apparent that there was an injury/abrasion to the heart. (R.195). Specifically, as the dye was inserted for contrast purposes, the dye flowed towards the heart creating a stain, thereby demonstrating an injury had occurred. (R.98, 194, 196-97; Flash drive-Fluro # 2). Fluro # 2 showed the catheter had become improperly "tethered" to the heart. (R.402). The injury was further indicated in a third fluoroscopy (hereinafter "Fluro#3"). (Fluro#3).

After Respondent Mori improperly inserted the sheath and injured Mr. Dibernardo's heart, his blood pressure dropped significantly, putting him at risk of brain damage. (R. 115, 189, 200, 341, 597-98). The heart injury damaged the surface of Mr. Dibernardo's heart, and caused it to bleed. (R. 83, 572). Respondent Mori accordingly called for a cardiac surgeon, but he was occupied with another patient. (R. 572, 603). However, the bleeding and potential health risks became so severe that Respondent Mori could not wait and initiated autotransfuses, in which Mr. Dibernardo's blood was taken from around his heart and placed back into him through a line placed in his groin while he waited for an emergency surgery. (R. 83, 114, 372, 438, 603-04).

During the surgery, the surgeon found the area in the heart that has been scraped by the sheath, and a clot was located and removed. (R.103, 202-03, 572, 553, 604). When Mr. Dibernardo came out of surgery he was placed on a ventilator and admitted to the intensive care unit (ICU). (R.104, 236, 597). Mr. Dibernardo was briefly removed from the ventilator, but was

placed back on because his body could not function or maintain requisite levels of stability without the assistance of the ventilator. (R.236, 251, 589, 593). Ultimately, his family made the difficult decision to remove the ventilator and Mr. Dibernardo passed away. (R. 82, 238-40, 391, 597, 599).

Because of Mr. Dibernardo's injuries, Appellant brought this lawsuit alleging Respondents were negligent, careless, reckless, willful, and wanton in their care of Mr. Dibernardo by failing to exercise medical treatment within the standard of care. (R.29). Specifically, Appellant alleged Respondents breached the standard of care by removing and replacing the catheter with a sheath; failing to document the repositioning of the catheter and replacement of the sheath; and improperly manipulating and repositioning the catheter resulting in the trauma to Mr. Dibernardo's heart. (R.29).

At trial, no one disputed the fact that Mr. Dibernardo's heart was injured during the procedure conducted by Respondent Mori.⁸ (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, 197, 314-15, 321, 342, 343, 400). Further during cross examination of Respondent Mori and his experts,

⁸ 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).

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. 316, 323-24, 149 S.E.2d 761, 764 (1966). 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). This appeal followed.

STANDARD OF REVIEW

"The standard of review for an appeal of an action at law tried by a jury is restricted to corrections of errors of law." *Magnolia N. Prop. Owners' Ass'n, Inc. v. Heritage Cmty., Inc.*, 397 S.C. 348, 358, 725 S.E.2d 112, 117 (Ct. App. 2012).

ARGUMENT

APPELLANT IS ENTITLED TO A NEW TRIAL BECAUSE THE TRIAL COURT ERRED IN FAILING TO INCLUDE THE REQUESTED JURY CHARGE AND APPELLANT WAS PREJUDICED BY THIS EXCLUSION.

Appellant is entitled to a new trial based on the trial court's failure to charge the jury with the requested charge. The trial court's belief that the requested charge changed the burden of proof was an error of law. As explained herein, South Carolina law allows an inference of negligence in medical malpractice cases, including the inference of negligence when the factors for the control of the instrumentality are satisfied. Appellant was entitled to the requested charge based on Respondent Mori's admission, along with circumstantial evidence presented at trial— including the testimony of Dr. Shah, Dr. Schob, Dr. Story; the fluoroscopy recordings; the echos; and medical records. This error prejudiced Appellant because it prohibited the jury from contextualizing the evidence, testimony, and admission by Respondent Mori as it relates to the inference of negligence that can be made. Accordingly, this Court should reverse and grant Appellant a new trial.

"A trial court must charge the current and correct law." *In re Estate of Pallister*, 363 S.C. 437, 451, 611 S.E.2d 250, 258 (2005). "The law to be charged must be determined from the evidence presented at trial." *State v. Mattison*, 388 S.C. 469, 479, 697 S.E.2d 578, 583 (2010). "The substance of the law is what must be charged to the jury, not any particular verbiage." *Id.* An appellate court will not reverse the trial court's decision regarding jury instructions unless the trial court committed an abuse of discretion. *Hennes v. Shaw*, 397 S.C. 391, 402, 725 S.E.2d 501, 507 (Ct. App. 2012). "An abuse of discretion occurs when the trial court's ruling is based on an error of law or is not supported by the evidence." *Cole v. Raut*, 378 S.C. 398, 404, 663 S.E.2d 30, 33 (2008). In reviewing an alleged error in charging, an appellate court will consider the trial

court's jury charge as a whole in light of the evidence and issues presented at trial. *Hennes*, 397 S.C. at 402, 725 S.E.2d at 507. "Ordinarily, a trial [court] has a duty to give a requested instruction that correctly states the law applicable to the issues and evidence." *Ross v. Paddy*, 340 S.C. 428, 437, 532 S.E.2d 612, 617 (Ct. App. 2000). The Court of Appeals in *Burns v. South Carolina Commission for Blind*, explained:

If the requested charge states a sound principle of law that is applicable to the case, and not otherwise covered by the charge, refusal to charge it is error and requires a new trial. Moreover, when general instructions to the jury are insufficient to enable the jury to understand fully the law of the case and issues involved, a refusal to give a requested charge is reversible error.

323 S.C. 77, 80, 448 S.E.2d 589, 591 (Ct. App. 1994) (internal citations omitted).

To warrant reversal, the party seeking the requested jury charge must demonstrate error and prejudice. *Pittman v. Stevens*, 364 S.C. 337, 340, 613 S.E.2d 378, 380 (2005). "An alleged error is harmless if the appellate court determines beyond a reasonable doubt that the alleged error did not contribute to the verdict." *Wells v. Halyard*, 341 S.C. 234, 237, 533 S.E.2d 341, 343 (Ct. App. 2000); *see also Stephens v. CSX Transp., Inc.*, 415 S.C. 182, 197-98, 781 S.E.2d 534, 542 (2015) ("If, as a whole, the charges are reasonably free from error, isolated portions which might be misleading do not constitute reversible error. This holistic approach to jury instructions is linked to the principle of appellate procedure that '[a]n error not shown to be prejudicial does not constitute grounds for reversal.'" (quoting *Ardis v. Sessions*, 383 S.C. 528, 532, 682 S.E.2d 249, 250 (2009))).

Appellant requested the following charge with respect to the control of instrumentality:

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.541, 602). This requested charge is based on *Childers*. 248 S.C. at 323–24, 149 S.E.2d at 764, (R.541). The trial court refused to charge the requested language because it reasoned the charge “establishes a different standard, a different burden of proof that is not in accordance with our medical malpractice burden of proof that the plaintiff has.” (R.541). However, the requested charge represents an accurate and correct statement of the law. The requested charge does not shift the burden; rather, it clarifies that the jury may draw an inference of negligence under circumstances like that presented by Appellant—where evidence has been adduced that had the instrument that caused the injury been managed with proper care, no injury would have occurred.

As our jurisprudence has acknowledged inferences are appropriate based on control of an instrumentality and, additionally, are certainly allowed in medical malpractice cases. In *Childers*, the respondent sustained injuries when his motorcycle overturned after colliding with debris from a wooden traffic sign that was lying in his traffic lane. It was undisputed that the appellant’s crew had been working on the shoulder of the traffic lane the entire day, and blocked off the lane because material was thrown into the lane as the crew completed its ditch digging. 248 S.C. at 320–21, 149 S.E.2d at 763. During the day, the appellant’s crew placed this traffic sign into the lane; however, the appellant contended an employee removed the sign from the lane at the end of the work day, well before the respondent’s accident. *Id.* A jury found the appellant was negligent for the respondent’s injuries and the trial court denied appellant’s post-trial motion. On appeal, the appellant argued the respondent could not prove negligence because there was no evidence that the appellant was the proximate cause of the injury. *Id.* at 322, 149 S.E.2d at 763. Further appellant suggested the only inference that could be drawn from the evidence presented at trial was that an unknown automobile had struck the sign that the appellant’s crew placed in the shoulder, serving as an intervening independent act; thereby arguing no inference of negligence could be made. *Id.*

The Supreme Court disagreed and explained "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." *Id.* at 322, 149 S.E.2d at 764. In reviewing the facts of the case, the Court found there was sufficient evidence "to support a legitimate inference of negligence" by the appellant. *Id.* Despite the testimony of the crew's foremen that the sign had been removed from the lane and placed on the shoulder with lights, one witness testified that when he passed the area around 10:00 p.m. the traffic sign was in the lane, not on the shoulder. *Id.* Further, he stated when he passed the scene an hour later around 11:00 p.m. the sign had been broken and was lying in the road. *Id.* A second witness near the scene did not see the sign being struck but heard the event occur around 10:30 p.m. *Id.* Moreover, the witness who past the scene both times testified that there was no light around the sign when he passed at 10:00 p.m. *Id.* The Court explained that in construing the evidence together, a reasonable inference could be drawn that the appellant's work crew failed to move the sign. *Id.*

In support of its holding, the Court relied on *Sheperd v. United States Fidelity & Guaranty Company*, 233 S.C. 536, 106 S.E.2d 381 (1958), in which it previously acknowledged a prima facie inference of negligence is sufficient to satisfy the burden of proof for proximate cause. *Id.* The Court block quoted the control of the instrumentality language, now requested by Appellant as a jury charge. *Id.* In applying that language to the facts of *Childers*, the Court explained the appellant was the entity with the management and control of the sign. *Id.* at 316, 149 S.E.2d 765. While the appellant had witnesses that said the sign was not left in the street, the Court found that the position of the sign at the time of the injury and the testimony offered at trial were "strong circumstantial evidence that the appellant's witnesses were mistaken." *Id.* As such, the Court

found that an inference of negligence properly satisfies the burden of proof in establishing proximate cause.

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 malpractices cases. In *Green v. Lilliewood*, then-Justice Ness reversed the grant of a directed verdict, explaining that an inference of negligence could satisfy proximate cause when there was an admission of error by the defendant doctor and circumstantial evidence of the doctor's culpability. 272 S.C. 186, 191, 249 S.E.2d 910, 912 (1978). In reaching this decision, then-Justice Ness noted the Court could not ignore the admission by the defendant doctor and there was "strong circumstantial evidence" of the defendant doctor's negligence in reviewing the chain of events in the defendant doctor's treatment of the plaintiff.⁹ *Id.* In sum, the Court held there was sufficient evidence to allow the inference of negligence and for the matter to be submitted to the jury. *Id.* Thus, an inference of negligence, when properly supported by evidence and testimony, satisfies the plaintiff's burden of proof as to proximate cause in a medical malpractice case.

Further, the Supreme Court, relying on *Childers*, explained in *Bramlette v. Charter-Med.-Columbia* that in a medical malpractice action a defendant "may be held liable for anything which appears to have been a natural and probable consequence of his negligence." 302 S.C. 68, 72, 393 S.E.2d 914, 916 (1990) (citing *Childers*). Thus, "a plaintiff therefore proves legal cause by establishing the injury in question occurred as a natural and probable consequence of the

⁹ In *Green*, after the defendant doctor performed the medical procedure to insert an intrauterine device (IUD), the plaintiff developed varying problems and symptoms. *Id.* at 191-92, 249 S.E.2d at 913. The plaintiff returned to the defendant doctor a year later to have the IUD removed and have a tubal ligation performed. *Id.* The plaintiff's pain continued and months later plaintiff learned defendant doctor never removed the IUD. The plaintiff eventually underwent three painful procedures to remove the IUD, and two significant surgeries to remove her uterus and an ovary to abate the pain caused by defendant doctor's actions and inaction. *Id.*

defendant's negligence." *Id.* Notably, in order for the *Childers*' Court to reach the conclusion relied on by the *Bramlette* Court in a medical malpractice case, the factors of instrumentality of control had to be satisfied. Similarly, in the instant case, the lack of care in the control of the instrumentality caused the injury and it is therefore the natural and probable consequence of that negligence.

Accordingly, Appellant's requested charge reflects a correct and current statement of the law that is applicable to this case. Contrary to the trial court's ruling, the burden of proof remained with Appellant. To be entitled to this inference Appellant had to put forth sufficient evidence and testimony to show that (1) the pericardiocentesis was under the management of Dr. Mori at the time of the injury, (2) if the procedure was performed with the requisite care the injury sustained by Mr. Dibernardo would not have occurred, and (3) no other explanation could justify the injury. Therefore, Appellant had to satisfy the above elements in order to receive the charge and had to satisfy those elements to the jury's satisfaction to allow them to even make this inference. Moreover, this is only one aspect of negligence; Appellant was still required to put forth the requisite evidence and testimony to also demonstrate duty, breach, and damages.

A review of the testimony and evidence presented at trial shows the factors of the charge were satisfied. First, it is undisputed that Respondent Mori was in charge of the procedure and control of the instrumentality when the injury occurred. (R. 1995, 205, 400). In fact, Respondent Mori admitted at trial that an abrasion occurred during his procedure. (R.314).¹⁰

¹⁰ Additionally, the echocardiograms and fluoroscopy recordings provide further proof of the injury that occurred under the control of Respondent Mori. (Fluro # 1, Fluro # 2, Fluro # 3,); *see also* (R. 197) ("This picture proves that the insertion of this sheath and catheter damaged the heart to sufficient capacity to cause bleeding which resulted in the patient's blood pressure dropping, subsequent events having to go to emergency surgery."); (R.198-99) (describing the staining or dye was not normal; "It's indicative of injury to the heart"). The parties' experts also testified that Mr. Dibernardo's heart was injured during the procedure. Dr. Schob, Appellant's expert,

Second, trial testimony established that, if the procedure had been done properly, Mr. Dibernardo's injury would not have occurred. Importantly, Respondent Mori repeatedly agreed that if he had performed the pericardiocentesis properly, by either correctly inserting the sheath or needle, the injury would not have occurred. (R.314, 343). He agreed, "If you do all of those things properly, you should not cause an injury to the heart" and "you should not tear up the heart tissue" if you are performing the procedure correctly. (R.315). Additionally, he testified Mr. Dibernardo's injury is the exact injury "doing the procedure properly is meant to avoid." (R.315). Respondent Mori also agreed that improperly inserting the sheath is the only way a sheath can cause Mr. Dibernardo's injury, and if he had put the sheath in properly it would not injure the patient. (R.341-42).

This is further supported by the testimony of both parties' experts. Dr. Schob, testified if the sheath and dilator/introducer is inserted properly, pursuant to the normal standard, this type of injury does not occur. (R.191, 197). Similarly, Dr. Story testified that if the widely accepted standards are followed in the insertion of either a sheath or needle there is no injury to the heart. (R.412-13).

Third, and closely tied to the second factor, through the course of trial Appellant elicited testimony that there is no other explanation for the injury. Respondent Mori's admission in and of itself is enough to demonstrate the injury should not have occurred and there is no reason for the injury. While Respondents discussed other possible complications to the procedure, this testimony merely reflects why the decision is rightly left for the jury and does not negate the fact

explained that "the x-ray images clearly without a doubt demonstrate . . . the point where the heart was damaged" under the control of Respondent Mori. (R.208). Dr. Story, Respondent's expert, testified "the injury to the heart was either caused by the needle or the sheath" both of which were under the sole control of Respondent Mori. (R.408).

that Respondent Mori and two experts acknowledged that the injury sustained by Mr. Dibernardo is not one that occurs if the sheath or the needle is properly inserted. This is analogous to *Childers* in which the Court found the foreman and crew were mistaken about their belief that they properly moved their instrument. Notably, proving the absence of explanation was Appellant's burden, which was achieved through setting forth the standard of care, the correct method to perform the procedure, expert testimony in support of Appellant's position, and cross-examination of Respondent Mori and his experts. At no point did the burden shift to Respondents. For these reasons, the trial court erred in not providing the requested charge.

The trial court's failure to charge the jury pursuant to *Childers* prejudiced Appellant by failing to inform the jury that it may infer causation. This thwarted the underlying rationale of giving jury charges—which is to assist the jury in its role as a fact-finder and advise it on how it may distill the evidence to determine whether the required party has satisfied its burden. *Trial Handbook for South Carolina Lawyers* § 34:1 (“The purpose of jury instructions is to enlighten the jury and aid it in arriving at a correct verdict.”) (citing *State v. Leonard*, 292 S.C. 133, 355 S.E.2d 270 (1987)). Reviewing the charge as a whole, the trial court failed to adequately apprise the jury that the evidence adduced could allow it to infer negligence.

As to circumstantial evidence, the trial court charged:

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.*

(R.521). As to proximate cause, the trial court charged:

[T] he plaintiff must prove that the defendant's negligence proximately caused the plaintiff's damages. *Proximate cause is something that produces a natural chain of events which in the end brings about the injury.* It is a direct cause of the injury. To prove that the defendant's negligence proximately caused the plaintiff's injury the plaintiff must first prove causation in fact. This is proven by showing that the injury would not have occurred but for the defendant's negligence. The plaintiff must also prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This means that *the injury occurred as a natural and probable consequence of the defendant's negligence.*

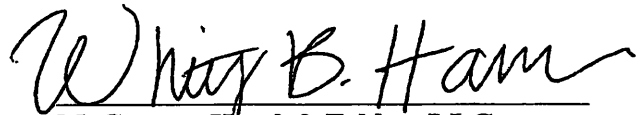
(R.527-28) (emphasis added). While these two charges refer to inference and natural consequence, they fail to sufficiently connect the legal proposition advanced by Appellant's requested charge. Appellant's requested charge not only bridges the concepts of inference and natural consequence, but also sets forth the correct statement that an inference can be made based on the three elements of control being satisfied. The charges as a whole never instructed the jury that it was allowed to make such a connection.

This inference was vital to Appellant's case. Given the complexity of the underlying procedure, the fact that both experts and Respondent Mori agreed that proper care with the instrument would avoid injury needed to be highlighted as a basis for drawing the inference that it was the lack of care and control of the instrumentality which proximately caused this injury. More succinctly put, a procedure involving invading the area surrounding the heart sounds eminently and inherently perilous to a layman; therefore, a charge clarifying that this injury could have been avoided simply by using proper care was essential to the jury's consideration of the evidence. As such, the jury was never told that under South Carolina law evidence and testimony presented by Appellant allows them to infer Respondent Mori was negligent based on circumstantial evidence. This prejudicial error requires and warrants a new trial.

CONCLUSION

Based on the foregoing, the trial court erred in failing to charge the jury with the control of instrumentality charge. For the reasons stated herein, reversal and a new trial are warranted.

Respectfully submitted,


McGowan, Hood & Felder, LLC

Whitney B. Harrison
1517 Hampton Street
Columbia, South Carolina 29201
(803) 779-0100
wharrison@mcgowanhood.com

Chad McGowan
1539 Health Care Drive
Rock Hill, South Carolina 29732
cmcgowan@mcgowanhood.com

ATTORNEYS FOR APPELLANT

**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

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.

FINAL BRIEF OF RESPONDENTS

George C. Beighley
Carmen V. Ganjehsani
RICHARDSON, PLOWDEN & ROBINSON, PA
1900 Barnwell Street (29201)
Post Office Drawer 7788
Columbia, South Carolina 29202
(803) 771-4400
**ATTORNEYS FOR RESPONDENTS
CAROLINA CARDIOLOGY
ASSOCIATES, PA AND
NARESH MORI, MD**

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COUNTERSTATEMENT OF ISSUE ON APPEAL

The Trial Court correctly refused to give the jury Appellant's requested charge which would have invited the jury to find negligence or malpractice of the physician based solely upon the occurrence of an adverse result during a medical procedure because such a charge is contrary to a plaintiff's burden of proof in a medical malpractice action and because furthermore, the evidence at trial, in which it was repeatedly shown that the procedure performed on Appellant's decedent carried with it a number of known potential complications, did not support Appellant's requested jury charge.

COUNTERSTATEMENT OF THE CASE

This case arises out of a medical malpractice action filed by Appellant Lorrie Dibernardo, individually and as the Personal Representative of the Estate of Anthony Dibernardo (“Mr. Dibernardo”), against Respondents Carolina Cardiology Associates, PA (“Carolina Cardiology”) and Naresh Mori, MD (“Dr. Mori”).

On March 23, 2015, Appellant filed her Complaint against Respondents in the York County Court of Common Pleas, alleging Mr. Dibernardo suffered a fatal injury during a pericardiocentesis. [R.pp. 29-49; Compl.] Respondents answered on April 29, 2015, denying the material allegations of the Complaint and further asserting that “any injuries or damages as alleged in the Complaint were due to and caused by [Mr. Dibernardo’s] underlying medical condition, and complications arising therefrom” [R.pp. 50-53; Answer.]

The case proceeded to trial before The Honorable R. Scott Sprouse and a jury on September 12, 2016. [R.p. 54; Tr. p.1.] On September 15, 2016, the jury returned a verdict in favor of Respondents, finding Dr. Mori did not violate generally accepted standards of medical care in his treatment of Mr. Dibernardo. [R.pp. 544, l. 15 – 545, l. 14; 1-3; Tr. pp. 491, l. 16 – 492, l. 14; Verdict.]

Appellant filed and served her notice of appeal on or about September 26, 2016.

COUNTERSTATEMENT OF THE FACTS

Mr. Dibernardo was a patient of Carolina Cardiology from approximately 2005 until his passing in 2013 and was primarily seen by Dr. Jay K. Shah, a cardiologist with Carolina Cardiology. [R.pp. 128, l. 1-129, l. 9; Tr. pp. 75, l. 1 – 76, l. 9.]

Mr. Dibernardo was born with Noonan's syndrome, a genetic disorder which caused him to have a larger than normal heart, as well as other physical abnormalities. As a result, Mr. Dibernardo had a longstanding history of heart problems. He had a history of congestive heart failure, and the left and right atria of his heart had dilated massively and already failed as a consequence of his genetic condition. Mr. Dibernardo had a pathologic over-thickening of the heart muscle which led to his condition of progressive heart failure for which he dealt with for many years. Over the years, he also developed significant edema, or swelling of the lower extremities. Mr. Dibernardo also suffered from ascites which is fluid buildup inside the abdomen. His heart had failed to such an extent that the fluid had built up in both the legs and the abdomen. In addition, Mr. Dibernardo had a condition known as atrial fibrillation for which he was on blood thinner medication. Because of Mr. Dibernardo's numerous heart conditions, it became increasingly hard for him to breathe with any amount of effort whatsoever and his lifestyle was severely limited. [R.pp. 111, ll. 13-25; 130, ll. 2-8; 131, ll. 10-19; 259, l. 19 – 260, l. 21; 363, l. 24 – 365, l. 17; 366, ll. 1-15; 428, l. 18 – 429, l. 7; 548; 550-552; Id. at pp. 58, ll. 13-25; 77, ll. 2-8; 78, ll. 10-19; 206, l. 19 – 207, l. 21; 310, l. 24 - 312, l. 17; 313, ll. 1-15; 375, l. 18 – 376, l. 7; P. Ex. 1, p.1; P. Ex. 2.]

Dr. Shah eventually diagnosed Mr. Dibernardo with a large pericardial effusion. [R.pp. 173, ll. 21-22; 549; Tr. p. 120, ll. 21-22; P. Ex. 1, p. 2.] A pericardial effusion

occurs when there is a build-up of fluid in the sac surrounding the heart. [R.pp. 130, ll. 9-15; 173, ll. 10-14; 366, ll. 12-15; Tr. pp. 77, ll. 9-15; 120, ll. 10-14; 313, ll. 12-15.] Mr. Dibernardo had a massive pericardial effusion which was causing high pressures within his heart chambers and in turn causing the size of the heart to be increased preventing the heart from functioning normally which resulted in the shortness of breath experienced by Mr. Dibernardo. [R.pp. 169, ll. 7-12; 261, ll. 10-17; Id. at pp. 116, ll. 7-12; 208, ll. 10-17.]

Mr. Dibernardo's symptoms markedly worsened in the months preceding July 2013. [R.pp. 143, ll. 23-25; 429, ll. 8-14; Id. at pp. 90, ll. 23-25; 376, ll. 8-14.] On June 14, 2013, Dr. Shah saw Mr. Dibernardo and noted that Mr. Dibernardo complained of increasing difficulty breathing, ankle swelling, and the inability to walk in his house without difficulty breathing. [R.p. 143, ll. 9-22; Id. at p. 90, ll. 9-22.]

Dr. Shah again saw Mr. Dibernardo on July 19, 2013. Mr. Dibernardo informed Dr. Shah that he could no longer walk in his house without losing the ability to breathe. [R.p. 142, ll. 10-12; Id. at p. 89, ll. 10-12.] Dr. James Story, a cardiologist admitted at trial as an expert in the field of cardiology and invasive cardiology, opined that Mr. Dibernardo was suffering from class four heart failure at this time – meaning the heart is failing to do its job as a pump such that a patient has signs and/or symptoms of heart failure at rest and has difficulty conducting minimal activities - and “was a very sick man.” [R.pp. 361, ll. 2-10; 362, ll. 17-19; 365, ll. 7-16; 366, ll. 10-20; 386, ll. 2-10; 429, ll. 18-23; Id. at pp. 308, ll. 2-10; 309, ll. 17-19; 312, ll. 7-16; 313, ll. 10-20; 333, ll. 2-10; 376, ll. 18-23.] Dr. Michael Foster, an interventional cardiologist also admitted at trial as an expert in the field of cardiology and invasive cardiology, concurred that Mr.

Dibernardo was having class four congestive heart failure when he was seen by Dr. Shah on July 19, 2013. [R.pp. 425, l. 22-426, l. 4; 427, ll. 22-24; 429, ll. 8-25; Id. at pp. 372, l. 22 – 373, l. 4; 374, ll. 22-24; 376, ll. 8-25.] The five-year survival rate for heart failure is only twenty percent. [R.p. 366, ll. 21-22; Id. at p. 313, ll. 21-22.]

Dr. Shah convinced Mr. Dibernardo to be seen in the hospital to try to alleviate the large amount of fluid around his heart which was contributing to Mr. Dibernardo's decline, and Mr. Dibernardo ultimately agreed. [R.pp. 142, ll. 8-15; 429, ll. 8-14; Id. at pp. 89, ll. 8-15; 376, ll. 8-14.] Mr. Dibernardo was admitted to Piedmont Medical Center by Dr. Shah on July 19, 2013. [R.pp. 259, ll. 5-8; 548-549; 550-552; Id. at pp. 206, ll. 5-8; P. Ex 1; P. Ex. 2.]

Dr. Shah believed Mr. Dibernardo needed a surgical evaluation for his worsening of fluid around the heart. Mr. Dibernardo had a difficult effusion and for that reason he was referred to surgery. For a complicated pericardial effusion, surgery is the preferred option for treating the effusion. Mr. Dibernardo, however, refused to undergo any surgical procedure to open the pericardium to drain the fluid. [R.pp. 141, l. 23 – 142, l. 4; 244, ll. 7-9; 260, l. 22 – 261, l. 5; 318, ll. 11-15; 321, ll. 21-23; 367, ll. 9-14; 431, ll. 4-17; Tr. pp. 88, l. 23 – 89, l. 4; 191, ll. 7-9; 207, l. 22 – 208, l. 5; 265, ll. 11-15; 268, ll. 21-23; 314, ll. 9-14; 378, ll. 4-17.]

In the hospital, after declining direct surgical intervention, Mr. Dibernardo met with Dr. Mori, an interventional cardiologist with Carolina Cardiology. [R.pp. 257, ll. 2-16; 259, ll. 3-18; Id. at pp. 204, ll. 2-16; 206, ll. 3-18.] Because Mr. Dibernardo had declined surgery, Dr. Mori felt it was reasonable to offer to perform a procedure called a pericardiocentesis to remove the fluid. [R.p. 261, ll. 6-13; Id. at p. 208, ll. 6-13.]

A pericardiocentesis is a procedure whereby fluid is drained and removed from the space around the heart usually through a tube or catheter. [R.p. 169, ll. 4-25; Id. at p. 116, ll. 4-25.] If surgery is eliminated as an option, a pericardiocentesis is the next best option to provide relief for a patient suffering from a pericardial effusion. All experts at trial, including Appellant's expert, agreed it was appropriate for Dr. Mori to recommend Mr. Dibernardo undergo a pericardiocentesis to remove the fluid from around his heart in light of Mr. Dibernardo's refusal to undergo surgery: [R.pp. 213, ll. 22-25; 220, ll. 6-10; 367, ll. 1-18; 431, ll. 4-20; Id. at pp. 160, ll. 22-25; 167, ll. 6-10; 314, ll. 1-18; 378, ll. 4-20.]

Dr. Mori believed that Mr. Dibernardo's initial presenting symptoms – the shortness of breath, swelling of the legs, and swelling of the abdomen – were symptoms of heart failure and would have become progressively worse without this treatment. [R.p. 292, ll. 8-20; Id. at p. 239, ll. 8-20.] Appellant's expert, Dr. Alan Schob, agreed that if left untreated, Mr. Dibernardo's heart condition would have continued on a downhill progression. [R.p. 221, ll. 9-14; Id. at p. 168, ll. 9-14.]

As with all cardiac procedures, there are risks associated with even a properly performed pericardiocentesis. Because a pericardiocentesis involves the insertion of a needle and catheter or other tube into the space surrounding the heart containing the fluid, there is a risk of striking veins, vessels, or the heart muscle itself. Therefore, the most common and prominent complication from a pericardiocentesis is bleeding from injury to the heart or one of the vessels close to the heart. Other complications include arrhythmia and risk of infection. [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; Id. at pp. 78, l. 22 - 79, l. 7; 89, ll. 16-23; 208, l. 18

– 209, l. 5; 314, l. 19 – 315, l. 16; 378, l. 21 – 379, l. 15.] Compounding the risk of complications arising from the procedure was Mr. Dibernardo's multiple underlying medical issues and physical conditions, including a deformed chest cavity. [R.pp. 142, l. 25; 260, ll. 17-21; 264, ll. 20-23; 512, ll. 15-16; Id. at pp. 89, l. 25; 207, ll. 17-21; 211, ll. 20-23; 459, ll. 15-16.]

Mr. Dibernardo was advised of the risks of a pericardiocentesis and informed of the complications which could occur during the procedure, including bleeding. [R.pp. 142, ll. 16-23; 262, ll. 6-11; Id. at pp. 89, ll. 16-23; 209, ll. 6-11.] Mr. Dibernardo understood all risks and complications of the procedure, continued to decline surgery, and opted to undergo a pericardiocentesis to try to improve his symptoms. He signed an informed consent indicating that he understood the risks of the procedure. [R.pp. 262, l. 12 – 263, l. 7; Id. at pp. 209, l. 12 – 210, l. 7.]

Mr. Dibernardo was taking a blood thinner and therefore, when he was admitted to the hospital on July 19, 2013, his blood was very thin. Due to this, the procedure was delayed until July 22, 2013 to allow the blood thinner to be eliminated from his system in order for the blood to begin clotting normally. [R.pp. 143, ll. 1-7; 433, l. 5-21; Id. at pp. 90, ll. 1-7; 380, ll. 5-21.]

At trial, Dr. Mori described the pericardiocentesis performed on Mr. Dibernardo on the morning of July 22, 2013. Dr. Mori's description of the procedure illustrated the numerous risks and complications he encountered due to not only the normal risks of a pericardiocentesis, but from Mr. Dibernardo's underlying medical conditions and physical anatomy.

The procedure began with the placement of a local anesthetic and a small incision in the chest area, and the subsequent insertion of a hollow needle with a syringe attached into the pericardial space through what is called the subxiphoid process, meaning the needle is inserted under the sternum, or breast bone, toward the heart at a 45-degree angle. [R.pp. 264, ll. 1-5; 266, ll. 19-23; 369, l. 20 – 370, l. 3; 434, ll. 3-21; Id. at pp. 211, ll. 1-5; 213, ll. 19-23; 316, l. 20 – 317, l. 3; 381, ll. 3-21.] The subxiphoid approach is the safest and most commonly used approach for a pericardiocentesis. [R.pp. 212, ll. 18-20; 317, ll. 9-10; 318, ll. 20-22; 319, ll. 20-22; Id. at pp. 159, ll. 18-20; 264, ll. 9-10; 265, ll. 20-22; 266, ll. 20-22.] A syringe is attached to the needle, aspirating as the needle is inserted so the physician will know when he has reached the pericardial space because fluid will be withdrawn. [R.p. 434, ll. 19-21; Id. at p. 381, ll. 19-21.]

Dr. Mori explained that while an injury to the heart or a vessel should not occur, there is nevertheless always a risk of injury and bleeding because the physician is entering the space with a sharp object. Because the physician is inserting a sharp needle into the space surrounding the heart, there is a risk of injury by entering the blood vessels, either a vein or artery, or even the heart muscle itself. In Mr. Dibernardo's case, the risk was magnified because of his enlarged heart. The enlarged heart was very close to the space in which the needle had to be inserted, significantly increasing the risk of injury and bleeding because of the limited space for the needle insertion without touching the heart. Dr. Mori testified that Mr. Dibernardo's heart condition increased the risk of potential complications from the pericardiocentesis. [R.pp. 264, ll. 1-19; 266, ll. 19-23; 274, ll. 5-8; Id. at pp. 211, ll. 1-19; 213, ll. 19-23; 221, ll. 5-8.]

In addition, Mr. Dibernardo had an abnormal anatomy. He had a deformity in the chest area called ectis exoskeleton in which the chest bone is not flat as in most humans but rather caved in, and the deformity in Mr. Dibernardo's chest area made it more difficult for Dr. Mori to access the area with the needle. [R.pp. 260, ll. 17-21; 264, ll. 20-23; 512, ll. 15-16; Id. at pp. 207, ll. 17-21; 211, ll. 20-23; 459, ll. 15-16.]

Further complicating a pericardiocentesis procedure is that the needle is to be inserted into the space surrounding the heart – a fibrous membrane – in which fluid has accumulated. The fluid, however, is not evenly distributed around the heart. The width of fluid is different from one area to the next. If the fluid was evenly distributed, insertion of the needle without injury would be more possible because the physician would be aware of the exact space for needle insertion available before hitting the heart muscle or a vessel. But because the fluid is not distributed evenly, it is much more difficult for the physician to determine the amount of space available for the needle insertion. In addition, in Mr. Dibernardo's case, there was not as much fluid around the right ventricle of his heart and most of the fluid was located behind the left ventricle. Therefore, there was not much fluid for access around the right ventricle where the needle was to be inserted which increased the risk of injury by hitting a vessel or the heart muscle itself. Dr. Mori discussed this complication with Mr. Dibernardo prior to the procedure. [R.pp. 265, ll. 1-19; 273, l. 13 – 274, l. 5; 274, l. 16 – 275, l. 8; 276, ll. 9-11; 315, ll. 20-25; Id. at pp. 212, ll. 1-19; 220, l. 13 – 221, l. 5; 221, l. 16 – 222, l. 8; 223, ll. 9-11; 262, ll. 20-25.]

Finally, the heart is not static. Dr. Mori explained it moves around in the pericardial fluid. Therefore, the heart is not a fixed target. Because the heart is moving

and not staying still, there is a risk of injury from the insertion of the needle because the needle could stick the moving heart. Dr. Mori described this as a known complication from the procedure. [R.pp. 274, ll. 9-15; 315, l. 20 – 316, l. 4; 368, l. 17 – 369, l. 1; Id. at pp. 221, ll. 9-15; 262, l. 20 – 263, l. 4; 315, l. 17 – 316, l. 1.]

In summary, the pericardiocentesis on Mr. Dibernardo began with Dr. Mori's insertion of the needle at about a forty-five (45) degree angle into the pericardial space of Mr. Dibernardo under an echo (ultrasound) and fluoroscopy (similar to an x-ray movie) and under telemetry monitoring called electrocardiographic ("ECG") guidance¹. These aids were to assist Dr. Mori in determining whether the needle was being inserted properly without injuring the heart or any vessel. [R.pp. 265, l. 22 – 266, l. 2; 267, ll. 4-6; 311, ll. 2-5; 312, ll. 1-18; 314, ll. 2-15; Id. at pp. 212, l. 22 – 213, l. 2; 214, ll. 4-6; 258, ll. 2-5; 259, ll. 1-18; 261, ll. 2-15.]

Dr. Mori testified that at some point the procedure and insertion of the needle does become blind as the needle is entering the pericardial space. The physician is unable to see where the needle is going even with the use of x-ray technology because the x-ray is a two-dimensional imaging technique yet the heart is three-dimensional. As such, at some point, the x-ray imaging becomes of no value in providing guidance. [R.pp.

¹ While the Appellant asserts Dr. Mori used EKG, or an alligator clip guidance, Dr. Mori used telemetry electrocardiographic guidance. [R.pp. 311, ll. 4-5; 312, ll. 12-18; 314, ll. 2-15; Id. at pp. 258, ll. 4-5; 259, ll. 12-18; 261, ll. 2-15.] There was no evidence at trial that Dr. Mori's use of telemetry electrocardiographic guidance violated any standard of care. This is one reason why an alarm would not sound if Dr. Mori had hit the heart because of his use of different monitoring. [R.p. 176, ll. 1-6; Id. at p. 123, ll. 1-6.] In addition, no alarm would sound if a vessel not near the heart was hit by the needle, which could have occurred in this case to cause Mr. Dibernardo's bleeding. [R.pp. 176, ll. 1-6; 178, ll. 10-13; 414, l. 16 – 415, l. 8; Id. at pp. 123, ll. 1-6; 125, ll. 10-13 (explaining only arteries or veins hit near the heart would signal an alarm); 361, l. 16 – 362, l. 8.] Further, under ECG guidance, the physician instead monitors for premature beats that might signify that the physician is in contact with the ventricle. [R.p. 312, ll. 1-8; Id. at p. 259, ll. 1-8.]

266, ll. 3-5; 435, ll. 6-10; Id. at pp. 213, ll. 3-5; 382, ll. 6-10.] As noted above, the blind approach, coupled with the size and swinging motion of Mr. Dibernardo's heart, as well as the lower amount of fluid around the right ventricle where the needle is inserted, all leads to a risk of bleeding. [R.p. 275, ll. 17-25; Id. at p. 222, ll. 17-25.]

Dr. Mori inserted the needle using the xipoid approach as described above. Because of Mr. Dibernardo's difficult anatomy, it took Dr. Mori more than one attempt to insert the needle. [R.p. 281, ll. 2-6; Id. at p. 228, ll. 2-6.]

According to Dr. Mori, once the physician feels fluid coming back, it is confirmed that the needle has entered the pericardial space. [R.pp. 266, ll. 6-11; 267, ll. 5-10; 435, ll. 11-15; Id. at pp. 213, ll. 6-11; 214, ll. 5-10; 382, ll. 11-15.] A flexible guide wire is passed through the center of the needle. This is a thin wire which serves as a guide for the catheter intended to be placed in the pericardium. A pigtail catheter, which is a relatively small catheter with a little loop on the end and a series of very small, tiny holes, is then inserted. The catheter is designed to allow fluid to filter into the catheter and be aspirated out through that catheter. Once it is determined on the fluoroscopy that the catheter is in place, the guide wire is removed. [R.pp. 267, ll. 16-25; 435, l. 16 – 436, l. 6; Id. at pp. 214, ll. 16-25; 382, l. 16 – 383, l. 6.]

Dr. Mori was able to confirm proper placement of the pigtail catheter around 10:40 a.m. [R.pp. 268, ll. 3-18; 269, ll. 12-17; 276, ll. 12-17; Id. at pp. 215, ll. 3-18; 216, ll. 12-17; 223, ll. 12-17.] Dr. Mori began drawing the fluid from Mr. Dibernardo's pericardial space but what started out as pinkish fluid became "frank bloody." It took a few minutes for the color to change from pink to bloody. The fluid coming out became increasingly bloody, and Dr. Mori began having difficulty getting any fluid out at all.

[R.pp. 269, ll. 18-23; 281, l. 7 – 282, l. 2; 307, l. 4 – 308, l. 6; 371, ll. 2-9; 436, ll. 11-25; Id. at pp. 216, ll. 18-23; 228, l. 7 - 229, l. 2; 254, l. 4 – 255, l. 6; 318, ll. 2-9; 383, ll. 11-25.] The bleeding was concerning to Dr. Mori, and he believed if Mr. Dibernardo kept bleeding, he would develop a fatal condition known as cardiac tamponade. With cardiac tamponade, blood will eventually fill the pericardial space, the heart chambers become compressed, and the patient has a drop in blood pressure and ultimately suffers cardiac arrest. [R.pp. 269, l. 5 – 270, l. 21; 271, l. 8 – 272, l. 10; 282, ll. 14-18; Id. at pp. 216, l. 5 - 217, l. 21; 218, l. 8 – 219, l. 10; 229, ll. 14-18.]

Dr. Mori further testified that the echocardiogram showed the first signs of a blood clot around 10:53 a.m. which confirmed the existence of bleeding. The appearance of the blood clot on the echocardiogram was confirmed by Respondents' cardiology experts. [R.pp. 276, l. 24 – 277, l. 17; 282, ll. 9-11; 302, ll. 4-9; 383, l. 24 – 384, l. 8; 424, ll. 11-17; 445, ll. 17-25; Id. at pp. 223, l. 24 – 224, l. 17; 229, ll. 9 -11; 249, ll. 4-9; 330, l. 24 – 331, l. 8; 371, ll. 11-17; 392, ll. 17-25.] The timing of the blood clot indicated that the bleeding occurred as a result of a needle injury, of which, as Dr. Mori had previously explained, was a known risk and complication of the procedure compounded by the size of Mr. Dibernardo's heart, the anatomy of his chest, and the movement of the heart. [R.pp. 277, ll. 5-23; 343, ll. 5-12; Id. at pp. 224, ll. 5-23; 290, ll. 5-12.]

Dr. Mori initially removed the pigtail catheter to flush it out in order to try to remove any clot or debris out of the little holes and then reinserted it. [R.pp. 371, ll. 14-17; 437, ll. 1-11; Id. at pp. 318, ll. 14-17; 384, ll. 1-11.] Due to the hemorrhagic conversion from a pinkish fluid to bloody fluid and Dr. Mori's concerns about the

bleeding and the overall condition of Mr. Dibernardo, Dr. Mori then made a decision to remove the catheter and change to a sheath. [R.pp. 272, ll. 11-15; 302, ll. 4-9; Id. at pp. 219, ll. 11-15; 249, ll. 4-9.] The sheath is made of soft plastic with a single large hole at the end of the sheath larger than the holes on the pigtail catheter. [R.pp. 371, ll. 18-24; 437, ll. 13-15, ll. 23-25; Id. at pp. 318, ll. 18-24; 384, ll. 13-15, ll. 23-25.] The sheath, according to Dr. Mori, was inserted around 10:59 a.m. The sheath was only inserted after Dr. Mori observed bleeding which occurred as a result of the needle injury. [R.p. 277, ll. 8-23; Id. at p. at 224, ll. 8-23.] Dr. Mori recognized the needle injury early in the procedure and stated he had a definite change in color from the fluid being drained from initial pink to frank blood towards the end. [R.p. 277, ll. 18-23; Id. at p. 224, ll. 18-23.]

Dr. Mori made the decision to insert the sheath in an attempt to save Mr. Dibernardo's life. [R.pp. 277, l. 24 – 278, l. 1; Id. at pp. 224, l. 24 – 225, l. 1.] Dr. Mori was not getting enough fluid through the catheter which he suspected had clogged up. The decision to change to the sheath was to treat the bleeding. [R.pp. 278, ll. 3-8; 334, l. 17 – 335, l. 14; Id. at pp. 225, ll. 3-8; 281, l. 17 – 282, l. 14.] Dr. Mori chose a larger and longer sheath over a smaller sheath because of the size of Mr. Dibernardo's heart. [R.p. ____; Id. at p. 226, ll. 19-25.] He further confirmed that he had inserted enough guide wire to properly exchange the catheter for a sheath. [R.pp. 279, l. 19 – 280, l. 10; Id. at pp. 226, l. 19 – 227, l. 10.]

Due to the evidence of bleeding and Mr. Dibernardo's risk of developing cardiac tamponade and ultimately cardiac arrest, Dr. Mori testified that it would not have been appropriate to have simply left the original pigtail catheter in for fluid to drain and to have sent Mr. Dibernardo to the intensive care unit. [R.pp. 282, l. 3 – 283, l. 1; Id. at pp.

229, l. 3 – 230, l. 1.]. Respondents' cardiology experts, Dr. Story and Dr. Foster, agreed that leaving the original pigtail catheter in, attaching it to a drain, and sending the patient to the recovery room would not have been appropriate. [R.pp. 385, ll. 10-22; 450, ll. 2-9; Id. at pp. 332, ll. 10-22; 397, ll. 2-9.]

In response to the significant bleeding, Dr. Mori immediately called for the surgeon. Because of the degree of bleeding, Dr. Mori was worried about injury to the heart and called for the surgeon to find the source of the bleeding and take further measures to treat the source. [R.p. 283, ll. 2-10; Id. at p. 230, ll. 2-10.] The surgeon was not immediately available, however, and therefore, Dr. Mori began the process of an autotransfusion whereby blood from the source of the bleeding, here the pericardium, is withdrawn and given back to the patient through a sheath placed in the femoral vein – the vein in the leg. These efforts were undertaken to halt the drop in blood pressure. Dr. Mori's efforts to autotransfuse Mr. Dibernardo were successful in stabilizing him until the surgeon was available. Mr. Dibernardo's blood pressure improved due to the autotransfusion. Mr. Dibernardo was alert and talking following the autotransfusion and never lost consciousness or became unresponsive. [R.pp. 217, ll. 13-23; 283, l. 11 – 284, l. 8; 285, l. 18 – 286, l. 5; 372, ll. 5-12; 438, ll. 8-25; Id. at pp. 164, ll. 13-23; 230, l. 11 – 231, l. 8; 232, l. 18 – 233, l. 5; 319, ll. 5-12; 385, ll. 8-25.]

After Mr. Dibernardo was stabilized, the surgeon was able to see him and agreed Mr. Dibernardo needed surgery because of the significant bleeding. [R.p. 286, ll. 6-9; Id. at p. 233, ll. 6-9.] During surgery upon Mr. Dibernardo, the surgeon removed a large blood clot and found an abrasion across the right ventricle possibly from the sheath. The surgeon found no significant ongoing bleeding from this abrasion and placed a piece of

SurgiSeal, a type of gel, on the abrasion “just in case.” No stitches were required to repair the heart. [R.pp. 288, l. 3 – 290, l. 2; 315, ll. 5-7; 375, ll. 2-22; 572; Id. at pp. 235, l. 3 – 237, l. 2; 262, ll. 5-7; 322, ll. 2-22; P. Ex. 5, p. 2.]

The sheath did not penetrate the heart. The surgeon found no hole in the heart. There was no damage to the heart requiring stitches. While the sheath came into contact with the right ventricle of the heart, such contact was a known potential risk of using the sheath but the use of the sheath was necessary to control the bleeding. [R.pp. 287, l. 7 – 288, l. 2; 375, ll. 2-25; 376, ll. 1-4; Tr. pp. 234, l. 7 – 235, l. 2; 322, ll. 2-25; 323, ll. 1-4.]

Dr. Mori testified that the sheath’s contact with the heart wall was not sufficient to account for all the blood he had to pull out of Mr. Dibernardo. The significant bleeding and the blood clot were present before the sheath placement occurred. Dr. Story opined that the needle possibly struck a small artery or vessel, some which can be half a millimeter in diameter that the surgeon would not have seen during the operation. By exchanging the catheter for a sheath, Dr. Mori managed a known complication – injury to the heart or vessel by the initial needle insertion – in accordance with the generally accepted standards of care. [R.pp. 290, l. 7 – 291, l. 3; 310, ll. 18-22; 376, ll. 5-8; 385, ll. 2-9; 414, l. 16 – 415, l. 8; 419, l. 16 – 420, l. 1; 424, ll. 11-17; Id. at pp. 237, l. 7 – 238, l. 3; 257, ll. 18-22; 323, ll. 5-8; 332, ll. 2-9; 361, l. 16 – 362, l. 8; 366, l. 16 – 367, l. 1; 371, ll. 11-17.]

Respondents’ cardiology expert, Dr. Story, agreed that the injury to the heart was caused by the initial needle insertion based on the amount of bleeding and the timing of the blood clot and that Dr. Mori appropriately managed the bleeding complication that occurred during the procedure. [R.pp. 385, ll. 2-5; 408, ll. 6-16; Id. at pp. 332, ll. 2-5;

355, ll. 6-16.] Dr. Story concurred that the sheath's contact with the heart wall could not have produced all the bleeding Dr. Mori encountered, further indicating that the bleeding was due to an injury caused by the initial needle insertion. [R.pp. 376, ll. 1-8; 408, ll. 6-16; Id. at pp. 323, ll. 1-8; 355, ll. 6-16.]

Mr. Dibernardo survived the heart surgery and was placed on a ventilator. [R.p. 291, ll. 4-11; Id. at p. 238, ll. 4-11.] Due to the surgery and Mr. Dibernardo's underlying medical conditions, Mr. Dibernardo was not successful in coming off the ventilator, and Mr. Dibernardo's family, specifically his wife, ultimately elected to terminate the ventilation. [R.pp. 251, ll. 9-12; 293, ll. 13-17; pp. 198, ll. 9-12; 240, ll. 13-17.] Mr. Dibernardo died on July 24, 2013. [R.p. 599; P. Ex. 10.] Following Mr. Dibernardo's death, Appellant brought this lawsuit alleging that Respondents Carolina Cardiology and Dr. Mori failed to perform an appropriate pericardiocentesis. [R.pp. 29-49; Compl.]

At trial, Dr. Mori explained that even if the physician does everything properly during a pericardiocentesis and all precautions are taken, complications can still occur as did in Mr. Dibernardo's case. [R.pp. 315, ll. 12-18; 316, ll. 1-4, 10-20; Tr. pp. 262, ll. 12-18; 263, ll. 1-4, 10-20.] He further testified that a pericardiocentesis is never 100 percent fool proof and that even if the procedure is performed with all appropriate steps taken, an injury can still occur. [R.pp. 344, ll. 7-17; 347, ll. 1-4; Id. at pp. 291, ll. 7-17; 294, ll. 1-4.] The fact that an injury occurs is not indicative of a physician's departure from the standard of care and even if the standard of care is met, a patient can still have a complication. [R.p. 347, ll. 5-15; Id. at p. 294, ll. 5-15.]

Cardiology experts at trial, Dr. Story and Dr. Foster, concurred that Dr. Mori complied with the generally accepted standards of medical care in performing the

pericardiocentesis and conducted the procedure appropriately. [R.pp. 363, ll. 4-23; 370, ll. 17-19; 421, ll. 13-22; 451, ll. 9-17; Id. at pp. 310, ll. 4-23; 317, ll. 17-19; 368, ll. 13-22; 398, ll. 9-17.] Dr. Story confirmed that a pericardiocentesis is a difficult procedure given the insertion of a needle in a tight space with a beating, moving heart. [R.pp. 368, l. 10 – 369, l. 1; Id. at pp. 315, l.10 - 316, l. 1.] He further explained that even if safeguards are used during the procedure, injuries can still occur and the fact that an injury or bleeding occurs during the procedure does not mean that the physician has done anything wrong. [R.pp. 369, ll. 2-15; 413, ll. 23-24; 417, l. 23 – 418, l. 4; 420, ll. 12-15; Id. at pp. 316, ll. 2-15; 360, ll. 23-24; 364, l. 23 – 365, l. 4; 367, ll. 12-15.] In a procedure involving the placement of a sharp needle near a beating heart, even if a physician performs all appropriate steps, an injury can occur and the existence of an injury is not evidence of malpractice. [R.p. 421, ll. 4-12; Id. at p. 368, ll. 4-12.] According to Dr. Story, complications can occur even if all normal and standard procedures are followed for either the initial needle insertion or the insertion of the sheath. [R.pp. 375, ll. 2-10; 417, l. 23 – 418, l. 4; Id. at pp. 322, ll. 2-10; 364, l. 23 – 365, l. 4.]

Dr. Foster likewise agreed that complications can occur even when a physician properly performs a pericardiocentesis and that evidence of bleeding during the procedure is not by itself evidence that the physician committed malpractice. A physician can perform the procedure with the highest standard of care and still have a bleeding complication. [R.pp. 431, l. 21 – 432, l. 25; Id. at pp. 378, l. 21 – 379, l. 25.] Dr. Foster agreed with Dr. Story that complications can occur even if all proper

techniques are followed for either the initial needle insertion or sheath insertion. [R.pp. 465, ll. 5-14; Id. at pp. 412, ll. 5-14.]

In Dr. Foster's opinion, the bleeding that occurred during the procedure on Mr. Dibernardo occurred because of the needle stick. The needle insertion is the most common reason why bleeding occurs during a pericardiocentesis. The needle is the only sharp instrument utilized during the procedure. [R.pp. 439, l. 23 – 440, l. 5; Id. at pp. 386, l. 23 – 387, l. 5.] Because the insertion of the needle is essentially a "blind stick," there are all sorts of structures in the body that can get in the way and can be injured, including organs grossly enlarged because of a patient's condition. [R.p. 440, ll. 6-13; Id. at p. 387, ll. 6-13.] Dr. Foster also testified that it was not surprising that Dr. Mori did not initially draw back blood after the needle insertion because fluid will clear out of the needle first before blood is drawn back. [R.pp. 440, l. 21 – 442, l. 2; Id. at pp. 387, l. 21 – 389, l. 2.]

In addition, while Appellant argued before the jury at trial that Mr. Dibernardo's blood pressure did not drop until after the sheath was inserted, which Appellant believed showed that the injury was caused by the alleged improper insertion of the sheath and not the needle, Dr. Foster explained that even for grave injuries, blood pressure does not begin to drop until usually thirty minutes after the injury. [R.pp. 442, l. 8 – 444, l. 6; Id. at pp. 389, l. 8 – 391, l. 6.]

Dr. Foster also confirmed that the blood clot was visible on the echocardiogram prior to the insertion of the sheath and had to have occurred prior to the sheath's insertion. Given the blood that Dr. Mori was drawing out, the presence of the blood clot, and the timing of the blood pressure drop, Dr. Foster opined that the injury to Mr.

Dibernardo occurred prior to the insertion of the sheath.² [R.pp. 445, ll. 9-25; 467, l. 5 – 468, l. 7; Id. at pp. 392, ll. 9-25; 414, l. 5 – 415, l. 7.]

Appellant's expert, Dr. Schob, agreed that performing a pericardiocentesis on a patient has a number of risks associated with it, including the risk of bleeding. [R.pp. 212, l. 21 – 213, l. 2; Id. at pp. 159, l. 21 – 160, l. 2.] He further agreed that bleeding can occur even when the procedure is performed within the standard of care. [R.p. 213, ll. 3-6; Id. at p. 160, ll. 3-6.] Dr. Schob acknowledged that the occurrence of a bleeding complication does not by itself mean that the physician committed malpractice. [R.pp. 213, ll. 7-10; 224, ll. 4-10; Id. at pp. 160, ll. 7-10; 171, ll. 4-10.] He also conceded that the riskiest time of a pericardiocentesis is during the insertion of the needle. [R.p. 177, ll. 20-23; Id. at p. 124, ll. 20-23.] Dr. Schob further agreed that the needle was the sharpest instrument utilized during Mr. Dibernardo's pericardiocentesis – sharper than the sheath or catheter. [R.p. 213, ll. 3-16; Id. at p. 163, ll. 3 – 16.]

At trial, Respondents Carolina Cardiology and Dr. Mori argued to the jury that a known, potential complication occurred during the pericardiocentesis performed by Dr. Mori on Mr. Dibernardo, a patient who had a massive heart and a large effusion along with a difficult anatomy, which Dr. Mori managed appropriately by exchanging the catheter for a sheath and by conducting an autotransfusion to stabilize Mr. Dibernardo. Despite the longstanding principle that an adverse result does not equal malpractice, Appellant requested the following jury charge:

² There was some dispute at trial about the timing of the blood clot and whether timing on the images from the cath lab were off. Appellant tried to argue at trial the clot appeared after the sheath was inserted but Dr. Foster confirmed at trial that it would have been impossible for a blood clot to form only a minute and a half after the sheath was inserted even if Appellant's timing was assumed. [R.pp. 467, l. 5 – 468, l. 7; Tr. pp. 414, l. 5 – 415, l. 7.]

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; Id. at pp. 487, l. 8 – 488, l. 11; Court's Ex. 3.]

The Trial Court declined to give Appellant's requested charge, ruling that such a charge "establishes a different standard, a different burden of proof that is not in accordance with our medical malpractice burden of proof that the plaintiff has." [R.p. 541, ll. 5-11; Tr. p. 488, ll. 5-11.]

The jury returned a verdict in favor of Respondents Carolina Cardiology and Dr. Mori, finding that Dr. Mori did not violate generally accepted standards of medical care in his treatment of Mr. Dibernardo. [R.pp. 1-3; 544, l. 16 – 545, l. 14; Verdict; Tr. pp. 491, l. 16 – 492, l. 14.] Appellant's appeal followed, challenging the Trial Court's ruling declining to give the above-requested charge regarding control of the instrumentality.

ARGUMENT

The Trial Court correctly refused to give the jury Appellant's requested charge which would have invited the jury to find negligence or malpractice of the physician based solely upon the occurrence of an adverse result during a medical procedure because such a charge is contrary to a plaintiff's burden of proof in a medical malpractice action and because furthermore, the evidence at trial, in which it was repeatedly shown that the procedure performed on Appellant's decedent carried with it a number of known potential complications, did not support Appellant's requested jury charge.

The jury in this case heard the evidence from both parties and resolved the issues of fact in favor of Respondents Carolina Cardiology and Dr. Mori, specifically finding that Dr. Mori did not violate generally accepted standards of medical care in performing the pericardiocentesis on Mr. Dibernardo. [R.pp. 1-3; 544, l. 16 – 545, l. 14; Verdict; Tr. pp. 491, l. 16 – 492, l. 14.] Appellant seeks a new trial solely on the basis of the Trial Court's refusal to give the following instruction to the jury:

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; Tr. pp. 487, l. 8 – 488, l. 11; Court's Ex. 3.]

The Trial Court properly refused to charge the jury with Appellant's requested instruction because not only does it not accurately state the law and the burden of proof for a medical malpractice case in South Carolina, the charge was incongruous with the evidence presented at trial – that known complications can occur during a properly performed pericardiocentesis.

A trial court must only charge the current and correct law. In re Estate of Pallister, 363 S.C. 437, 451, 611 S.E.2d 250, 258 (2005). The law to be charged to the jury is determined by the evidence at trial, and in reviewing jury charges for error,

appellate courts must consider the charge as a whole in light of the evidence and issues presented at trial. Id.; Keaton ex rel. Foster v. Greenville Hosp. Sys., 334 S.C. 488, 497, 514 S.E.2d 570, 575 (1999). A jury charge is correct if, when read as a whole, it contains the correct definitions and adequately covers the law. Pallister, 363 S.C. at 451, 611 S.E.2d at 258.

An appellate court will not reverse a trial court's decision regarding jury instructions unless the trial court abused its discretion. State v. Lemire, 406 S.C. 558, 565, 753 S.E.2d 247, 251 (Ct. App. 2013). 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. Id. To warrant reversal, a trial court's refusal to give a requested jury charge must be both erroneous and prejudicial to the requesting party. State v. Mattison, 388 S.C. 469, 479, 697 S.E.2d 578, 583 (2010).

To prevail in a medical malpractice action, a plaintiff must present (1) evidence of the generally recognized practices and procedures that would be exercised by competent practitioners in a defendant's field of medicine under the same or similar circumstances, (2) evidence that the defendant departed from the recognized and generally accepted standards, practices, and procedures in the manner alleged by the plaintiff, and (3) evidence that the defendant's departure from the generally accepted standards and practices was the proximate cause of the plaintiff's injuries and damages. Hoard ex rel. Hoard v. Roper Hosp., Inc., 387 S.C. 539, 546, 694 S.E.2d 1, 4–5 (2010).

Critically, a plaintiff in a medical malpractice action must prove that the physician was negligent by departing from the recognized and generally accepted practices for the procedure performed. A plaintiff can prove a physician's negligence by direct or

circumstantial evidence, Cox. v. Lund, 286 S.C. 410, 334 S.E.2d 116 (1985); however, a plaintiff must prove each element of negligence, including the physician's lack of due care. Snow v. City of Columbia, 305 S.C. 544, 555, 409 S.E.2d 797, 803 (Ct. App. 1991).

Notably, South Carolina does not recognize the doctrine of *res ipsa loquitur*. See, e.g., Legette v. Smith, 265 S.C. 573, 578, 220 S.E.2d 429, 430 (1975); Snow, 305 S.C. at 555 n.7, 409 S.E.2d at 803 n.7. Therefore, "[t]he plaintiff's 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." Reiland v. Southland Equip. Serv., Inc., 330 S.C. 617, 634-35, 500 S.E.2d 145, 154 (Ct. App. 1998); see also Bellamy v. Hardee, 242 S.C. 71, 77, 129 S.E.2d 905, 908 (1963) ("The doctrine of *res ipsa loquitur* does not apply in this state and the mere failure of the [equipment] in this case, without more, does not give rise to a presumption of negligence on the part of anyone."); King v. J.C. Penney Co., 238 S.C. 336, 338-40, 120 S.E.2d 229, 230 (1961).

Instead, as this Court has recognized, "[i]n an action for negligence, the plaintiff must prove by direct or circumstantial evidence that the defendant did not exercise reasonable care. South Carolina's rejection of *res ipsa loquitur* is consistent with its general adherence to fault based liability in tort. It also comports with the normal rules of proof, which require the plaintiff to prove affirmatively each element of his cause of action." Snow, 305 S.C. at 555 n.7, 409 S.E.2d at 803 n.7.

The rejection of *res ipsa loquitur* has been equally applied by the courts of this State in medical malpractice actions. For example, in Fletcher v. Med. Univ. of South Carolina, 390 S.C. 458, 702 S.E.2d 372 (Ct. App. 2010), 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 testified that he did not find any evidence in the medical records which indicated the hospital's physicians used any improper techniques during the operation. Accordingly, the trial court directed a verdict in favor of the hospital on the medical malpractice claim where the plaintiff presented no evidence of negligence in the performance of the procedure. Id. at 462-63, 702 S.E.2d at 374.

The patient appealed the directed verdict in favor of the hospital to this Court. Id. at 462, 702 S.E.2d at 374. In affirming the directed verdict based upon the patient's failure to present any evidence of how the physicians deviated from the standard of care, 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*, the Court stated 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)³ 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. Id. 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)⁴] 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, 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).

Therefore, based upon South Carolina's rejection of *res ipsa loquitur* and the principles espoused by this Court, it is well-established that the mere fact that an injury or

³ This case 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 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. Nevertheless, the reasoning employed by this Court in Bowie I remains instructive.

⁴ 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.

adverse result occurs during a medical procedure does not indicate that a physician was negligent or committed malpractice.

Despite this long-standing requirement in medical malpractice actions, Appellant argues the Trial Court erred in refusing her requested charge to the jury:

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; Tr. pp. 487, l. 8 – 488, l. 11; Court's Ex. 3.]

The requested charge directly contradicts the very requirement in medical malpractice actions that a plaintiff prove a physician departed from the recognized and generally accepted standards, practices, and procedures. The requested charge also invokes the doctrine of *res ipsa loquitur* which the South Carolina courts have expressly rejected. In requesting this particular charge, Appellant asks this Court to conclude that the adverse result which occurred during the pericardiocentesis performed on Mr. Dibernardo is alone and sufficient enough for a jury to find malpractice and negligence on the part of Carolina Cardiology and Dr. Mori. Such is not the law of medical malpractice in South Carolina and had the Trial Court given this charge to the jury, it would have constituted reversible error had the jury rendered a verdict in favor of Appellant.

Appellant's requested charge would have further directly contravened the Trial Court's instruction to the jury, to which Appellant did not object, that a physician cannot insure a positive result and is not negligent simply because an adverse result in fact occurred during a procedure:

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. 525, ll. 15-22; Tr. p. 472, ll. 15-22.]

Appellant bases her requested charge on the case of Childers v. Gas Lines, Inc., 248 S.C. 316, 323-24, 149 S.E.2d 761, 764 (1966). In Childers, the plaintiff brought an action for personal injuries sustained when his motorcycle collided with debris from traffic signs left at a construction site by a gas company. 248 S.C. at 319, 149 S.E.2d at 762. The gas company had denied that it left the sign in the street, but the court noted “[t]he position of the sign at the time the injury was sustained in this case is strong circumstantial evidence that [the gas company’s] witnesses were mistaken in denying that the sign was left on the asphalt portion of the street.” Id. at 324, 149 S.E.2d at 765.

The Childers court, observing the principle that “[p]roof of negligence may rest entirely on circumstances, and circumstantial evidence alone may authorize a finding of negligence,” found that the above referenced evidence was sufficient to require submission of the gas company’s negligence to the jury. Id. at 322, 149 S.E.2d at 763-64. In its holding that sufficient circumstantial evidence existed to warrant submission of the gas company’s negligence to the jury, the Childers court referred to the case of Shepherd v. U.S. Fid. & Guar. Co., 233 S.C. 536, 541-42, 106 S.E.2d 381, 383 (1958) which originally cited the language of the charge requested by Appellant.

In Shepherd, the plaintiff brought an action after his automobile collided with the defendant’s runaway automobile which had been parked by the defendant in her driveway. 233 S.C. at 539-40, 106 S.E.2d at 382. The defendant testified that she knew

she had set the brakes before leaving the vehicle because that was her fixed habit. Id. After the collision with the plaintiff's automobile, the runaway automobile was found not to have had its brakes set and to be in neutral gear. Id. The court, in dismissing the contention of the defendant that this evidence was insufficient to submit to the jury on the issue of her negligence, held that the unexpected presence on the highway of the automobile without a driver raised a prima facie inference of negligence on the part of the owner. Id. at 540-41, 106 S.E.2d at 383-84. Like Childers, this was a case in which there was strong circumstantial evidence that the defendant's denial of the facts was wrong.

In both Childers and Shepherd, the courts merely cited the language of Appellant's requested charge to illustrate the circumstantial nature of the facts of the two cases and to explain the appropriateness of the submission of such circumstantial cases of negligence to a jury. In fact, the Shepherd court explicitly recognized that the doctrine of *res ipsa loquitur* was not accepted in South Carolina and that its opinion should not relieve a plaintiff of the burden of proof, even where the plaintiff faces a difficulty of proof. Shepherd, 233 S.C. at 542, 106 S.E.2d at 383.

The facts of Childers and Shepherd further did not arise in the medical malpractice context and there has never been an opinion in this State in a medical malpractice action where the language used in Childers and Shepherd was approved to ease a plaintiff's burden of proof in such an action. Appellant nevertheless seeks to use the language of Childers and Shepherd to in essence charge the jury that because an injury occurred during Mr. Dibernardo's pericardiocentesis, Carolina Cardiology and Dr. Mori violated the standard of care.

At most, under the reasoning of the Childers and Shepherd cases, the Trial Court was only required to have instructed the jury on the use of circumstantial evidence, which the Trial Court did:

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; Tr. pp. 468, ll. 9-25; 469, ll. 3-7.]

Therefore, if Appellant's argument is that she was merely asking the Trial Court to charge the language of Childers and Shepherd to illustrate the circumstantial nature of the case, the Trial Court adequately did so. See also Green v. Lilliewood, 272 S.C. 186, 249 S.E.2d 910 (1978), cited by Appellant in support of her requested charge, but which merely recognizes that a medical malpractice recovery may be based on circumstantial evidence and which opinion supports the circumstantial evidence charge given by the Trial Court in this case. It is not error for the trial judge to refuse a specific request to charge when the substance of the request is included in the general instructions. Varnadore v. Nationwide Mut. Ins. Co., 289 S.C. 155, 160, 345 S.E.2d 711, 715 (1986).

In addition, the Trial Court did not err in refusing to give the specific charge requested by Appellant because the elements of the charge were not supported by the evidence presented at trial. 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.

The trial focused on the known complications which can occur during an even properly performed pericardiocentesis, which in this case was compounded by Mr. Dibernardo's physical condition. Dr. Mori and Respondents' cardiology experts described in detail how Mr. Dibernardo's injury could have occurred even under the proper standard of care.

The evidence presented established that the most common and prominent complication from a pericardiocentesis is bleeding. [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; Tr. pp. 78, l. 22-79, l. 7; 89, ll. 16-23; 208, l. 18 – 209, l. 5; 314, l. 19 – 315, l. 16; 378, l. 21 – 379, l. 15.] As explained by Dr. Mori and Respondents' cardiology experts, Dr. Story and Dr. Foster, 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. 5-14; Id. at pp. 262, ll. 12-18; 263, ll. 10-20; 291, ll. 7-17; 294, ll. 1-15; 316, ll. 2-15; 360, ll. 23-24; 364, l. 23 – 365, l. 4; 367, ll. 12-15; 378, l. 21 – 379, l. 25; 412, ll. 5-14.]

While there was a dispute between Appellant and Respondents at trial as to whether Mr. Dibernardo's injury occurred from the initial needle insertion or insertion of the sheath, in either procedure both Dr. Mori and Dr. Story testified that possible injury from insertion of the sheath was a known complication which also would not indicate a physician's departure from the standard of care. [R.pp. 287, l. 17 – 288, l. 2; 375, ll. 2-10; 417, l. 23 – 418, l. 4; Id. at pp. 234, l. 17 – 235, l. 2; 322, ll. 2-10; 364, l. 23 – 365, l. 4.]

Even Appellant's expert, Dr. Schob, 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; Id. at pp. 159, l. 21 – 160, l. 10; 171, ll. 4-10.]

The charge requested by Appellant would require the evidence at trial to at a minimum establish that the accident was the type that would not occur if proper care was used which Dr. Mori and all experts at trial, including Appellant's expert, refuted.

Further, the requested jury charge would only be applicable if the defendant could not explain why the injury or accident occurred. The testimony of Dr. Mori and cardiology experts Dr. Story and Dr. Foster thoroughly disclosed how Mr. Dibernardo's injury could have occurred even with proper care. 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; Id. at pp. 211, ll. 1-19; 213, ll. 19-23; 221, ll. 5-15; 262, l. 20-263, l. 4; 315, l. 10 – 316, 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; Id. at pp. 212, ll. 1-19; 220, l. 13 – 221, l. 5; 221, l. 16 – 222, l. 8; 262, 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; Id. at pp. 207, ll. 17-21; 211, ll. 20-23; 459, ll. 15-16.] At some point the insertion of the needle is blind, even with aids used for guidance, and there are all sorts of structures in the body, from tiny vessels to organs, that can be stuck and injured. [R.pp. 266, ll. 3-5; 414, l. 18; 415, l. 8; 435, ll. 6-10; 440, ll. 6-13; Id. at pp. 213, ll. 3-5; 361, l. 18 – 362, l. 8; 382, ll. 6-10; 387, ll. 6-13.]

The trial was replete with evidence by Respondents explaining the very reasons why Mr. Dibernardo's injury occurred during the pericardiocentesis despite Dr. Mori's compliance with the standard of care. For this additional reason, the Trial Court properly denied Appellant's requested jury instruction.

Furthermore, 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.

Appellant attempts to argue that Dr. Mori and Dr. Story testified at trial that Mr. Dibernardo's injury would not have occurred if the procedure had been performed properly. Appellant erringly takes their testimony 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; Id. at pp. 261, l. 16 – 263, l. 20; 288, l. 15 – 292, l. 22.]

Appellant also misconstrues Dr. Story's testimony. Dr. Story explained that the intent of a proper pericardiocentesis is not to cause an injury to the patient, including the patient's heart, but that even with the best standard of care and techniques used, complications and injuries can occur. [R.pp. 412, l. 4 – 413, l. 24; Id. at pp. 359, l. 4 – 360, l. 24.]

The evidence presented at trial highlighted the number of risks and complications which can occur from a pericardiocentesis, especially on a patient such as Mr. Dibernardo who suffered from a massively enlarged heart and a large pericardial effusion and who had a deformity in his chest area. A difficult procedure was made more difficult by Mr. Dibernardo's condition. Any instruction to the jury which would have permitted the jury to find negligence and malpractice against Carolina Cardiology and Dr. Mori based upon the occurrence of the injury to Mr. Dibernardo would have been in error.

As a final point, the Trial Court's refusal to give Appellant's requested charge to the jury, a charge which in itself would have been improper, was in any event not prejudicial to Appellant. A trial court's refusal to give a requested jury charge must be both erroneous and prejudicial to the requesting party before an appellate court will reverse a trial court's decision to not give the requested charge. State v. Mattison, 388 S.C. 469, 479, 697 S.E.2d 578, 583 (2010).

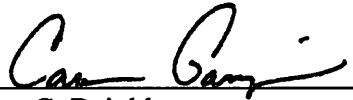
No prejudice resulted to Appellant from the Trial Court's refusal to give the requested charge. In the closing statement to the jury, Appellant's counsel repeatedly argued to the jury that if the physician had followed the standard of care, injury to Mr. Dibernardo would not have occurred and that his injury was indicative of a violation of the standard of care. [R.pp. 478, ll. 19-25; 480, ll. 8-16; 484, ll. 12-13; 487, ll. 20-25; 517, ll. 21-22; Tr. pp. 425, ll. 19-25; 427, ll. 8 – 16; 431, ll. 12-13; 434, ll. 20-25; 464, ll. 21-22.] The jury heard this argument and rejected it. Any alleged error by the Trial Court in refusing Appellant's requested jury instruction was therefore harmless.

The requested charge sought by Appellant would have permitted a jury to find negligence and malpractice by Carolina Cardiology and Dr. Mori based upon the fact of Mr. Dibernardo's injury 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 cardiology experts, Dr. Story and Dr. Foster, 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. The Trial Court therefore properly declined to give Appellant's requested jury charge on the control of the instrumentality.

CONCLUSION

For the reasons set forth herein, Respondents Carolina Cardiology Associates, PA and Naresh Mori, MD respectfully request this Court to affirm the jury verdict finding that Dr. Mori did not violate the generally accepted standards of medical care in his treatment of Mr. Dibernardo and to further deny Appellant's appeal for a new trial.

Respectfully submitted,



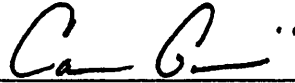
George C. Beighley
Carmen V. Ganjehsani
RICHARDSON, PLOWDEN & ROBINSON, PA
1900 Barnwell Street (29201)
Post Office Drawer 7788
Columbia, South Carolina 29202
(803) 771-4400
**ATTORNEYS FOR RESPONDENTS
CAROLINA CARDIOLOGY ASSOCIATES,
PA AND NARESH MORI, MD**

September 18, 2017.

CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that this Final Brief of Respondents complies with Rule 211(b), SCACR.

Respectfully submitted,



George C. Beighley
Carmen V. Ganjehsani
RICHARDSON, PLOWDEN & ROBINSON, PA
1900 Barnwell Street (29201)
Post Office Drawer 7788
Columbia, South Carolina 29202
(803) 771-4400
ATTORNEYS FOR RESPONDENTS
CAROLINA CARDIOLOGY ASSOCIATES,
PA AND NARESH MORI, MD

September 18, 2017.

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

R. Scott Sprouse, Circuit Court Judge

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

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

V.

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

Reply Brief

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SC Court of Appeals
McGowan, Hood & Felder, LLC

Whitney B. Harrison
1517 Hampton Street
Columbia, South Carolina 29201
Phone: (803) 779-0100

Chad McGowan
1539 Health Care Drive
Rock Hill, South Carolina 29732
Phone: (803) 327-7800

ATTORNEYS FOR APPELLANT

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ARGUMENT

This appeal concerns the simple application of tort law. The inquiry is whether the trial court erred in failing to include Appellant's requested charge on the control of an instrumentality.¹ The answer rests in the fact that South Carolina law allows an inference of negligence in medical malpractice cases. More specifically, South Carolina law allows an inference of negligence when the factors for control of the instrumentality are satisfied. Appellant was entitled to the requested charge based on Respondent Mori's admission, along with other circumstantial evidence presented at trial. This error prejudiced Appellant because it denied the jury crucial information on inferring negligence—an inference well supported in this case by physical evidence, expert testimony, and Respondent Mori's admissions on the witness stand.

There are three legal principles that cannot be disputed. One, a plaintiff has two distinct burdens of proof in tort law: the burden of going forward with evidence and the burden of persuading the jury on an issue. *See, e.g.*, Rule 301, SCRE ("a presumption imposes on the party against whom it is directed the burden of going forward with evidence to rebut or meet the presumption, but does not shift to such party the burden of proof in the sense of the risk of non-persuasion, which remains throughout the trial upon the party on whom it was originally cast."); *Pike v. S.C. Dep't of Transp.*, 343 S.C. 224, 230-231, 540 S.E.2d 87, 90-91 (2000); *King v. J.C. Penny Co.*, 238 S.C. 336, 340, 120 S.E.2d 229, 230 (1961). Two, a plaintiff can meet the burdens

¹ 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).

of proof through direct evidence as well as circumstantial evidence, which allows a reasonable inference of negligence. *See e.g., Snow v. City of Columbia*, 305 S.C. 544, 553–55, 409 S.E.2d 797, 803–04 (Ct. App. 1991). Three, an inference of negligence or reference to the lack of a defendant’s explanation of events does not mean that the burden of proof has shifted to a defendant; rather it indicates the plaintiff has satisfied the burden of going forward with the evidence, and a jury with proper instruction on the law will determine if the plaintiff has satisfied the second burden of persuading the jury. *See, e.g. Rule 301, SCRE; Tucker v. Reynolds*, 268 S.C. 330, 336, 233 S.E.2d 402, 406 (1977); *Brock v. Carolina Scenic Stages*, 219 S.C. 360, 366, 65 S.E.2d 468, 470 (1951).

Respondents attempt to refute these basic tenants and argue the trial court properly disallowed the charge because the charge describes *res ipsa loquitur* and changes the standard for medical malpractice by shifting the burden of proof to Respondents. This contention confuses the distinction between *res ipsa loquitur* and our jurisprudence’s acknowledgment that an inference is often appropriate based on control of an instrumentality. This inference does not shift the burden of proof. Further, Respondents incorrectly contend the circumstantial evidence charge was sufficient to address the concerns underlying Appellant’s request for the charge.

At the outset, Appellant agrees with Respondents that the doctrine of *res ipsa loquitur* has been rejected in South Carolina. *Eickhoff v. Beard-Laney, Inc.*, 199 S.C. 500, ___, 20 S.E.2d 153, 155 (1942) (noting South Carolina courts have declined to adopt the doctrine of *res ipsa loquitur*). As this Court is aware, “*res ipsa loquitur* means the thing speaks for itself.” *O’Leary-Payne v. R.R. Hilton Head, II*, 371 S.C. 340, 348, 638 S.E.2d 96, 100 (Ct. App. 2006) (internal citation omitted). *Res ipsa loquitur* 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”). Unlike a circumstance invoking *res ipsa loquitur*, in *Childers*, as in the present case, there was a known “responsible human agency” to indicate fault and coupled with specific factual circumstances—established by testimony—warranted an inference of negligence.² *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 Bramlette 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 malpractices 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.³

² Appellant relies on her Brief for a full discussion of this case and factual application. *See* Appellant’s Brief at 13-4.

³ Respondents take issue with the requested charge in a medical malpractice setting, however they point to no authority that suggests the basic tenants of negligence do not apply to medical negligence. The reason being that medical malpractice is a category of negligence and the requested inference is allowed in all negligence cases if the elements are satisfied. *Dawkins v. Union Hosp. Dist.*, 408 S.C. 171, 176, 758 S.E.2d 501, 503-04 (2014) (explaining “medical malpractice is a category of negligence, the distinction between medical malpractice and negligence claims is subtle, there is no rigid analytical line separating the two causes of action”).

Respondents argue *Fletcher v. Medical University of South Carolina*, and its progeny prove the requested charge invokes the doctrine of res ipsa loquitur, and therefore would be improper. 390 S.C. 458, 463–65, 702 S.E.2d 372, 374–75 (Ct. App. 2010). A review of these cases demonstrates the exact opposite. In *Fletcher*, the plaintiff underwent a bypass surgery and following discharge experienced bloating and shortening of breath. Plaintiff argued defendant doctors failed to inform her of such potential risks. 390 S.C. at 461–62, 702 S.E.2d at 373–74.

During trial, 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 loquitur when the only basis was the expert saying a breach occurred. *Id.*

In reaching this decision, the Court of Appeals relied on *Cox v. Lund*, 286 S.C. 410, 334 S.E.2d 116 (1985) and *Bowie by Bowie v. Hearn*, 292 S.C. 223, 355 S.E.2d 550 (Ct. App. 1987) (*Bowie I*). 390 S.C. at 464, 702 S.E.2d at 374–75. In *Cox*, decedent died because his colon was perforated during a colonoscopy. 286 S.C. at 413, 334 S.E.2d at 118. At trial, decedent's expert testified defendant doctor breached the standard of care when decedent's colon was unprepared for the procedure and opined that no colonoscopy should have been performed. *Id.* The expert's opinion was based on a review of relevant medical charts and x-rays. 286 S.C. at 414–15, 334 S.E.2d at 119. The Supreme Court found the testimony and documentary evidence satisfied the statutory requirements of proof for medical malpractice. 286 S.C. at 415, 334 S.E.2d at 119.

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. The Court explained under plaintiff’s theory of recovery “the doctors in *Cox* 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.” 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. *Id.*

Significantly, 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).⁴ Both of these

⁴ 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

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.

Notably, pursuant to *Cox* and *Bowie II*, the present case is distinguishable from *Fletcher* and proves the requested charge is not res ipsa loquitur based on the medical records and testimony presented at trial. *Cox*, 286 S.C. at 415, 334 S.E.2d at 119; *Bowie II*, 294 S.C. at 345, 364 S.E.2d at 469.⁵ Trial testimony established that if the procedure had been done properly, Mr. Dibernardo's injury would not have occurred. Respondent Mori repeatedly agreed that if he had performed the pericardiocentesis properly, by either correctly inserting the sheath or needle, the injury would not have resulted. (R.314, 343). He agreed, "If you do all of those things properly, you should not cause an injury to the heart" and "you should not tear up the heart tissue" if you are performing the procedure correctly. (R. 315). Additionally, he testified Mr. Dibernardo's injury is the exact injury "doing the procedure properly is meant to avoid." (R. 315). Respondent Mori also agreed that improperly inserting the sheath is the only way a sheath can cause Mr. Dibernardo's injury, and if he had put the sheath in properly, then it would not injure the patient. (R. 341-42). This is further supported by the testimony of both parties' experts. Dr. Schob testified if the sheath and dilator/introducer is inserted properly, pursuant to the normal standard, then this type of injury does not occur. (R. 191, 197). Similarly, Dr. Story testified that if the widely accepted standards

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).

⁵ While Appellant believes the testimony and evidence satisfies the standard set forth in *Bowie II* and *Cox*, and is distinguishable from the absence of evidence in *Fletcher*, out of an abundance of caution to preserve her argument, she will be arguing against precedent. A motion to argue against precedent is forthcoming.

are followed in the insertion of either a sheath or needle, then there is no injury to the heart. (R> 412-13).

For these reasons, Respondents mischaracterize the requested charge as *res ipsa loquitur*. Accordingly, Appellant's requested charge reflects a correct and current statement of the law that is applicable to this case.

Contrary to the trial court's ruling and Respondents' argument, the burden of proof remained with the Appellant. South Carolina courts have recognized that when an inference or presumption is made, the burden remains with plaintiff to prove the case to the jury. *Tucker*, 268 S.C. at 336, 233 at 405. ("The burden to prove his case is always on the plaintiff, whether the defendant introduces evidence or not."); *Grier v. Cornelius*, 247 S.C. 521, 148 S.E.2d 338 (1966). Courts have explained any suggestion that "it is the duty of the defendant to go forward with his proof" is stated for the sole purpose that "if he expects to win, it is his duty to do so, or take the risk of an adverse verdict, and not that any burden of proof rested on him." *Id.* Moreover, showing a lack of explanation by the defendant does not shift the burden of proof from the plaintiff. *Brock*, 219 S.C. at 366, 65 S.E.2d at 470.⁶ Thus, the requested charge does not shift burdens; rather it clarifies that the jury may draw an inference of negligence under circumstances like those

⁶ In *Brock*, the minor plaintiff died from injuries in a collision with a bus and the truck, in which the plaintiff was traveling in as a passenger, on a rainy foggy day. 219 S.C. at 361-63, 65 S.E.2d at 468-69. The issue before the court was whether there was testimony or evidence that warranted an inference of negligence of the bus. *Id.* The plaintiff and her father, the driver, died instantly and there were no other eye witnesses. *Id.* There was no direct evidence of speed or placement on the highway, and pictures taken after indicated. *Id.* All debris from the accident was on the side of the highway, and examination of the bus after the accident showed the tires were worn. *Id.* The Court found that given the circumstances coupled with the "absence of any explanation of the defendants warranted an inference" that the bus was not being driven within its lane. *Id.* at 366, 65 S.E.2d at 470. Despite the inference, the Court explained despite the difficulty of proof the plaintiff was not relieved of the burden of proof. *Id.*

Appellant presented here—i.e. where evidence has been adduced that had the instrument that caused the injury been managed with proper care, no injury would have occurred.

To be entitled to this inference, Appellant had to put forth sufficient evidence and testimony to show that (1) the pericardiocentesis, specifically the needle and sheath, was under the management of Respondent Mori at the time of the injury, (2) if the procedure was performed with the requisite care the injury sustained by Mr. DiBernardo would not have occurred, and (3) no other explanation could justify the injury.⁷ Therefore, Appellant had to satisfy the above elements in order to receive the charge and had to satisfy those elements to the jury's satisfaction for the inference to be made.

While the parties disagree about the interpretation of the facts, it does not negate that Appellant put forth sufficient evidence to satisfy the charge's elements. Respondent Mori, and both experts testified that when the procedure is done properly no injury occurs. (R. 103, 114, 193-94, 197, 202-03, 314-15, 321, 342, 343, 400, 572, 553, 604). Appellant readily agrees with Respondents that they discussed other possible complications to the procedure during trial. (R. 191, 193-94, 197, 314-15, 321, 342, 343, 400). However, evidence was put forth by Appellant during trial that there is no explanation or stated reason in the medical records to change the instruments in Mr. DiBernardo's heart, which was properly functioning at the time of the switch from the catheter to a sheath. (R.95-96, 335, 337, 603). Under Appellant's theory, as supported by evidence and testimony at trial, the J-wire was not inserted far enough into the pericardium, leaving it unable to perform its function of protecting the heart. (R.194). Following this switch, it became apparent there was an injury/abrasion to the heart. (R.195). The second fluoroscopy

⁷ As discussed in Appellant's Brief, a review of the testimony and evidence presented at trial shows the charge's factors were satisfied. *See* Appellant's Brief at 15-17.

(Fluro #2) showed the catheter had become “tethered” to the heart. (R. 98, 194, 196-97; Fluro #2 video). The parties perceived differences in the testimony merely reflects why the decision is properly left to the jury, and does not negate that Appellant satisfied the elements to receive the requested charge.

In addressing Appellant’s prejudice argument, Respondents incorrectly suggest the circumstantial evidence charge encompassed the principles from Appellant’s requested language.⁸ Reviewing the charge as a whole, the trial court failed to adequately advise the jury that evidence adduced could allow it to infer negligence based specifically on the control of the instrumentality. *Hennes v. Shaw*, 397 S.C. 391, 402, 725 S.E.2d 501, 507 (Ct. App. 2012). The purpose of giving a jury charge is to assist the jury in its role as a fact-finder and provide context for the evidence that was presented during trial. *Trial Handbook for South Carolina Lawyers* § 34:1 (“The purpose of jury instructions is to enlighten the jury and aid it in arriving at a correct verdict.”) (citing *State v. Leonard*, 292 S.C. 133, 355 S.E.2d 270 (1987)). While the circumstantial evidence charge refers to an inference, generally, as well as the proximate cause charge, neither sufficiently connects the legal propositions. At best the circumstantial evidence charge informs the jury that evidence allows an “inference” from proof that is not actually established but is based on something that can be inferred “in light of ordinary experience and common sense.” (R.521). In comparison, the requested charge allows the jury to make an inference if Appellant proved an instrument caused an injury that was under control of the defendant, and that injury does not occur when the instrument is managed properly. (R.541, 602).

⁸ In similar fashion, Respondents direct the Court’s attention to the fact that Appellant did not object to the jury charge that explains a physician cannot insure a positive result. (Resp. Brf. 25-26). As discussed in relation to *res ipsa loquitur*, Appellant contends this is not a circumstance in which the mere occurrence warrants negligence nor does Appellant suggest that the evidence merely suggests an adverse result.

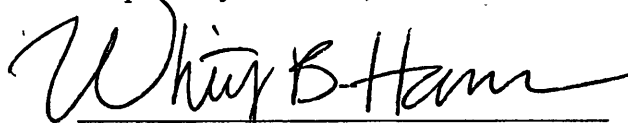
Solely relying on the circumstantial evidence charge is misplaced and prejudices Appellant. The charge makes no suggestion that Appellant can be afforded an inference of negligence based on the evidence presented at trial. Instead, it generally suggests the jury can make an inference—absent any direction on the type of inference or the that this specific inference is allowed under South Carolina law. Further, the charge fails to provide the necessary context for the jury to appreciate the evidence given the complexity of the procedure and the fact that both experts and Respondent Mori agreed that proper care of the instrument would have avoided the injury. A comparison between the circumstantial evidence charge and the requested charge highlight that the circumstantial evidence charge is a more general charge, while the requested charge is tailored to the facts presented at trial. *See e.g., State v. Day*, 341 S.C. 410, 418, 535 S.E.2d 431, 435 (2000) (finding a trial judge's refusal to specifically tailor the self-defense charge to adequately reflect the facts and theories presented by the defendant is reversible error); *State v. Fuller*, 297 S.C. 440, 443, 377 S.E.2d 328, 330 (1989) (holding a trial judge's refusal to include an additional requested jury charge is reversible error where the facts and circumstances presented at trial warrant such a charge).

This inference was vital to Appellant's case. A charge clarifying that this injury could have been avoided simply by using proper care was essential to the jury's consideration of the evidence. As such, the jury was never told that under South Carolina law evidence and testimony presented by Appellant allows them to infer Respondent Mori was negligent based on circumstantial evidence. This prejudicial error requires and warrants a new trial.

CONCLUSION

Based on the foregoing, Appellant is entitled to a new trial based on the trial court's failure to charge the jury with the control of instrumentality charge. This error prejudiced Appellant because it prohibited the jury from contextualizing the evidence, testimony, and admission by Respondent Mori as it relates to the inference of negligence that can be made. For the reasons stated herein, reversal and a new trial are warranted.

Respectfully submitted,



McGowan, Hood & Felder, LLC

Whitney B. Harrison
1517 Hampton Street
Columbia, South Carolina 29201
(803) 779-0100
wharrison@mcgowanhood.com

Chad McGowan
1539 Health Care Drive
Rock Hill, South Carolina 29732
(803) 327-7800
cmcgowan@mcgowanhood.com

ATTORNEYS FOR APPELLANT