

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

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

Appellate Case No. 2016-001986

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

v.

The Medical University of South Carolina Respondent

RECORD ON APPEAL - VOLUME III OF IV

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SC Court of Appeals

Robert B. Ransom
LEVENTIS & RANSOM
Post Office Box 11067
Columbia, SC 29211
803-765-2383
bertcone@aol.com

Alex Apostolou
3443 Rivers Avenue
North Charleston, SC 29405
843-853-3637
alex@apostoloulaw.net

ATTORNEYS FOR THE
APPELLANT SHON TURNER

Other Counsel of Record:

M. Dawes Cooke, Jr.

John W. Fletcher
BARNWELL, WHALEY,
PATTERSON & HELMS
Post Office Drawer H
Charleston, SC 29402
843-577-7700

ATTORNEYS FOR THE
RESPONDENT
MEDICAL UNIVERSITY OF
SOUTH CAROLINA

1 that this man was on, coming up with a new opinion that
2 is designed -- I don't concede that it does -- but is
3 designed to get past the obvious deficits that they had
4 that led us to move for summary judgment, where we
5 pointed out the very lines of his testimony that were
6 fatal. And then he secretly has new opinions on the
7 wrongful death, and that's our objection there.

8 THE COURT: Well, you received it when?

9 MR. COOKE: January -- April 11.

10 THE COURT: April 11th. Okay. But you had
11 received an email prior that it was going to be
12 changed, didn't you?

13 MR. COOKE: Well, I sent him an email and said, we
14 want you to --

15 THE COURT: I'm just asking you, he sent you --
16 did you receive the email where he said, I don't
17 remember the date, but his opinion was going to change?

18 MR. COOKE: He said he would get back to me as
19 soon as he could, as to whether there was any change in
20 the testimony. And this April 11th was where he -- he
21 did get back to me.

22 THE COURT: Okay. Anything else?

23 MR. COOKE: Nothing further.

24 THE COURT: Thank you so very much. Motion
25 denied. All right. Are we ready to bring the jury?

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1 MR. COOKE: Yes.

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

3 (WHEREUPON, the jury enters the courtroom at
4 approximately 9:57 a.m.)

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

6 THE COURT: All right. Thank very much. Call
7 your next witness, please.

8 MR. RANSOM: Your Honor, the plaintiff calls Donna
9 Embrey.

10 DONNA EMBREY, after
11 having been duly sworn, testified as follows:

12 THE CLERK: Please state your first and last name,
13 and spell your last name loudly and clearly into the
14 microphone.

15 THE WITNESS: Donna Embrey, E-m-b-r-e-y.

16 **DIRECT EXAMINATION BY MR. RANSOM:**

17 Q. Good morning, Ms. Embrey. How are you today?

18 A. Good morning, Mr. Ransom.

19 Q. You were the nurse anesthetist who was
20 responsible for Mr. Mikell's anesthesia care on October
21 1, 2010; correct?

22 A. Yes, sir.

23 Q. Okay. I want to show you on this board, part
24 of his anesthesia record -- for the record, what I'm
25 showing you is page 36 of 99, and that's part of the --

1 I think -- one minute anesthesia record; are you
2 familiar with this?

3 A. Yes, sir. I have seen it before, yes.

4 Q. So up here in this top row with oxygen
5 saturation values, we see that there are a number of
6 boxes that are empty, including the time period with
7 7:41 through 7:48; correct?

8 A. Yes, sir.

9 Q. The reason those boxes are empty is because
10 there was a problem -- a glitch, a malfunction,
11 whatever you want to call it, with the anesthesia
12 software that was supposed to be recording that data in
13 the chart; correct?

14 A. Correct.

15 Q. Okay. And I want there to be no question, as
16 we begin your testimony today, that you made some phone
17 calls and sent some text messages to a technician to
18 try to fix that computer problem; correct?

19 A. Correct. If I may explain, I sent two Simon
20 page text messages. And to the best of my
21 recollection, received one phone call.

22 Q. All right.

23 A. From Annette.

24 Q. One phone call.

25 A. Before she fixed it and got the data to convey

1 correctly.

2 Q. Well, we've marked the -- the text messages
3 here as Plaintiff's Exhibit 12. And what you'll notice
4 there at the bottom is your first text message was sent
5 at 7:39. And it said, "hey, call me, R-E N-O-R-A" --
6 that means Non Operating Room Anesthesia -- "patient
7 not in transfer bucket, thanks, Donna" -- correct?

8 A. Yes.

9 Q. Okay. And in response to that, you got a
10 phone call? And the --

11 A. No, sir --

12 Q. -- next --

13 A. No, sir.

14 Q. -- the next text message that you sent --

15 A. Mr. Ransom, I'm sorry, I did not get a phone
16 call. That's why I repaged her.

17 Q. Okay. Well, at 7:46, you sent the second text
18 message and it didn't say, hey call me -- it said,
19 "hey, call me back"?

20 A. Correct. Just meaning -- I meant call me --
21 call me at this number.

22 Q. Okay. And we can agree that after that first
23 phone call, but before you got the problem fixed, you
24 administered the Propofol to Mr. Mikell?

25 A. Say that again.

1 Q. We can agree that after the first phone call,
2 but before the problem was fixed, you administered the
3 Propofol to Mr. Mikell?

4 A. Correct.

5 Q. No question about that?

6 A. No question about it.

7 Q. Okay. So at a time where you are trying to
8 correct a problem with the computer system, you are
9 putting your patient to sleep?

10 A. Yes, sir. I initiated Propofol, yes --

11 Q. Okay.

12 A. I did.

13 Q. Now, there are a number of different printouts
14 of the anesthesia record in this case; correct?

15 A. Yes, I have seen many.

16 Q. And I want to just take a second with the jury
17 here now to go through these, so that they can have
18 some understanding. The first one that we have is what
19 I've marked as Plaintiff's Exhibit 1. And if you'll
20 look down at the bottom, you'll see it's got MUSC page
21 502; do you see that?

22 A. I do.

23 Q. Okay. And you'll notice that this record has
24 been printed on October 1, 2010, at 1346?

25 A. Yes, I see that.

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1 Q. About 1:46 in the afternoon; right?

2 A. Yes, sir.

3 Q. And you'll see that there are page numbers
4 down in the middle of the bottom; right?

5 A. Yes, sir.

6 Q. Okay. And it indicates that there are five
7 pages; correct?

8 A. Yes.

9 Q. So, we see page two, page three, page four,
10 page five; correct?

11 A. Yes.

12 Q. There is no page one, is there?

13 A. Not that you are showing me.

14 Q. Well, if there is a page one, perhaps Mr.
15 Cooke or Ms. Fleming will present it to you. The next
16 one that we have is what's been marked as Plaintiff's
17 Exhibit 2. And you'll notice that down in the lower
18 left, this one is dated October 1, 2010, and it's timed
19 at 1:34:47; do you see that?

20 A. Yes, sir.

21 Q. Okay. And that's really just about a minute
22 after the first one, after Exhibit 1; correct?

23 A. Yes, sir.

24 Q. All right. And you'll notice that this one is
25 nine pages. And on the last of -- or rather on page

1 eight of nine, we see what we refer to as the
2 narrative; do you see that?

3 A. I do.

4 Q. Okay. And I've highlighted this part up here
5 and that's an entry under the initials EWN; do you see
6 that?

7 A. I do.

8 Q. Whose initials are those?

9 A. Eric Nelson.

10 Q. Okay. And you'll see that it says, "Memo,
11 came into room, patient hypoxic, with junctional rhythm
12 and no palpable pulse, ACLS Protocol initiated. Mayday
13 team called", correct?

14 A. I do.

15 Q. And what is the time of that entry?

16 A. Eight o'clock.

17 Q. Eight o'clock. Thank you. Now, the next
18 record that we have is what's been marked as
19 Plaintiff's Exhibit 3. And you'll see that this one
20 was printed out on October 2, 2010, at 1815?

21 A. Yes, sir.

22 Q. So that's at about 6:15 in the evening, the
23 day after Mr. Mikell's procedure?

24 A. Yes, sir.

25 Q. And you'll notice when we look at the entry,

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1 where it says -- it's right here, "memo, patient came
2 into room" -- "or came into room, patient hypoxic with
3 junctional rhythm and no palpable pulse. ACLS
4 protocol. And Mayday team called" -- whose initials is
5 that entry under?

6 A. Mine.

7 Q. All right. And what's the time?

8 A. At 7:56. I had corrected it the day before --
9 the afternoon before to make sure times were accurate.

10 Q. Right. So you went into the electronic record
11 and changed Dr. Nelson's entry?

12 A. Yes, sir. I changed the time of it, uh-huh.

13 Q. And you changed it from being his entry at
14 8:00 to being your entry at 7:56?

15 A. Correct.

16 Q. Now, how many years have you worked as a nurse
17 anesthetist at MUSC?

18 A. At MUSC, I have been there since July of 2007.

19 Q. Okay. And this entry that you changed here on
20 this chart here, that we see there on Plaintiff's
21 Exhibit 3, that's the only time that you can ever
22 remember going back into an anesthesia record and
23 changing a doctor's entry?

24 A. I'm not certain about that because sometimes
25 with -- if you have several personnel involved in a,

1 critical situation in the OR, you all might be doing
2 and caring for the patient, and not contemporaneously
3 charting necessarily all the time. So I can't say I
4 have, you know, collaborated with docs and
5 anesthesiologists and other CRNAs after the fact to
6 make sure that our record is reflected accurately as
7 far as meds given. Sometimes somebody is just
8 scribbling it down as best they can, and just making
9 sure that everything is accurate. Because you're not
10 necessarily charting contemporaneously when there's
11 something very critical going on.

12 Q. Well, I had asked you about that in a
13 deposition that you gave me back in February of this
14 year. Do you need me to remind you of what your answer
15 was then?

16 A. Yes, sir, you can.

17 Q. All right. Bear with me and I'll see if I can
18 get it. All right. So we're looking at pages 154 and
19 155 of your testimony from February of this year. And
20 you'll see up there, beginning at line 24 on page 154,
21 I asked you the question, "Well, what was the rule
22 there at the Medical University in October of 2010
23 about a nurse changing a doctor's entries in the
24 medical record?" And you said, "I'm not sure". And I
25 asked you, "Have you ever done that before?" And you

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1 said, "Not that I recall. Not that I recall." And
2 then I asked you, "Have you ever done it since?" And
3 you said, "Not that I can recall". All right.

4 A. All right, sir.

5 Q. And then the next question that I asked you
6 was, "In terms of a patient that's in respiratory
7 arrest, is four minutes an important period of time?"
8 And you said, "Sure, yes."

9 Then I asked you, "What about a patient that's
10 in cardiac arrest?" And you said, "Yes." Then I asked
11 you, "What about a doctor's time to respond to a Mayday
12 call, is a four minute period an important time
13 period?" And, again, your answer was, "Yes".

14 A. Yes, sir.

15 Q. So, you had gone back into the anesthesia
16 record the day after Mr. Mikell's event, and changed
17 Dr. Nelson's entries so that it looked as though he had
18 come into the room four minutes earlier than what he
19 himself had charted?

20 A. No, sir. I believe I made all of my edits on
21 the narrative that afternoon, that evening before I
22 left. Because -- because it was a Friday, and I wanted
23 the record to reflect accurately. That's when I edited
24 and finished editing --

25 Q. Okay.

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1 A. -- on my narrative to reflect everything
2 accurately.

3 Q. Well, you don't disagree, though, that on
4 October 2nd, the day after Mr. Mikell's cardiac arrest,
5 you went back into his electronic record and rearranged
6 some of the entries?

7 A. I don't recall editing on the 2nd. I recall
8 printing and looking at it, and making sure that
9 everything was accurate from any anesthesia standpoint,
10 that I had entered everything accurately.

11 Q. You wanted to make sure that everything was
12 the way you wanted it to be. And one of the ways that
13 you made sure that the changes you had made to the
14 record were completed in the computer system was you
15 printed out the anesthesia record?

16 A. Say that again.

17 Q. You wanted to make sure that the changes you
18 had made to the anesthesia record were finalized in the
19 computer system, and one of the ways that you confirmed
20 that they had been finalized, was you printed out the
21 anesthesia record?

22 A. Yes, sir. Yes, sir.

23 Q. And then with the anesthesia record that you
24 printed out, you shredded it?

25 A. Yes, sir. Yes.

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1 Q. Okay. And I had asked you at a deposition
2 that I took from you back in March -- I'm sorry --
3 August of 2014, if you had any explanation for why
4 these various anesthesia records were printed on these
5 different dates. And do you remember what you told me?

6 A. No, sir, I don't recall.

7 Q. All right. Well, let's go ahead and take a
8 look then. Now, this is from page 99 of your August
9 2014 deposition.

10 (A portion of a video deposition was played in
11 open court.)

12 BY MR. RANSOM:

13 Q. So, that was your answer when I took your
14 deposition at a time before I had the audit trail; do
15 you remember that?

16 A. Do I remember that answer -- not specifically.

17 Q. Well, do you remember that at your first
18 deposition, I hadn't been provided any of the audit
19 trails for the anesthesia record, so I couldn't really
20 ask you anything about what those records show?

21 A. All right, sir.

22 Q. Do you remember that?

23 A. Vaguely.

24 Q. But I was ultimately provided a couple of
25 audit trails, and I've got one of them that's marked

1 here as Plaintiff's Exhibit 11; let's take a look at
2 that. So you see up at the top, it says "audit trail
3 by patient", and it gives the dates from October 1st to
4 October 2nd. All right. And, importantly, the audit
5 trail doesn't tell us anything that's been done with
6 this record after October 2nd. All right. Now, I want
7 to point your attention down here to the bottom of the
8 first page.

9 A. Yes, sir.

10 Q. And you'll see the document control number is
11 4988; do you see that?

12 A. I do.

13 Q. And it indicates under your name in the left
14 hand column, that somebody has hit the print command in
15 order to print the anesthesia record, and that's being
16 done on October 1st, 2010, at 1815?

17 A. That afternoon, yes, uh-huh.

18 Q. So that's about 6:25 in the evening?

19 A. Correct.

20 Q. That is not the date of the printout on
21 Plaintiff's Exhibit 1, and it's not the date of the
22 printout on Plaintiff's Exhibit 2, and it's not the
23 date of the printout on Plaintiff's Exhibit 3. So,
24 what did you do with the anesthesia record that you
25 printed there at 6:25 in the evening on October 1st?

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1 A. To the best of my recollection, after I was
2 done editing, after I was done with cases in the DDC
3 that day, I went back and made sure that the time
4 narrative was appropriate and accurate as far as timing
5 and everything of the events that occurred in my
6 narrative.

7 And so after I printed it out, I believe to the
8 best of my recollection, I put it in the DDC chart,
9 which had gone up to I believe the MSICU.

10 Q. All right. So the record that this audit
11 trail shows that you printed at 6:25 in the evening on
12 October 1st, it's your testimony that you put it in
13 Mr. Mikell's chart?

14 A. Yes, sir.

15 Q. Have you ever seen that record again?

16 A. The thing is, if different people edit and
17 they print it out, they can replace their edited and
18 narrated record as well. So I'm not certain if that
19 one is the one that -- do you follow what I'm saying --
20 actually ended up in a chart. I'm not sure if anyone
21 else went in and did any -- any type of editing non
22 contemporaneously on this case. So I -- I can't be
23 sure it was the one that I believe that I put in the
24 chart after I was done editing my narrative that
25 evening.

1 Q. Is that the one that you took out the next
2 day, on October 2nd, and shredded after you made other
3 changes in the record?

4 A. No, sir. I just believe that I looked at the
5 record the next day.

6 Q. Well, okay, so --

7 A. I was just looking at it visually.

8 Q. Do you have any explanation for us why this
9 version of the record, that was clearly printed out
10 that date and that time, it just sort of magically
11 disappeared?

12 A. Say that again now.

13 Q. Where is it?

14 A. Where is what?

15 Q. The anesthesia record that you printed out on
16 October 1, 2010, at 6:25 p.m.?

17 A. I'm not sure. I'm fairly certain that I put
18 that copy in the chart, because I felt like that
19 correctly reflected everything that anesthesia did.

20 Q. Can we at least agree that you were the only
21 one that did anything with it?

22 A. Did anything with what? I'm sorry.

23 Q. You didn't give to it a nurse; you didn't give
24 it to a doctor. Whatever happened to it, is what you
25 did with it?

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1 A. No, sir. There's a lot of hands on a chart.
2 Even if I put it there, I don't know if it got, you
3 know, if it was manipulated or pages missing. I'm not
4 certain of that. I can't speak to that.

5 Q. All right. Now, in terms of the missing
6 day -- the empty boxes here on page 36 of 99, that's
7 explained by the PICIS anesthesia software not properly
8 recording the data; correct?

9 A. Yes, sir.

10 Q. And I had asked you about that at your
11 deposition back in August of 2014; do you remember what
12 you told me at that time?

13 A. I do not.

14 Q. All right. Let's take a look at that.

15 (A portion of a video deposition was played in
16 open court.)

17 BY MR. RANSOM:

18 Q. So when I asked you if you had any comment
19 about whether or not Mr. Mikell's oxygen saturation
20 levels were being accurately recorded --

21 A. Recorded or on the monitor?

22 Q. Well, I said -- I asked "recorded". Do you
23 want me to play it back?

24 A. Oh, okay. No, sir.

25 Q. Okay.

1 A. That's fine.

2 Q. And this is the problem that we have up here,
3 isn't it?

4 A. It is.

5 Q. All right. So when I asked you if you had any
6 comment about whether there was a problem with the
7 values being accurately recorded, you said you couldn't
8 recall?

9 A. Correct. I'm not sure if I had seen the
10 exhibit or not, or if the variables had populated.

11 Q. Well, and the reason you didn't say anything
12 about it when I took your deposition in August of 2014,
13 was because you didn't really want me to know that
14 there had been a malfunction with the software, and
15 that you had been on the phone and sending text
16 messages?

17 A. No, sir. No, sir.

18 Q. Did you say anything about the phone calls and
19 text messages when I took your deposition in August of
20 2014?

21 A. I don't recall.

22 Q. And when I asked you, as we just saw, was
23 there any problem with the machine accurately recording
24 the values -- don't you think maybe that would have
25 been the time to say, yes, there was a computer system

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1 malfunction, and I was sending text messages and making
2 phone calls to correct it?

3 A. I don't -- I don't recall that I necessarily
4 was -- was being evasive. I knew that I saw an
5 appropriate oxygen saturation number on the monitor
6 when I hooked him up, put monitors on, oxygen initiated
7 Propofol, I would not have done any of those things or
8 proceeded with the case if there was a problem.

9 Q. I wasn't asking you about that. I was asking
10 you to help me to understand why these boxes are empty.
11 And the question I asked was, "Was there any problem
12 with the machine accurately recording those values?"
13 And you didn't tell me that there had been a software
14 malfunction. You didn't tell me that you had been on
15 the phone with a technician. You told me you couldn't
16 recall any problem.

17 A. Yes, sir. I think it was my belief that if I
18 saw -- if I saw values on the screen, that there would
19 be no problems repopulating those. And I, you know, I
20 was not familiar with -- with the one minute variables
21 and exactly what numbers were -- were missing on the
22 chart. I was -- I wasn't that familiar with it.

23 Q. And when I asked you -- I had a chance to take
24 your deposition a second time in February of this year,
25 and you remember I asked you the same questions I'm

1 asking you right now, Ms. Embrey, why did you not play
2 straight with me when I asked you about this at your
3 first deposition -- do you remember what you told me?

4 A. No, sir, I don't.

5 Q. You said that you didn't want to volunteer any
6 information if you didn't have to?

7 A. No, sir. At my first deposition, Mr. Ransom,
8 it was -- what I wanted to do was answer your questions
9 accurately and honestly, like I always have.

10 Q. All right. See, I asked you at your second
11 deposition, this is at pages 215 and 216, "When I took
12 your deposition last Fall, you didn't never tell me
13 anything about making phone calls to Annette Thompson,
14 did you?" And your answer was, "Do you mean paging her
15 for?" And I said, "Paging her, talking to her on the
16 phone, trying to communicate with her about this
17 problem that we've been discussing today?" And you
18 said, "I think I probably at our first deposition, was
19 just answering your questions as honestly and
20 accurately as I could."

21 A. Yes, sir.

22 Q. And I said, "I mean, did you know back then,
23 meaning in August of 2014, that you had conversations
24 and emails and phone calls with Annette Thompson, or
25 were you forgetting it then?" And you answered, "No,

1 sir. I knew. I knew back then that I had." And I
2 said, "Would you agree with me that you never mentioned
3 anything about it?" And your answer was, "Again, I
4 don't recall. If you did not ask me, then I don't
5 recall volunteering the information to you."

6 And then we continued this discussion. "All
7 right. You don't remember me putting the real time
8 graph in front of you, and asking you who could explain
9 why it wasn't accurate?" You said, "I remember you
10 giving me the graph."

11 "And you remember me giving you the anesthesia
12 record and asking you if you could explain why it was
13 so unusual?" And you said, "I guess I assumed that you
14 knew that PICIS been paged, because there was a problem
15 with the record." And a little bit later you said, "I
16 don't think I was volunteering a lot."

17 Now, you would agree with me that nobody
18 informed either myself or my client until last Fall
19 about this communication problem, this software glitch,
20 that resulted in all of these boxes being empty? You
21 didn't tell me in your deposition in August of 2014,
22 and your lawyers didn't tell me until the Fall of 2015;
23 right?

24 A. All right, sir. Yes, sir.

25 Q. So, why were you withholding that information?

1 A. Oh, I wasn't withholding information. I
2 didn't necessarily recall how many times I paged
3 Annette. A lot of this was -- was many years later.
4 You know, after looking at documents and refreshing my
5 memory, I recalled them better. But I could not recall
6 every detail.

7 Q. All right. Let's talk a little more about the
8 entries that you changed in the anesthesia record.

9 A. Yes, sir.

10 Q. Now, this board that I'm going to put up
11 here -- and I'll see if I can get this on the overhead
12 as well.

13 This is from Plaintiff's Exhibit 2 and it's page
14 611. So, again, we see that Dr. Nelson has entered
15 under his initials at the time of 8:00, this
16 information that begins "memo, came into room, patient
17 hypoxic". All right. And we can agree that you went
18 back and changed that entry?

19 A. Yes. Yes, I did.

20 Q. And I had asked you about that change in entry
21 in your deposition -- do you remember what you told me?

22 A. No, sir.

23 Q. All right. Well, let's take a look at that.
24 And I believe this is from pages 24, 69 and 70 of your
25 testimony in August of 2014.

1 (A portion of a video deposition was played in
2 open court.)

3 BY MR. RANSOM:

4 Q. So you were pretty insistent, you told me
5 three different times when you were sworn under oath to
6 tell the truth?

7 A. Yes, sir.

8 Q. That this 7:56 entry, that we see here, was
9 Dr. Nelson charting under your name right here. And
10 I'm referring right now on this board to MUSC page 494?

11 A. Okay. Initially when Eric charted at 8:00, he
12 was charting after the fact obviously. He was kind of
13 going over the -- the recent and previous few minutes
14 events. He charted. But when I went back in and
15 edited the time that the Mayday was called, and he
16 entered the room, we turned the patient supine, et
17 cetera, then it was under my name. My initials were
18 the last ones on the record as -- as charting that.

19 Q. Ms. Embrey, again, looking back here on the
20 overhead at page 611, that entry, "memo, came into
21 room, patient hypoxic" -- that's not Dr. Nelson
22 charting under your name, is it? That's Dr. Nelson
23 charting under his own name and --

24 A. Yes, sir.

25 Q. And you went back and changed it?

1 A. Yes, sir.

2 Q. And when I was asking you about it at your
3 deposition in August of 2014 --

4 A. Yes.

5 Q. -- you just lied to me, didn't you?

6 A. In what way? I'm sorry, Mr. Ransom.

7 Q. You kept telling me over and over again that
8 that was Eric charting under your name. The truth of
9 the matter was, that was you changing his entry. Why
10 did you keep telling me that he was charting under your
11 name when what really happened was you went back and
12 changed his entry? You didn't tell me that. You said,
13 "he's charting under my name". That's not what
14 happened?

15 A. No, sir. He was charting under his own name
16 when he made the 8:00 non contemporaneously. When I
17 edited it, I changed the time, but I did not say "memo,
18 Nelson came into room" -- do you follow what I'm
19 saying? When I edited it, I was the last one to edit
20 that afternoon. It comes up under my initials. And
21 that is -- that is actually what is meant by that
22 narrative.

23 Q. Because you kept telling me that this was the
24 accurate sequence of events right here on this page,
25 494, that this was the accurate sequence. All right.

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1 We weren't talking about page 611. And you kept
2 telling me that's Eric charting under my name, meaning
3 the system is open under my initials. Let's explain
4 that to the jury. So when you open up this PICIS
5 anesthesia software, it requires a user name and a
6 password; correct?

7 A. Yes.

8 Q. And then once the system is open under Donna
9 Embrey's user name and password, any entries that are
10 made come in under your initials?

11 A. Yes.

12 Q. And end up under your name on the audit trail
13 unless somebody else comes in and logs in under their
14 own user name and password. And what happened was,
15 that at 8:00, Dr. Nelson came in and logged into the
16 system. And his entry was that at 8:00, he had come
17 into the room, the patient was hypoxic with a
18 junctional rhythm, which means by the way -- Mr. Mikell
19 is in big trouble, right? And so what Eric says is,
20 it's at 8:00 that he comes back into the room.

21 And you realize, of course, that if your patient
22 is hypoxic and in a junctional rhythm, and you haven't
23 gotten Dr. Nelson back in the room, and you fiddled
24 around and fooled around with text messages and phone
25 calls, and four minutes have gone by, while Mr. Mikell

1 is over there holding his breath, you got a big
2 problem?

3 A. No, sir.

4 Q. And so you go back, and you get in the system,
5 and you change Dr. Nelson's entries to shave four
6 minutes off the time that he came back into the room;
7 that's what you did?

8 A. No, sir. I changed it to accurately reflect
9 when he entered the room, and helped us turn the
10 patient, and initiated the Mayday, and did all those
11 things. Yep. He's -- he's charting that all of these
12 things went on just previously to when he was charting.

13 Q. And you didn't tell Dr. Nelson that you were
14 going to change his entry? And you didn't get his
15 permission, and he didn't know anything about that? He
16 found out about it -- Dr. Nelson found out that you had
17 changed his entry in his chart when I asked him about
18 it at his deposition in this case; right?

19 A. All right, sir. If you're telling me that.

20 Q. Well, because you never went to Eric and said,
21 can we take a look at this record and make sure that
22 it's accurate; did you?

23 A. I did not. I do not recall going to him. No,
24 I do not.

25 Q. And you never went to him and said, I think

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1 that the times that you entered in the chart are
2 inaccurate, is it okay with you if I change them? You
3 never did that?

4 A. I never -- I do not recall doing that, no.

5 Q. And you never went to him and said, by the
6 way, Eric, I know that the anesthesia department is
7 going to be conducting an investigation into what
8 happened to Mr. Mikell, and so you may wish to know
9 that I have changed your entries in the record?

10 A. I do not recall doing that.

11 Q. But you did know that there was going to be an
12 investigation, didn't you?

13 A. At what point?

14 Q. At some point because any time a patient at
15 the Medical University --

16 A. Of course.

17 Q. -- suffers an unexpected cardiac arrest, the
18 hospital requires that there be an investigation, and
19 you knew that?

20 A. Yes, sir.

21 Q. And that's why it was so important to you to
22 go back after the fact, and rearrange these entries in
23 this chart to make it look as though everything had
24 been done with textbook perfect accuracy?

25 A. No, sir. I wanted the record to accurately

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1 reflect the times and what was going on, including the
2 Mayday initiation, defibrillation, intubation, and
3 everything else that the five or six of us who were in
4 the room --

5 Q. Well, that's right. You wanted it -- to make
6 it look as though nobody had done anything wrong?

7 A. No, sir. I wanted it to accurately reflect
8 the time of everything that went on, that we did for
9 Mr. Mikell.

10 Q. Now, one of things that you told me when I
11 took your deposition the second time in February of
12 this year, was that out of this desire to try to make
13 the record as accurate as possible, you had gone to
14 Mr. Mikell's room in the Intensive Care Unit and had
15 gotten his chart?

16 A. Yes.

17 Q. Right?

18 A. Yes.

19 Q. And you took his chart, and you went to a
20 computer terminal where you could access this narrative
21 record?

22 A. In the MSICU, yes, sir.

23 Q. And you told me that, again, because you
24 wanted the entries in the chart to be accurate, that
25 you took a document that was in his medical chart, and

1 used it for you to rely upon so that you wouldn't have
2 to rely on your memory for this process of making the
3 chart more accurate; right?

4 A. Yes, sir, uh-huh.

5 Q. And I asked you what was the document that you
6 were relying on?

7 A. Yes, sir.

8 Q. Do you remember what you told me?

9 A. Not exactly, but it was -- it was the code
10 record.

11 Q. It was the Mayday record?

12 A. Yes, sir.

13 Q. Okay. Now, do you remember me asking you at
14 your deposition in August of 2014 about this Mayday
15 record that you had in his chart to rely upon to
16 complete the narrative?

17 A. Do I remember you asking me? Not
18 specifically. Not specifically.

19 Q. Let's take a look at that.

20 (A portion of a video deposition was played in
21 open court.)

22 BY MR. RANSOM:

23 Q. So this record that was in Mr. Mikell's chart,
24 and that nobody can find now that we're in this
25 lawsuit, that you say that you used in order to

1 accurately complete this narrative?

2 A. Yes, sir.

3 Q. I asked you about it three times in August of
4 2014; you didn't remember anything about it?

5 A. I did. The only thing that I could probably
6 add to that, to shed light on my testimony, I do not --
7 I did not refresh myself with that case as far as the
8 documentation, the different edits, the different edits
9 on the narrative. The record itself. The timing, et
10 cetera, prior to that deposition. So -- but in looking
11 at it, and looking at the time that the Mayday was
12 called and then the defibrillation specifically, the
13 intubation specifically, it helped supplement and
14 helped me edit my narrative.

15 There would be no other way that I would know
16 specifically what times, you know, the -- when CPR was
17 initiated, et cetera, all of that good stuff. None of
18 that was actually contemporaneous -- very little -- very, very,
19 very few of those events were contemporaneously charted
20 in the narrative. So that's where I -- I would have
21 gotten it. So at the time, I must not have -- I must
22 not have recalled it.

23 Q. And you -- you'll remember back in August of
24 2014, when you came to your deposition, you had Ms.
25 Fleming and Mr. Cooke there on behalf of the Medical

1 University, they were providing counsel for you; right?

2 A. Yes, sir.

3 Q. And you had your own lawyer there, Mr. Early?

4 A. Yes, sir.

5 Q. All right. And we had given you plenty of
6 notice that the deposition was coming up?

7 A. Yes.

8 Q. So are you telling the jury that the reason
9 that you gave these answers that we are seeing on these
10 video clips, is because you were somehow or another
11 caught off guard, and didn't understand the facts of
12 what had happened?

13 A. No, sir. I wouldn't say that -- I just did
14 not readily recall --

15 Q. Well --

16 A. -- how -- how I came up with editing my
17 narrative.

18 Q. And then one of the things that a witness is
19 allowed to do when they give a deposition, is what we
20 call read and sign; where the court reporter, much like
21 our court reporter here is taking down everything
22 that's said, they prepare a preliminary transcript.
23 And then this is made available to the witness to
24 review, to make sure that it's truthful, accurate, and
25 complete. You can make any changes that are necessary

1 if you misremembered, misspoke, or got something wrong?

2 A. Yes. Yes.

3 Q. All right. You actually exercised your right
4 to read and sign the transcript of your testimony in
5 August of 2014?

6 A. Yes, sir.

7 Q. You didn't make any changes, did you?

8 A. I do not recall making any changes, no.

9 Q. In fact, you actually signed a document that
10 I've got marked here as Plaintiff's Exhibit 51, making
11 no changes. And you signed it on October 5th -- well,
12 it looks like October 7th of 2015. It's actually
13 notarized October 19, 2015; is that your signature
14 right there?

15 A. Yes, sir, it is.

16 Q. Okay.

17 MR. RANSOM: Your Honor, we'd offer Plaintiff's
18 Exhibit 51 into evidence.

19 THE COURT: Any objection?

20 MR. COOKE: No objection.

21 (WHEREUPON, Plaintiff's Exhibit 51 was admitted
22 into evidence.)

23 BY MR. RANSOM:

24 Q. Now, August of 2015 would be 14 months after
25 your testimony in this case, in August of 2014, 14

1 months later?

2 A. Yes, sir.

3 Q. You, once again, swore in front of a notary
4 that there wasn't any change that needed to be made to
5 your testimony in order for it to be truthful,
6 accurate, and complete?

7 A. Yes, sir.

8 Q. Thank you. So that would be a second time
9 that you swore falsely?

10 A. May I explain, please?

11 Q. Sure.

12 A. May I explain -- I may not have read my sworn
13 testimony from the deposition in its entirety, and I'm
14 not certain that I was familiar with my edits and the
15 timing of my edits as accurately as I am now.

16 So I would not have -- I would not have given
17 false testimony. Everything I tell you, Mr. Ransom, is
18 accurate and honest to the best of my recollection. So
19 at the time, it just didn't -- it did not raise a red
20 flag. It did not raise a red flag that I had, you
21 know, I had said anything that I knew not to be honest,
22 so.

23 Q. Now, Ms. Embrey, please, you're digging
24 yourself in a hole here. Do you not remember last
25 summer -- and I can't recall if it was July or

1 August -- you sat there and exercised your memory once
2 again, and remembered, oh, I saw the Mayday record. It
3 was in Mr. Mikell's chart and I used it to complete
4 this narrative. And that was three or four months
5 before you signed Exhibit 51?

6 A. Case in point, I do not believe I read the
7 2014 deposition as accurately as I should have, so that
8 is -- that is my fault.

9 Q. And you didn't testify as accurately as you
10 should have in 2014 either; did you?

11 A. I testified as accurately and honestly as I
12 recalled.

13 Q. Now, in terms of this software malfunction,
14 the policies and procedures for anesthesia services of
15 the Medical University have been marked as Plaintiff's
16 Exhibit 8. As the certified nurse anesthetist, you are
17 a part of the anesthesia department there at the
18 Medical University?

19 A. Yes, sir.

20 Q. Okay. And the anesthesia department's
21 policies and guidelines would apply to your activities?

22 A. Yes, sir.

23 Q. Have you ever seen the document that's
24 entitled, Policies and Basic Standards of Anesthesia
25 Care?

1 A. Yes, sir.

2 Q. One of the things that these policies and
3 procedures require is that every time you go to provide
4 anesthesia to a patient, you are required to check out
5 the system before you get started; isn't that right?

6 A. Yes, sir.

7 Q. So, I've got page four of six, document
8 control number 2563 on the overhead. This is from
9 Plaintiff's Exhibit 8. And it says, "Prior to
10 administering anesthesia, the practitioner
11 administering anesthesia" -- and in Mr. Mikell's case,
12 there were two of you, right? Yourself and Dr. Nelson?

13 A. Yes, sir.

14 Q. Okay. So, "Prior to administering anesthesia,
15 the practitioners administering anesthesia will check
16 and document the readiness, availability, cleanliness,
17 sterility, where indicated, working condition, and the
18 alarm systems of all equipment to be used"; am I
19 reading that correctly?

20 A. Yes, sir, absolutely.

21 Q. Would that -- I mean, you would agree with me
22 that that would include all of the electronic equipment
23 that you are using; right?

24 A. In general, but there was a time when we were
25 paper charting non contemporaneously, or every five

1 minutes, or every 15 minutes. So we make an effort,
2 but it does not always cooperate.

3 Q. Okay. So it's pretty obvious before you get
4 started, you're supposed to check all the equipment and
5 make sure that it's in working condition. And if the
6 PICIS system is not accurately recording the oxygen
7 saturation values --

8 A. Yes, sir.

9 Q. -- this would be an example of the equipment
10 not working properly?

11 A. No. The equipment working properly would be
12 me seeing an appropriate oxygen sat. Once I've got
13 Mr. Mikell on monitors, nasal cannula oxygen is in, and
14 I have an appropriate O2 sat that is working versus
15 changing it to another finger, or an ear, or a nose
16 where it can pick up a little bit better. So that's
17 the focus in number one.

18 Q. Do we need to go back to where we started this
19 morning, where you agreed that it was after you had
20 made the first phone call to the technician, but before
21 you had the problem solved, that you gave Mr. Mikell
22 the Propofol? Do you remember that? That was just
23 like an hour ago?

24 A. I do. I do.

25 Q. Okay. So we can agree then that you didn't

1 comply with this policy, you didn't make sure that the
2 equipment was working properly, you put your patient to
3 sleep while you had a problem?

4 A. No. I did not have a problem, but the
5 computer charting was not communicating with what I was
6 seeing on the monitors.

7 Q. And you were sending text messages and making
8 phone calls to try to solve that problem while your
9 patient was under anesthesia?

10 A. None of that affected Mr. Mikell's care, no.

11 Q. Okay. The other thing that Plaintiff's
12 Exhibit 8 requires is checking the machine to make sure
13 it's working properly before you started isn't enough,
14 it says all accurate -- it says "all information is to
15 be accurately recorded on the anesthesia record?"

16 A. Yes.

17 Q. "This shall at least" -- meaning at a minimum
18 -- "include monitoring data"?

19 A. Absolutely.

20 Q. So as we've seen, the anesthesia machine is
21 not accurately recording all of the vital signs
22 information in the chart, and that's why all of those
23 boxes are empty? And you knew that before you gave
24 Mr. Mikell the Propofol; right?

25 A. No, sir. I put a call -- I put a call into

1 Annette, and then started the Propofol, and the
2 procedure started.

3 Q. That's right.

4 A. And it was my hopes that -- it was my hope
5 that PICIS, the PICIS IT helper could repopulate what I
6 was seeing on the monitor.

7 Q. And Mr. Cooke had asked Dr. Kofke yesterday,
8 you weren't here, but he had asked Dr. Kofke repeatedly
9 about this part of the chart right here?

10 A. Yes, sir.

11 Q. That would indicate quite clearly apparently,
12 if this record is to be believed, that the Propofol was
13 started at 7:41 -- all right -- now, I'm referring to
14 page 3 of 99. Do you see that?

15 A. Yes, sir.

16 Q. Okay. Now, your first text message that you
17 sent, relative to this software problem, that was at
18 7:39?

19 A. Okay.

20 Q. And the last text message which reads, "hey,
21 can you call me back" was at 7:46?

22 A. All right, sir.

23 Q. So, once again, that fairly clearly
24 demonstrates that while you are in the process of
25 trying to solve this problem, you are giving Mr. Mikell

1 the anesthetic?

2 A. No, sir. I paged Annette at 7:39, before
3 Propofol was administered or the procedure started, to
4 get her to call me and transfer my chart. Because I
5 could not do it. And I recognized that before I
6 started the Propofol or the procedure started, so.

7 Q. Right. Well, that's my point, is that you
8 realized that there was a problem at 7:39?

9 A. After, uh-huh, yes.

10 Q. You didn't get the problem solved until
11 sometime after that last text message at 7:46. And in
12 the middle of all that, you're giving the Propofol to
13 your patient?

14 A. Yes, sir. I started the infusion, I did.

15 Q. And when I asked you at your deposition, why
16 it was that you had proceeded in that fashion, do you
17 remember what you told me?

18 A. No, sir.

19 Q. You said it was because you were busy and in a
20 hurry? Do you remember that?

21 MR. COOKE: What page are you referring to?

22 MR. RANSOM: This is page 32.

23 BY MR. RANSOM:

24 Q. This is on page 32 of your -- I think this is
25 your February 2016 deposition. I asked you, "So you

1 hadn't checked to make sure that part of the system was
2 working correctly?" Now, that's a reference to the
3 data recorder. And you said, "Nope". And I asked you,
4 "Why not?" And you said, "Well, I pulled it up. It
5 booted up", meaning the screen had come up.

6 A. Right.

7 Q. The anesthesia software screen had come up.
8 There was no problems like early in the morning,
9 meaning before Mr. Mikell had been brought in.

10 A. When I checked the room.

11 Q. "So when I roll in and I'm busy, you know,
12 getting Mr. Mikell in position, oxygen on, monitors on,
13 everything good, you know, kind of busy there, the
14 charting is kind of the last thing that I do".

15 A. Always. Patient first, and the chart I can
16 repopulate, catch up, or whatever. I mean, you know,
17 the computer charting is a fairly new thing. We used
18 to have to write everything non contemporaneously. So
19 it's -- it's not a critical part of the patient's care.
20 It's an -- it's an adjunct, so I'm not focused on that
21 as much as I'm focused on Mr. Mikell's care.

22 Q. Well, and I -- isn't that the answer because
23 Mr. Mikell --

24 A. I mean it totally is.

25 Q. Mr. Mikell isn't going to desaturation and go

1 into cardiac arrest because data is not filling those
2 boxes, he's going to go -- he's going to desaturate and
3 go into cardiac arrest because you're on the phone
4 sending text messages when that starts to happen?

5 A. No, sir. No, sir.

6 Q. And so whatever may be going on with the
7 anesthesia system recording function, you're absolutely
8 right, it is secondary to what's taking place with your
9 patient?

10 A. Absolutely.

11 Q. And if, in fact, instead of taking -- taking
12 care of your patient, you've got your back to him at a
13 keyboard, sending text messages, and over here on the
14 phone with a technician --

15 A. No, sir.

16 Q. -- that's malpractice; isn't it?

17 A. No, sir. The computer is here. The machine
18 is here. And Mr. Mikell is here. His head is right
19 here for a colonoscopy, so everything is like within
20 my -- within my suite -- my visual field. So, I did
21 not have my back to him at any -- at any time during
22 that procedure that I recall.

23 Q. Is this the way that the suite was set up as
24 is depicted here?

25 A. It is the way that the suite is set up. And

1 then once you have your patient with -- where the
2 pillow is -- is appropriate for a colonoscopy, once you
3 have the head of the bed, you're standing right around
4 where the chair is. This is your PICIS. You have to
5 make sure that you -- obviously have the -- the doors
6 open before the stretcher rolls in, because the
7 stretcher railing will impede your opening it. So you
8 open that.

9 Get him snuggled up to the machine. Get the
10 machine angled so that you can angle your computer
11 screen and see everything in a sweep, kind of this way
12 kind (indicating) -- kind of in a panoramic fashion.
13 So, yes, that looks exactly like Room D.

14 Q. If we were to just pretend for a moment that
15 this courtroom were set up somewhat similarly to the
16 way it's depicted in the picture, that computer screen
17 that's there on the right?

18 A. Yes.

19 Q. That's the PICIS anesthesia monitor and the
20 keyboard; correct?

21 A. Correct, yes.

22 Q. And that's the keyboard that you're using to
23 type these text messages?

24 A. Yes.

25 Q. And the PICIS anesthesia software, that's not

1 the software that you use to send text messages, is it?

2 A. No. No.

3 Q. So you've got to minimize or close out PICIS
4 and open up some other program --

5 A. Yes.

6 Q. -- in order to send those messages?

7 A. Yes, another icon.

8 Q. So if we were to pretend for a moment that
9 this courtroom is set up the way that this room is set
10 up, when you're using the keyboard, you're facing the
11 screen just as you are right now. And the patient
12 would be behind you, just like the TV monitor is?

13 A. No. I understand this is -- this is the set
14 up as you've photographed it, Rob, but when there's a
15 patient there, you angle the machine and you angle --
16 or at least I do -- angle the computer screen and the
17 keyboard, so that I can see everything going on.

18 I might type ten seconds (indicating) then I'm
19 looking at the monitor, and looking at him, making sure
20 that everything is rolling along.

21 Q. Okay. So you didn't check the equipment as
22 required by the policy because you were busy and in a
23 hurry?

24 A. No, sir. I checked the anesthesia equipment
25 and the monitoring, and I was able to pull up PICIS on

1 the computer. In other words, my computer was working.
2 It did boot up accurately at the time.

3 Q. Okay. I want to go back for a minute to these
4 anesthesia records. Now, you had gone into the system
5 on October 1st and made, what you said, you went
6 back -- at the end of your shift on October 1st, you
7 went and accessed the anesthesia record in order to
8 complete the record?

9 A. In order to accurately reflect the times on
10 the narrative.

11 Q. Okay. And then you went back into the system
12 again the next day on October 2nd?

13 A. Yes. To visually kind of look at
14 everything -- kind of all in one, yeah.

15 Q. And to print out the record and shred it?

16 A. Correct, yes.

17 Q. Now, let me show you what's marked as
18 Plaintiff's Exhibit 5. And this is yet another
19 printout of the anesthesia record. And you'll see that
20 this one has been printed out on April 2, 2013; do you
21 see that?

22 A. I do.

23 Q. And the audit trail is Plaintiff's Exhibit 11.
24 I'm going to switch back and forth for just a second.
25 Plaintiff's Exhibit 11 is the one that shows us that

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1 you had printed out the record on October 1st?

2 A. Yes.

3 Q. And then when we look at the second page, we
4 also see that you have printed it out on October 2nd?

5 A. Yes, sir.

6 Q. At 1814, and again at 1815?

7 A. Um --

8 Q. -- right -- and then lastly on this audit
9 trail, we also see that a Jeff Toohey has printed the
10 record on October 1st, at 1344, and he's done it twice?

11 A. Uh-huh.

12 Q. Do you see that?

13 A. That's recovery room, uh-huh. Jeff is an RN.

14 Q. Right.

15 A. In PACU.

16 Q. And that sort of correlates with Plaintiff's
17 Exhibit 2, where we see the print time of October 1st,
18 1347. So it looks like Exhibit 2 is the record that
19 Mr. Toohey printed out. Now, he's the nurse
20 anesthetist in the recovery room --

21 A. Registered nurse, yes.

22 Q. Right.

23 A. He's the one that took Mr. Mikell.

24 Q. So when Mr. Mikell had his heart shocked back
25 into rhythm, he's then taken out of the endoscopy

1 procedure room --

2 A. Yes.

3 Q. -- to an area of the hospital called the Post
4 Anesthesia Care Unit?

5 A. Yes.

6 Q. And Mr. Toohey is one of the people that's
7 managing his care there?

8 A. Yes.

9 Q. All right. And so what we see then is that
10 Mr. Toohey has accessed the system and printed the
11 anesthesia record, and that's what we have as
12 Plaintiff's Exhibit 2; right?

13 A. Yes.

14 Q. Okay. And it also looks as though Mr. Toohey
15 was the one who printed the record that's marked as
16 Exhibit 1 at 1346, where we're missing the first page.
17 Now, Ms. Embrey, did you go into Mr. Mikell's record
18 and take the first page of that first printout and do
19 something with it?

20 A. Absolutely not, sir, no. I edited later on
21 that afternoon in the computer. I edited my narrative,
22 so.

23 Q. Is that -- is that page one part of what you
24 shredded after you had changed the record?

25 A. I printed out the -- I printed out what I

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1 thought to be the entire record Friday evening, and
2 then -- to put in the chart in the MSICU. And then the
3 next day, to kind of just look at it visually, because
4 I was on a 24 hour shift that day. I just wanted to
5 make sure that the sequence of events and everything
6 that I put in was accurately reflected.

7 Q. Okay. Well, again --

8 A. But everything was in the computer, I -- I
9 can't -- I can't delete a page or any -- I can't delete
10 any data that's there. The page one is always there.
11 I was just editing the narrative in the narrative
12 section.

13 Q. Back on Plaintiff's Exhibit 11, this audit
14 trail -- again, my office has been provided in this
15 case the audit trail that only runs through October 2nd
16 of 2010, at 2359 -- that's like a minute before
17 midnight. Okay. And that's where this Exhibit 11
18 ends. We don't have the record of any other changes to
19 the anesthesia record after that, but those aren't the
20 only changes that have been made, are they?

21 A. I'm not -- I'm not certain.

22 Q. Well, that's what I say, when we look then at
23 what's marked as Plaintiff's Exhibit 5, we're going to
24 see that another part of the record has been altered.
25 And if you'll take a look -- ladies and gentlemen, this

1 is a little bit -- so, if we look at the record, that's
2 printed out on October 2nd at 1815, and that's about
3 the time that you were up in Mr. Mikell's room making
4 your last review of this; right?

5 A. Yes, sir, uh-huh.

6 Q. What we see is these entries under Dr.
7 Nelson's name at 7:48, all come grouped together -- do
8 you see that?

9 A. Yes.

10 Q. All right. And these relate to the
11 "anesthesiologist assessed the patient, reviewed the
12 chart, formulated the anesthesia plan"?

13 A. Yes.

14 Q. "He was medically directing the case." That
15 means he's in charge; right?

16 A. Right.

17 Q. Okay. He's present for induction. That means
18 when the patient is put to sleep; right? Then it says,
19 "I, or another attending anesthesiologist, was
20 immediately available," it says. So those four entries
21 that are timed at 7:48, they are all one right after
22 another?

23 A. Right.

24 Q. And that's on the record that's printed on
25 October 2nd. But now when we turn to the record that's

1 been printed in April of 2013 -- and again, I'd like us
2 to take judicial notice that this lawsuit was filed in
3 2012.

4 THE COURT: What was -- what was the date of the
5 filing? Do you know?

6 MR. RANSOM: I believe it was in November of 2012,
7 is what the record --

8 THE COURT: Does the defense agree with that? We
9 have November 6, 2012, the lawsuit was filed. The
10 Court will take judicial notice of that.

11 MR. RANSOM: All right. Thank you.

12 BY MR. RANSOM:

13 Q. So, now this -- this record is being printed
14 about six months after the lawsuit has been filed. And
15 we see these entries by Dr. Nelson at 7:48. Here's the
16 first two of them?

17 A. Okay.

18 Q. All right. And then here's -- the second two?

19 A. Right.

20 Q. At 7:48. But now there's an entry that's in
21 between them, under your initials?

22 A. I thought that was -- I thought that was
23 present on the afternoon that Mr. Mikell went to the
24 unit.

25 Q. So, what we see, Ms. Embrey, is that sometime

1 after -- well, sometime between October 2, 2010, and
2 April 2, 2013, you've gone back into the system, you've
3 changed the entries -- or the order of the entries, and
4 isn't it interesting that none of that shows up on the
5 audit trail that my office was provided?

6 A. No, sir. Because I did not -- I did not edit
7 anything in Mr. Mikell's record after -- after that --
8 after that afternoon evening.

9 Q. Ms. Embrey, do you think that the computer did
10 this all on its own?

11 A. I don't know, Mr. Ransom. I don't know.

12 Q. Do you think that somebody else logged in
13 under your user name and password, and changed that
14 record?

15 A. No. But that was there on a previous record
16 though. That was there in the narrative on a previous
17 record.

18 Q. Now, I want to ask you a little bit about this
19 idea that you've tried to explain some of these things
20 by saying that Dr. Nelson was charting under your name.
21 Do you remember you told me that three separate times
22 under oath, when you were trying to explain the entry
23 that you had changed from his initials to yours?

24 A. Yes, sir.

25 Q. All right. You tried to tell us that that was

1 because he was charting under your name?

2 A. I might have honestly thought that at the
3 time.

4 Q. Have you ever seen the PICIS anesthesia user
5 training manual, and this is the manual there at the
6 Medical University?

7 A. I've seen it. I've seen it.

8 Q. That teaches you how to do this electronic
9 charting?

10 A. Yes, sir. It was more of a one-on-one with a
11 PICIS team. I thumbed through this, but.

12 Q. We've got this marked as Plaintiff's Exhibit
13 44. And I apologize -- the document control numbers
14 are cut off, but I'm going to put the second page up
15 here on the screen. And the very first thing that this
16 manual talks about, point number one, is
17 confidentiality and security. And it says, "You must
18 also not leave the anesthesia manager log-in under your
19 user name for someone else to use. This is a
20 disciplinary matter."

21 A. I see that.

22 Q. Which means that if you're allowing someone
23 else to make entries in the record under your user
24 name, you could be fired for that; right?

25 A. I see that. However, with six or seven

1 anesthesia providers all doing for Mr. Mikell at the
2 same time, it is not always feasible to log out and
3 relog in under your name. There's kind of -- I guess a
4 trust within the people that are present in a critical
5 situation, that what you put in under my name is going
6 to be accurate.

7 Q. Recognizing that your job could be at stake if
8 you logged in under someone else's name, do you think
9 that somebody else would have gone into this chart
10 under your initials and changed the order of these
11 entries?

12 A. No, sir, but I edited the narrative that
13 afternoon and evening. And everything that's in there
14 under my name was put in, I believe that
15 afternoon/evening. That's why I wanted to be done with
16 it. That's why I stayed later than my shift that
17 evening, to make sure everything was accurate.

18 Q. And you said the reason that you wanted it to
19 be accurate was?

20 A. I wanted the record to reflect accurately what
21 we had done for Mr. Mikell. I mean, there was -- there
22 were at least six or seven of us anesthesia providers
23 at any given time while the code was going on, and we
24 were stabilizing Mr. Mikell, and giving meds and
25 starting drips. And everything prior to getting him up

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1 to the recovery room, there was -- there was a lot
2 going on. So there were a lot of people jumping on the
3 computer to add this, that, or the other. And I'm sure
4 I wasn't logged out at any time, which is fine, you
5 know. Because obviously most of us were busy -- at one
6 point extremely busy doing for Mr. Mikell and taking
7 care of what we needed to.

8 Q. So when we look at the first anesthesia record
9 that's printed out, and we look at the detail of the
10 narrative, and this is Plaintiff's Exhibit 2, we see
11 that there really isn't a whole lot of information
12 that's been entered; right? I mean, in essence, all
13 that got entered was this business right here,
14 transfer?

15 A. Right.

16 Q. And that's part of the process of trying to
17 correct the software problem?

18 A. Yes.

19 Q. And that entry is timed at 7:47?

20 A. Correct.

21 Q. I see everyone is straining to see that?

22 A. I believe that's when Annette, from PICIS,
23 kind of worked it out. And actually the chart was
24 transferred successfully.

25 Q. Okay. And -- and that's an electronic entry.

1 at 7:47; right?

2 A. Correct, yes.

3 Q. All right.

4 A. Yep.

5 Q. So, this helps us then to further identify
6 that even at 7:47, you're still on the keyboard doing
7 something to correct this problem?

8 A. Not necessarily.

9 Q. Okay.

10 A. No, not necessarily.

11 Q. All right. So there really isn't any
12 information that's entered in the record about what's
13 taking place at all? That's a pretty bare bones
14 record; right?

15 A. Say that again.

16 Q. I say, these entries right here are very
17 limited? They don't give us much description at all
18 about what's actually taking place with the patient?

19 A. No, sir. Including when Eric came in and
20 signed in his anesthesiology attestations at 7:48, that
21 was when he stepped in and I had just put the nasal
22 airway in, so.

23 Q. And that's why you went back -- when you
24 created the detailed narrative in order to put a whole
25 bunch of other stuff in there; right? And one of the

1 things --

2 A. Yes. I -- I edited that to include when
3 Nelson walked in, checked on me. I had just put the
4 nasal airway in. I said, the sats were fine. He was
5 still in a lateral position, all of that -- all of that
6 happened, uh-huh, at the same time that Eric came in to
7 chart his attestations.

8 Q. Right. So you've gone back in and you've
9 filled in all of this preop stuff; right?

10 A. Yes.

11 Q. And --

12 A. -- because I don't -- it normally populates
13 when you -- it normally populates when you hit
14 anesthesia start in holding. So I'm not sure -- I'm
15 not sure why I knew that it didn't populate, because I
16 was having no problems with the computer to my
17 knowledge in the holding area when we were looking at
18 the preop and kind of setting the record up and -- and
19 doing all that.

20 Q. And you filled in quite a number of entries at
21 7:51, Dr. Nelson's left the room?

22 A. Yes.

23 Q. 7:55, you've turned the patient. 7:56, Dr.
24 Nelson's back in the room. That's the entry that you
25 changed. 7:57, 7:57, then 8:01. My point being that

1 there's a number of entries in there that are timed
2 earlier than 8:00; correct?

3 A. Yes.

4 Q. Okay. And it's your testimony that you were
5 relying upon the Mayday record in order to be able to
6 accurately recount what had taken place during those
7 times?

8 A. Yes. That's the -- that's the only other
9 thing I would be able to look at, and talk about CPR,
10 defibrillation, intubation time. I could probably
11 guesstimate pretty well from other data that was
12 populating by then, as far as peak airway pressures,
13 tidal volume, et cetera, that comes across on a
14 ventilator. By, yeah, key times after -- after the
15 code was called.

16 Q. Right. The key times that would reflect,
17 amongst other things, when Dr. Nelson was coming in and
18 going back out; right? Because, I mean, they are there
19 --

20 A. Yes, yes, the narrative did, yes.

21 Q. And your testimony is that you were able to
22 accurately recreate those times by looking at the
23 Mayday record?

24 A. No. I was accurate -- I was reflecting on
25 them to accurately report the CPR, defibrillation

1 times. And then other -- other events that might have
2 gone on. Mostly defibrillation, CPR, what time the
3 code was called is -- was why I was looking at the
4 Mayday record.

5 Q. Well --

6 A. A Mayday record would not begin until the
7 Mayday is called. It would not reflect anything about
8 the case until the Mayday is called.

9 Q. How then were you being able to accurately
10 reconstruct all of these events?

11 A. I remembered him coming into the room as I put
12 the nasal airway in. We talked about it. We talked
13 about it after -- after the -- after the case at some
14 point. Then I said, well, you came in, you know, right
15 when I put the nasal airway in and everything was fine.
16 You know, we kind of just --

17 THE COURT: All right, let's -- I'm sorry. Go
18 ahead and finish. Excuse me.

19 A. Yes, Your Honor. So that was -- that was
20 accurately recorded. Because when he came in to record
21 his attestations, that was almost exactly the time I
22 just put the nasal airway in. He's like, you all
23 right. I'm like, he's fine. Yeah. The sats are up.
24 We're good. And he came around -- he has to really --
25 as you can imagine, that room is cozy. So he has to

1 come in behind me and get to my computer, log out, log
2 in, put his attestations in, then leave. So that took
3 about two or three minutes.

4 THE COURT: All right. Mr. Ransom, we're going to
5 take a break at this time.

6 MR. RANSOM: Yes, sir.

7 THE COURT: Madam Forelady, ladies and gentlemen
8 of the jury, leave your notepads. And please don't
9 discuss the case amongst yourselves. If you need
10 anything, let the bailiff know. We're going to take a
11 morning break at this time.

12 If you'll follow the bailiff to the jury room.

13 (WHEREUPON, the jury leaves the courtroom at
14 11:20 a.m.)

15 THE COURT: All right. Ms. Embrey, during the
16 break, don't discuss the case with anyone; do you
17 understand?

18 THE WITNESS: Yes, sir.

19 THE COURT: All right. We're going to take about
20 a 20 minute break. Thank you very much.

21 (WHEREUPON, a brief recess was taken.)

22 THE COURT: Anything from the plaintiff before we
23 bring in jury?

24 MR. RANSOM: Nothing, Your Honor.

25 THE COURT: Anything from the defendant?

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1 MR. COOKE: None, thanks.

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

3 (WHEREUPON, the jury enters the courtroom at
4 approximately 11:42 a.m.)

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

6 THE COURT: Thank you very much. Please continue.

7 MR. RANSOM: Thank you, Your Honor.

8 BY MR. RANSOM:

9 Q. Ms. Embrey, when was the last time that you
10 actually had the Mayday record in your possession?

11 A. Yes, sir, to the best of my recollection, the
12 one and only time that I would have looked at it to get
13 correct times on the defibrillation, and the CPR and
14 other things that went on within the Mayday, were
15 that -- that afternoon. That afternoon in the MSICU.

16 Q. That would be October 1st?

17 A. That would be October 1st, I believe, yes.
18 Yes. It was part of the chart. It was in the chart.

19 Q. Explain to the jury the process of how you
20 came to have it in your possession, if you will,
21 please?

22 A. It was in the chart. When I was editing the
23 narrative in the anesthesia record, when the patient
24 was in MSICU later in the afternoon, around 6:00, 6:30.

25 Q. When you say "it was in the chart", can you

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1 give us a physical description -- are you talking
2 electronic record, paper chart?

3 A. No, sir. It's a paper chart. I'm not sure
4 even if we have an electronic record of the Mayday. I
5 believe it's just a paper copy, because anybody can
6 grab it off the clipboard -- the nurses can grab it off
7 the Mayday cart that is brought into the room, and
8 start charting on it. So it was part of the chart in
9 the -- in the -- in the bind -- in the binder rings.

10 Q. So, when you went to the Intensive Care Unit
11 where Mr. Mikell was in the bed, there was a metal
12 binder hanging on the end of his bed?

13 A. I don't recall exactly where it was. I was --
14 I believe I asked -- I believe I asked one of the
15 nurses if they could bring me Mr. Mikell's chart and
16 record, et cetera, yes. I do not recall going to
17 Mr. Mikell's bedside that particular day. I do not
18 have that recollection.

19 Q. And in his physical record, you're talking
20 about sheets of paper that are tacked down with these
21 holes that are punched across the top?

22 A. Yes. Yes.

23 Q. And so the Mayday record was affixed to his
24 chart in that fashion?

25 A. It was as -- as best I can recall.

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1 Q. Where was it the last time you saw it?

2 A. That was the last time that I -- that I looked
3 at it or recalled looking at it was then to -- to edit
4 my narrative, and get the times correct.

5 Q. Well, so it was tacked down in his physical
6 chart that a nurse had helped you to find -- where did
7 you leave the chart?

8 A. I'll be honest, I don't recall if I -- if I
9 left it next to the computer where a lot of the
10 anesthesia and MDs that come in and out of MSICU work,
11 or if I left it with a particular person. I don't
12 recall. I don't recall, yeah.

13 Q. Well, now, are you telling us that you fumbled
14 it or did you return to where you got it from?

15 A. No, sir. I'm telling you that I left it on
16 the unit somewhere. I'm not sure exactly where in the
17 MSICU I left it. I can't recall.

18 Q. All right. Now, we have been talking before
19 the break about the Mayday record and the information
20 that it contained, and the fact that you were using it
21 in order to complete the entries in the narrative;
22 right?

23 A. Yes.

24 Q. Okay. And we have been talking a little bit
25 about what some of the information that you were

1 relying on the Mayday record to complete; right?

2 A. Yes.

3 Q. Okay. And one of the things that the Mayday
4 record showed was the time that Dr. Nelson came back
5 into the room?

6 A. I'm not sure if it reflected the time that he
7 came in the room. I know that it reflected the time
8 that the Mayday was called, and that defibrillation
9 occurred, what energy we defibrillated at; when CPR was
10 initiated, et cetera. I'm not sure if that -- if that
11 entry was -- was actually in the -- written in the
12 Mayday -- Mayday record.

13 Q. And in terms of being able to accurately
14 recreate the events, it was important for you to be
15 able to place a time on when it was that Dr. Nelson
16 came back into the room?

17 A. Yes, sir, I knew -- I knew when Dr. Nelson
18 came in the room because he actually came into the room
19 and helped us turn the patient supine. And -- and that
20 kind of -- in that moment, everything was kind of
21 starting to -- Mr. Mikell was becoming unstable, so a
22 lot of things kind of occurring within a minute or two.

23 Q. Right. And -- and to know when it was that
24 Dr. Nelson came in, I mean, that's pretty important;
25 isn't it?

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1 A. Yes, sir.

2 Q. And because you were going to change Dr.
3 Nelson's entry, that he came back into the room at
4 8:00, you were trying to figure out what time to change
5 that entry to?

6 A. I edited a lot of the narrative, like from the
7 beginning to the end, so just to reflect accurate
8 times.

9 Q. Right. And you say that you were able to
10 accurately change that entry from him coming in at
11 8:00, to him coming in at 7:56 because that information
12 was contained in the Mayday record?

13 A. Yes, sir. What time that the -- that the
14 actual Mayday was called.

15 Q. Okay. Well, but in terms of the time when Dr.
16 Nelson came back into the room, you were relying on --
17 because look what this entry says is that he came into
18 the room, and then a Mayday team was called; right?

19 A. Correct.

20 Q. All right.

21 A. Yes, all -- a lot of things are in that
22 sentence. And they occurred within a minute, a minute
23 -- you know, it's -- you know, it's, again, it's non
24 contemporaneous charting. So it's within a minute or
25 so of everything happening. There's a lot of things

1 that kind of transpired from the time that we turned
2 him, when he was becoming unstable, to the time that
3 the Mayday was called, so.

4 Q. That's right. And so what you're telling us
5 is, again, in order to try to recreate the events and
6 be able to accurately chart all of these things that
7 are happening, you're using the Mayday record as your
8 source. And one of the things that you say that the
9 Mayday record contains was the time -- not when the
10 Mayday was called, but when Dr. Nelson came into the
11 room?

12 A. I -- I don't recall editing from the Mayday
13 record about that, but.

14 Q. Well, I asked you about that at your
15 deposition on February 22nd of this year; do you
16 remember what you told me?

17 A. I do not.

18 Q. So I asked, and this is on page 152, carrying
19 over to page 153, the question was "So the Mayday
20 record shows the time that he came back into the room?"
21 And your answer was, "The Mayday reflected that, yes."
22 It says, "Is there any other record besides that Mayday
23 record that tells us that time?" And your answer was,
24 "Not to my knowledge, not to my knowledge."

25 A. All right, sir. So if I may explain, the fact

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1 that Eric came in and helped us turn him supine, and
2 then the Mayday was called, I knew for sure that when
3 the Mayday was called, Eric was -- I mean, I -- I
4 recall Eric coming and helping us turn Mr. Mikell from
5 his -- from his left side to his back -- from being on
6 his left side to his back, so.

7 Q. So you would agree that Mr. Mikell was already
8 in trouble when Dr. Nelson came into the room?

9 A. He had started to become unstable and
10 desaturate.

11 Q. And I think you've also said -- you would
12 agree with me that Dr. Nelson was not actually in the
13 room when you first gave Mr. Mikell the Propofol?

14 A. Not to -- not that I recall, no. When I
15 initiated Propofol, not that I recall. Eric was there.
16 He stepped in when I put the nasal airway in about --
17 you know, midway through the time that the scope was
18 in.

19 Q. Right.

20 A. When I made that notation, I know he stepped
21 in and did his computer work. And we talked about I
22 put a nasal airway in and everything was all right.

23 Q. Well, but you previously testified that Dr.
24 Nelson was not in the room when you first gave the
25 Propofol?

1 A. No, sir. When I started the drip I -- I
2 believe that -- I believe -- I do not recall him being
3 in the room.

4 Q. And what you testified is that this effort
5 that you undertook later that afternoon was to make the
6 entries in the narrative to be accurate; correct?

7 A. Yes, sir, as far as -- especially about the --
8 about the timing of how everything happened, including
9 the CPR and the defibrillation, et cetera.

10 Q. And one of the things that's particularly
11 important from a billing standpoint is that in order to
12 be able to send a bill to Mr. Mikell's insurance
13 company, you have to be able to certify that Dr. Nelson
14 was actually physically present in the room at the time
15 that the anesthetic agent is administered; right?

16 A. Yes, sir. So when you call that period of
17 anesthesia induction, it's a very general term,
18 meaning -- especially in the DDC, where we do upper and
19 lower endoscopies, and we start a Propofol drip, it's
20 kind of a general -- like a gradual Propofol drip that
21 is started, and the patient just kind of drifts off to
22 sleep, remains breathing spontaneously with oxygen and
23 supplemental. We call that an IV general anesthetic
24 because you're not able -- you're non-verbal. You're
25 sleeping. Your brain is unaware of anything going on.

1 So it's very common for us to induce for -- for an IV
2 general, for procedural cases with Propofol on a drip
3 versus the MDAs and the DOs always have to be there
4 when we're inducing to intubate and put the breathing
5 tube down. They are always present for that at the
6 Medical University, because it's medically supervised
7 and medically directed. But they are not necessarily
8 there for the -- for the moment that the Propofol drip
9 is started, no, no.

10 Q. Well, and to clarify, Mr. Mikell didn't get an
11 endotracheal tube --

12 A. No.

13 Q. He wasn't intubated?

14 A. No.

15 Q. That wasn't what happened with his case?

16 A. No, it was not, not until after we initiated
17 the -- initiated the Mayday. He was -- he was Propofol
18 drip with nasal cannula.

19 Q. So you wanted to make sure that all of the
20 entries and the time sequence was accurate in the
21 record; correct?

22 A. Yes.

23 Q. Okay.

24 A. Yes.

25 Q. But you didn't really make sure that all the

1 entries were accurate, did you? I mean, the only
2 entries that you were concerned with making accurate
3 were the ones that would have shown what was going on
4 at the time of Mr. Mikell's crisis? The entry that
5 showed when Dr. Nelson was coming back into the room,
6 and when the Mayday was called, when you were turning
7 the patient -- you spent a lot of time trying to
8 recreate those, so that they would look as though
9 everything was done just so; right?

10 A. Not actually recreate, I just edited -- mostly
11 edited the time stamp on what time everything occurred
12 in the sequence of him becoming unstable, us calling
13 the Mayday, intubating him, CPR defibrillation, et
14 cetera, for like that -- that 30, 40 minutes timeframe
15 that I wanted --

16 Q. The whole sequence --

17 A. -- everything to be --

18 Q. -- including when Mr. Mikell gets unstable,
19 when people are coming into the room, all of that, you
20 were making an effort to make sure that that was
21 accurate?

22 A. I was making sure that it was as accurate as I
23 could based on, you know, again, looking at the Mayday
24 record, which is where I would have gotten my
25 defibrillation and CPR.

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1 Q. Because that was part of the record that you
2 knew that the department would be scrutinizing when
3 they investigated this?

4 A. I -- I wasn't really thinking about that at
5 the time, I was just editing the -- the record to make
6 sure that it accurately reflected times and --

7 Q. Well --

8 A. -- and interventions.

9 Q. And one of the problems that you had, Nurse
10 Embrey, was there were certain entries in the record
11 that had been made under Dr. Nelson's initials, that
12 because of the lockout system in the software, you
13 couldn't change those; could you?

14 A. I'm not certain --

15 Q. At his entries --

16 A. Oh, right, his attestations, and everything.

17 Q. Right.

18 A. I'm pretty sure I cannot access those, yes.

19 That's his billing record and billing --

20 Q. So one of the things --

21 A. -- billing departments, et cetera -- I'm
22 sorry.

23 Q. One of the things that Dr. Nelson, himself,
24 charted was that he was medically directing the case;
25 correct?

1 A. Yes, sir.

2 Q. And medically directing the case is important
3 because you, as a nurse anesthetist, under state law
4 are not allowed to administer drugs like Propofol
5 unless you're acting under the supervision of a medical
6 doctor?

7 A. Correct, yes.

8 Q. And now when Dr. Nelson says that he's
9 medically directing the case, I mean, that's true;
10 right?

11 A. Absolutely. We made a -- we made a plan and
12 agreed upon what we would do with Mr. Mikell.

13 Q. He was directing your care and he was
14 supervising what you were doing?

15 A. Yes. Yes.

16 Q. And that's why he's making this entry right
17 here, attesting that he was present to direct and
18 supervising what you were doing?

19 A. Yes, but they are not necessarily present
20 during the entire case. The plan is made, and he may
21 step in, like he did, and check on things. If all is
22 well, then they will, you know, a lot of times they
23 will step in and out.

24 Q. And the other thing that we see under his
25 initials is that he's present for induction and he's

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1 timed that at 7:48; right?

2 A. All right, sir, uh-huh.

3 Q. But you've also got an entry under your
4 initials that's timed at 7:48, and this is saying that
5 he's coming into the room when the nasal airway goes
6 in?

7 A. Correct.

8 Q. Okay. So which -- which -- which one is true?

9 A. Which one is true as far as?

10 Q. Well, so he's saying that he's medically
11 directing the case, that he's present for induction of
12 anesthesia at 7:48. You've got at 7:48 that he's
13 coming in and the sats are coming up, and the -- you're
14 putting in a nasal airway; did that happen at the time
15 --

16 A. Not when I started the -- the initial Propofol
17 drip, no, not to my recollection.

18 Q. So, again, we can agree that Dr. Nelson was
19 not actually in the room at the time that Mr. Mikell
20 was administered the Propofol?

21 A. That's when I initiated the Propofol drip, not,
22 to the best of my knowledge.

23 Q. And, again, it was your testimony that the
24 Mayday record shows when he came back into the room and
25 that that's the only record that actually provides that

1 time?

2 A. Which time exactly now are you talking about?

3 Q. The time when Dr. Nelson came back into room.

4 A. Into the room at 56?

5 Q. Right.

6 A. Yes.

7 Q. That this was something that you were relying
8 upon the Mayday record, in order to be able to chart
9 that and recreate it --

10 A. I was -- I was correlating that time because a
11 lot went -- went on in that minute, minute and a half,
12 yes, when we turned him, started masking him, and
13 called a code.

14 Q. All right. Now, I want to try to wrap this
15 up. Plaintiff's Exhibit 10 is the audit trail that
16 shows every time somebody accessed this narrative part
17 of the record and changed it; you've seen this?

18 A. I believe I have, yes, sir.

19 Q. All right. So let's put this on the overhead.
20 And the first thing that we see -- I hope folks can see
21 this -- so the first thing that you see that's been
22 highlighted is over here in the right hand column, at
23 8:30 in the morning on October 1, Dr. Nelson has logged
24 in?

25 A. Right.

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1 Q. And he has created this entry that he came
2 into the room and the patient was hypoxic. That's a
3 memo, that's something he enters into the memo field;
4 and he's indicated that that took place at 8:00 a.m.;
5 correct?

6 A. Yes, sir.

7 Q. And then what we see here is that you have
8 come along at 5:34, later that evening, and you've
9 modified that entry in order to push that time back by
10 four minutes; correct?

11 A. Yes, and reflect that he came into the room,
12 helped us turn the patient, and then just when
13 Mr. Mikell was becoming unstable, yes.

14 Q. And as we've seen, just a moment ago, you were
15 doing that based on information that you say was in the
16 Mayday record?

17 A. To the best of my knowledge, yes.

18 Q. Now, the other thing that you've done is
19 you'll see there's an entry, and you had initially
20 created this at 5:35 on October 1st. And this
21 indicated when Dr. Nelson came in with this nasal
22 airway; right?

23 A. Right.

24 Q. And this shows that initially the system times
25 it at 1734?

1 A. Right.

2 Q. And then you changed it to be 7:50?

3 A. Right.

4 Q. And then it was changed again, but it stayed
5 at 7:50. And then it was changed again, and now it's
6 at 7:48 --

7 A. Forty-eight.

8 Q. And it's changed now a fifth time and now it's
9 at 7:48, and that was last done at about 6:22?

10 A. 6:22 on 10/1, yes.

11 Q. Now, what we're seeing here is you're
12 spending -- I mean, between 1735 and -- I'm sorry --
13 between 6:18 and 1822 -- that's almost two hours that
14 you're spending trying to rearrange these entries;
15 right?

16 A. Yes. I don't -- I don't recall looking at
17 things at -- at 4:00. I recall looking at them between
18 5:30 and 6:30 in the evening, so.

19 Q. All right. So you've changed it --

20 A. I'm not sure I was at -- I'm not sure at
21 4:18 -- I'm not sure where I was when I was looking at
22 it or -- actually, the time is same, so I didn't -- I
23 didn't actually change it at 6:22. But I don't -- I
24 don't recall where I was at 4:18, looking at the record
25 or -- yeah.

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1 Q. I guess the point would be that at 4:18 you
2 begin looking at that entry? All right.

3 A. Yes.

4 Q. And it's not until about two hours later that
5 you're finally satisfied with being able to say that
6 you want to leave that at 7:48?

7 A. Yes, sir. Because in the MSICU, between 5:30
8 and 6:30, was where I had access to the -- to the
9 Mayday record that I was looking at, I think, to get
10 timing accurate and -- as accurate as possible in the
11 narrative.

12 Q. Then the other thing that we see is, again,
13 there's your initials --

14 A. Uh-huh.

15 Q. -- and in the 4:19 to 4:30 timeframe, you're
16 coming in and creating an entry that Dr. Nelson has
17 left the room?

18 A. Right.

19 Q. And initially you put down a time of 7:50?

20 A. Right.

21 Q. And then you back that up to be 7:51; okay?

22 A. Right.

23 Q. Now, I want to finish up with this exhibit.
24 So what we've done on this first page is you've added
25 four minutes on that first change; correct?

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1 A. Yes, sir.

2 Q. All right. Then on the next change, you've
3 added two minutes, for a total of six; right?

4 A. Added two minutes meaning -- I'm sorry.

5 Q. Well, two minutes that doctor -- you've got
6 Dr. Nelson coming in the room two minutes --

7 A. Oh, where -- where I subtracted?

8 Q. Right.

9 A. Two minutes, yes.

10 Q. Right.

11 A. Yes.

12 Q. So it goes from 8:00 to 7:56. That's got him
13 coming into the room four minutes earlier?

14 A. Yes. Yes.

15 Q. Okay. It goes from 7:50 to 7:48, that's
16 another two minutes? All right.

17 A. I imagine, if I might explain, Mr. Ransom, I
18 imagine that looking at his attestation, and when he
19 came in and computer charted his attestations, I was
20 looking at that time that he entered the room. Because
21 I knew that Mr. Mikell was still lateral, that I put a
22 nasal airway in. Eric inquired about it, and I said
23 everything was fine. That his sats had come back up
24 and he -- and he was -- and he was doing well. He was
25 stable at that time.

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1 So I was -- I was backing it up to 7:48, because
2 I knew he was in the room, and I knew all of that
3 occurred within about two to three minutes when he
4 stepped in the room.

5 Q. Okay. And then the last change that you made
6 was this time when he goes out?

7 A. Yes.

8 Q. And you change that from 7:50 to 7:51, so
9 that's another minute. Four plus two, plus one is a
10 total of seven minutes. And that would be the ultimate
11 consequence of those three changes that you made in the
12 record would be to have Dr. Nelson present in the room
13 for an additional seven minutes?

14 A. Well, he was -- while the procedure was going
15 on, he was in there from 48 to approximately 51. He
16 spent two to three minutes in there charting, asking me
17 about the nasal airway, and my reply. In general, just
18 two to three minutes that he spent in the room. And
19 then the next time he stepped in was when we were
20 turning Mr. Mikell on to his back.

21 Q. So in this circumstance where your patient is
22 undergoing this critical desaturation process we see
23 with this V right here that ultimately leads to his
24 cardiac arrest, the fact of these various changes that
25 you've made in the chart, is to put Dr. Nelson back in

1 the room for another seven minutes while all of this is
2 going on; right?

3 A. No, sir. I note that he walked in and out
4 during the middle of the procedure. And then I note
5 when he walked back in and Mr. Mikell became unstable
6 and we started CPR.

7 Q. Now, do you remember at your deposition in
8 February -- I marked an exhibit that had this graph on
9 it -- and -- and I think it was page 499. And this was
10 the 15 minute record. I'll put this on the overhead as
11 well. All right. And you'll recall we had a fairly
12 lengthy discussion?

13 A. Yes.

14 Q. Where I was asking you to please tell me what
15 time it is -- what time it was when that desaturation
16 shows on that graph -- remember that?

17 A. I do.

18 Q. Okay. And I was asking you with respect to
19 where that graph starts right there, Ms. Embrey, can
20 you tell me what time it is when that starts -- when
21 that line starts plotting that downward trend?

22 A. Respectfully, Mr. Ransom, I've seen this same
23 graph on the one minute, the five minute, and the 15
24 minute records. So it does not seem to expand
25 accurately to the timeline, the data graph. I would

1 prefer it -- look at a number of variables, or
2 something else other than that graph.

3 Q. Well, do you remember at one point in time --
4 I think you told me that you felt that graph was
5 accurate?

6 A. I mean, it accurately reflects a -- a dip in
7 his saturation.

8 Q. Okay.

9 A. I will -- I will concede that, but I cannot
10 tell exact times and exact numbers from that graph.

11 Q. Well --

12 A. I have seen it on several different timelines.

13 Q. Yeah, I mean, there's been a lot with all
14 these different graphs that we've had, there has been
15 some question as we look at these records, and some of
16 them are a 15 minute graph, and some of them are a one
17 minute graph, and some of them are a 10 second graph.
18 And we've all had some consternation about the fact
19 that none of them seem to show the same thing. But
20 when I've asked you about it, you've told me, Mr.
21 Ransom, it's the graph that's on page 499, that I
22 believe is accurate; right?

23 A. I don't recall saying that. I might have felt
24 like it was the most accurate representation of the
25 graph, but it's difficult to kind of speak to numbers

1 and everything when you see it on so many different
2 timelines. I'd rather just look at the numbered
3 variables at the top of the page.

4 Q. Bear with me. Okay. So here at your
5 deposition in February, and this is at page 163 we're
6 talking about this. And I'm saying, "Can you identify
7 by the document control number what part of the record
8 you're looking at?" And you say, "This looks much more
9 accurate." And we go down here, and you say -- we are
10 talking about the page numbers -- and you -- I asked
11 you, it's 499 of 2,115. And I asked, "So is that an
12 accurate representation of the real time graph?" And
13 your testimony was, "It appears to be much more
14 accurate."

15 A. Than the one and five minute graph on the
16 timeline that you had shown me, yes.

17 Q. Okay. And, again, this is the 15 minute
18 record; right?

19 A. Yes, sir.

20 Q. That at various times you and various other
21 witnesses have told me -- because I'm trying to
22 understand this. I'm being told, no, this is the one
23 that's accurate and reliable. The question that I
24 imposed to you in your deposition was, looking at where
25 that downward sloping line starts to plot, which is the

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1 desaturation, I asked you, can you tell me what time is
2 it when that starts going off the cliff. And you told
3 me -- your answer at your deposition was, You thought
4 that all started at 8:00; do you remember that?

5 A. I do not recall that, no, sir.

6 Q. We got to that part -- again, if you'll turn
7 your attention to the real time graph on page 499, is
8 that accurate? It appears that it is more accurate
9 than the last one. And I asked, "What time does that
10 get started?" And I asked you, "About 7:42?" And you
11 said, "No".

12 And I asked you again, "Well, where does that
13 start? What does that represent in that block where
14 that V starts, what time" -- that's my question --
15 "What time does that start?" And you said, "So, it
16 looks like close to 8:00." And I said, "Is that your
17 answer?" And you said, "Yes, sir." "That drop in his
18 02 sats starts at 8:00; that's your testimony?" And
19 you said, "It looks like the data that is recorded on
20 the 15 minute data graph is starting right about 7:45,
21 7:46, when she got the chart up and running. It looks
22 like that's just when the data starts kind of coming
23 across."

24 A. Yes.

25 Q. Okay. So you first said 8:00, but then you

1 kind of changed that to about 7:45 to 7:46; right?

2 A. That would have been more accurate because
3 that was the -- the Propofol was started. I believe we
4 had kind of started the procedure. That, to me, I
5 think would have been a little more accurate. I might
6 have been answering what the lowest part of the V,
7 where that was falling at the 8:00 mark. I'm not
8 certain.

9 Q. Okay.

10 A. Like on this 15 minute, it appears that it
11 started shortly after 45 --

12 Q. Right.

13 A. Like 46, 47, and that's when -- that's when I
14 put the nasal airway in, and it pops back up to 94.

15 Q. 7:45 or 7:46, which would be during this time?

16 A. Yes.

17 Q. That you're on the phone, sending text
18 messages, trying to fix the problem. I don't have any
19 other questions.

20 A. Mr. Ransom, if I may? I --

21 THE COURT: No, ma'am, you may not.

22 A. Oh, yes, sir.

23 THE COURT: You can answer any questions. You're
24 not going to volunteer anything. Mr. Cooke, do you
25 want to start the cross -- I mean, I don't how long

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1 it's going to take. Do you want to take a lunch break
2 now, and come back, or do you want to start now?

3 MR. COOKE: If I have a choice --

4 THE COURT: I don't how long you're going to take
5 and I don't want to cut you short.

6 MR. COOKE: I would have to be interrupted, I
7 think, for lunch if I started now, so.

8 THE COURT: That's what I'm saying, do you want to
9 go ahead and take lunch now?

10 MR. COOKE: Yes, that would be fine.

11 THE COURT: And do all the cross at one time?

12 MR. COOKE: Yes, please.

13 THE COURT: Okay. That's fine. All right. Madam
14 Forelady, ladies and gentlemen of the jury, it's
15 12:15 -- be back in the jury room at 1:45, and we'll
16 continue at that time.

17 Please don't discuss the case with anyone else.
18 Leave your notepads -- which juror has a doctor's
19 appointment -- if you'll raise your hand.

20 (Juror complied.)

21 THE COURT: Okay. I'll let you know just as soon
22 as I can. Okay. Thank you very much for asking. See
23 you at 1:45.

24 (WHEREUPON, the jury leaves the courtroom at
25 12:17 p.m.)

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1 THE COURT: Anything from the Plaintiff before we
2 break for lunch?

3 MR. RANSOM: Nothing, Your Honor.

4 THE COURT: Thank you. Anything from the
5 defendant?

6 MR. COOKE: Nothing, thanks.

7 THE COURT: All right. Mrs. Embrey, I will tell
8 you, again, please, don't discuss the case with anyone
9 during the lunch break; do you understand?

10 THE WITNESS: Yes, sir.

11 THE COURT: All right. Thank you very much. See
12 you at 1:45.

13 (WHEREUPON, a lunch break was taken.)

14 (WHEREUPON, Court's Exhibit Nos. 2 and 3
15 marked.)

16 THE COURT: Anything before we bring in the jury?

17 MR. RANSOM: I would like to offer into evidence
18 the various exhibits that we used during the
19 examination --

20 THE COURT: Which ones?

21 MR. RANSOM: Permit me to get them in order here
22 for just a second. Plaintiff's Exhibits 1, 2 --

23 THE COURT: I think 2 is already in, isn't it?

24 MR. RANSOM: Okay --

25 THE COURT: It's in.

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1 MR. RANSOM: Four.

2 THE COURT: It's in.

3 MR. RANSOM: Five?

4 THE COURT: It's in.

5 MR. RANSOM: Six, 7, 8.

6 THE COURT: Eight -- eight is not in.

7 MR. RANSOM: All right. We'd offer that. Ten,
8 11, and 51.

9 THE COURT: Fifty-one?

10 MR. RANSOM: Fifty-one. And that's not on the
11 list.

12 THE COURT: I think 51 has already been introduced
13 -- all right -- does the defense have any objection to
14 1, 8, 10, and 11?

15 MR. COOKE: No objections.

16 THE COURT: All right. One admitted without
17 objection; 8 admitted without objection; 10 admitted
18 without objection; and 11 admitted without objection.

19 (WHEREUPON, Plaintiff's Exhibit Nos. 1, 8, 10 &
20 11 admitted into evidence.)

21 THE COURT: Anything else that you've overlooked
22 that you need to admit?

23 MR. RANSOM: Exhibit -- yeah, 51, which isn't on
24 the list, Judge. That was the --

25 THE COURT: Well, I think we've already admitted

1 that during the trial -- is that correct?

2 COURT REPORTER: Yes.

3 THE COURT: Fifty-one has already been admitted.

4 MR. COOKE: Do we have -- you say 1, 2, 3, 4, 5
5 and 6 are already in?

6 THE COURT: Yeah. One -- one through 12 are
7 already in; 14, 15, 17 through 31, 39, 40, 46 & 51.
8 And the -- the -- all right. Anything else that you
9 want to talk about admitting while we're talking about
10 that you haven't admitted -- or offered?

11 MR. RANSOM: Nothing at this time, Your Honor.

12 THE COURT: Okay. All right. Anything from the
13 defense before we bring the jury?

14 MR. COOKE: Nothing.

15 THE COURT: All right. Bring us the jury, please
16 sir.

17 (WHEREUPON, the jury enters the courtroom at
18 approximately 1:54 p.m.)

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

20 THE COURT: Thank you very much.

21 MR. COOKE: Thank you, Your Honor.

22 **CROSS EXAMINATION BY MR. COOKE:**

23 Q. Good afternoon, Ms. Embrey.

24 A. Good afternoon, Mr. Cooke.

25 Q. I'm going to sort of break this up into two

1 parts. And I'm going to start by asking you some
2 questions about the same thing that Mr. Ransom asked
3 you about, the records, and how records are kept and
4 what you did to the records and so forth. And then
5 we're going to spend a few minutes talking about what
6 you actually did that day for Mr. Mikell; would that be
7 all right?

8 A. Yes, sir.

9 Q. So let's start with trying to understand how
10 these records work. Let's start with Plaintiff's
11 Exhibit 3. Now, you can watch this on the monitor
12 right in front of you.

13 A. Yes, sir.

14 Q. And I'm going to zoom out a little bit.
15 You've already seen this several times. Can you read
16 that on your monitor?

17 A. I can.

18 Q. Would you tell the jury what this document is?

19 A. So this represents one of the pages in the
20 PICIS record that reflects the values that are coming
21 over from the monitor in numerical form, as well as
22 graphic form.

23 Q. All right. And does that look, other than the
24 red markings on here, does it look kind of like this?

25 A. Yes, sir.

1 Q. Okay. And is this what we've been referring
2 to as the 15 minute chart?

3 A. That's correct.

4 Q. Why do we call it -- why do you call it that?

5 A. Because it is being recorded. It has a time
6 line -- I'm sorry -- of 15 minute increments on the
7 across axis.

8 Q. And that's reflected across there -- across
9 the top?

10 A. Yes, sir.

11 Q. Now, we notice that there are all these words
12 down the left hand side -- what do those mean?

13 A. FIO2 is the percent of inspired oxygen. That,
14 generally speaking, is an estimation -- especially if
15 you have a nasal cannula on. It's an estimation of
16 what the monitor is picking up. That number is a lot
17 more accurate if you're intubated, and it's in the
18 breathing tube and out the breathing tube. SPO2 is --

19 Q. I'm sorry -- that FIO2, is that the -- is that
20 the concentration as it goes into the patient?

21 A. It is, yes, uh-huh, that's being delivered to
22 the patient, yes. SPO2 is the oxygen saturation.

23 Q. And that's the number we've been talking about
24 a lot this week; right?

25 A. Correct.

1 Q. Oxygen saturation. What does that -- what
2 does that tell you generally?

3 A. It tells us that the patient is getting -- is
4 getting enough supplemental oxygen for whatever it is
5 going on, the procedure or your anesthetic that you're
6 delivering, or both concurrently.

7 Q. Okay. And so that number --- like where it
8 says 47.5, 83.5, that's a percentage?

9 A. Correct. And as I understand it on the 15
10 minute across axis -- the numerical values that are
11 popping up are averaged in the PICIS system. It's not
12 a --

13 Q. We're going to get to that in a minute.

14 A. Exactly. Right. Right.

15 Q. So a healthy, normal person, would you want it
16 to be ideally in the -- in the 90s if you're not under
17 any distress or so forth?

18 A. Yes, sir. You know, preferably 93, 94, or
19 above -- above that.

20 Q. And then is there a general number that is
21 considered not compatible with life?

22 A. Well, less than -- less than 90 -- less than
23 90, you become concerned and try to do something
24 differently.

25 Q. Good.

1 A. You know with the airway, or add an airway
2 device maybe to support, or back off on your
3 anesthetic, or all of above. So, you know --

4 Q. We'll keep that in mind as we talk this
5 afternoon that -- less than 90 is when you start
6 thinking that you needed to do something for the
7 patient?

8 A. Exactly.

9 Q. Okay. Not necessarily an emergency?

10 A. But you -- if it's trending downward and not
11 getting better immediately, then you need -- you need
12 to do something different, yes, generally speaking.

13 Q. What is the next one down?

14 A. End Tidal CO₂, which is the -- as much as the
15 -- again, the device that you're using can train --
16 this is your expired end tidal CO₂, what's coming out
17 as you breathe out. Again, if you're -- if you're
18 delivering oxygen via cannula, it's in training and
19 giving you a -- a general range on that number.

20 If you have a breathing tube down, it's in the
21 tube, out the tube, so it's very much more accurate, I
22 would say, than a nasal cannula. But that is that
23 number. It's your expired end tidal -- end tidal CO₂
24 at the end of a tidal volume breath, what is that
25 number.

1 Q. Is that tidal like tides, t-i-d-a-l?

2 A. Tidal volume as in lung volume.

3 Q. The word tide -- spell that?

4 A. In other words, tidal volume -- t-i-d-a-l,
5 right. And it -- it beads at the end of a breath, you
6 know, your tidal volumes are how much you're taking
7 into the lungs. So it's at the end -- it's at the end
8 of expiration, what that number is.

9 Q. Okay. All right. Then the next one down is
10 Des out percentage, what does that mean?

11 A. Right. So that's Desflurane the expired
12 percentage. And Desflurane is one of the anesthesia
13 gases that we have on -- on our anesthesia machine, so
14 how much is being -- you may be dialed in at a certain
15 percentage, but what's been expired by the patient out
16 the breathing tube is a more accurate number. It's a
17 more accurate reflection of what the patient is
18 receiving. And it may be a little less or it may be
19 significantly less than what you've got dialed in.

20 Q. All right. Then the EKG rhythm, what is that?

21 A. Correct. So that is your -- that is your --
22 your electrocardiogram reading. That is exactly what
23 is going on. With that, we -- our monitors default to
24 lead to and de-lead -- so with an anterior and inferior
25 lead at the same time. We pretty much do that for

1 everyone.

2 Q. Okay. And SR is good; right?

3 A. Correct. That's sinus rhythm.

4 Q. Okay. And PEA is bad?

5 A. Pulseless electrical activity, yes. You have
6 activity on your EKG that you have no pulse.

7 Q. All right. RSPN -- is that what that says --
8 or what is that next thing down?

9 A. Yes, uh-huh. Respirations per minute.

10 Q. Respirations per minute. Okay.

11 A. Correct.

12 Q. Then tidal volume, what is that?

13 A. Yeah, so that's -- that again, more accurate
14 when you have a breathing tube down. It can tell you
15 exactly what's being delivered and accepted by the
16 patient's breathing tube via the ventilator on the
17 anesthesia machine. With a nasal cannula, it's an
18 estimate. It's an estimate because all you have is --
19 is the cannula prongs in the nose. You don't have
20 anything actually in the -- in the lungs.

21 (Court Reporter Interruption.)

22 BY MR. COOKE:

23 Q. She's trying to take down everything you say,
24 so just slow down a little bit.

25 A. Right. Right.

1 Q. Did you finish talking about tidal volume?

2 A. I did.

3 Q. What about PIP?

4 A. So peak inspiratory pressure is the amount of
5 pressure that the ventilator on the anesthesia machine
6 senses as you're delivering oxygen.

7 Q. And so that -- that would reflect how much
8 pressure is being put on the oxygen -- on the air going
9 into the patient?

10 A. Exactly. Again, this would be a more
11 applicable relevant and efficient -- efficiently
12 documented number once you have the breathing tube
13 down. You're looking that you're not forcing in too
14 much air and causing any trauma to the lungs. So you
15 want your peaks, generally speaking, about 12, 13, 14.

16 Q. Okay. And I think I know what the next one
17 is, temperature; and you do it in Celsius?

18 A. Correct, uh-huh. That's skin, esophageal,
19 nasal. We have many ways to -- to monitor that.

20 Q. Now, while I've got this one up here, what of
21 those -- how do those numbers get into that chart?

22 A. So, there is a cable that -- as I understand
23 it, my rudimentary understanding of it -- is that there
24 is a cable that runs from the Phillips monitor and our
25 anesthesia machine into the computer system. And it's

1 captured by PICIS, our program, when we pull up that
2 patient and that data on that machine in that room.

3 Q. Now, which of those numbers up there are --
4 are entries -- are entered by a machine and which are
5 entered by a human being?

6 A. As I understand it, all of the -- all of the
7 entries are the machine data that comes over.

8 Q. How about the rhythm, the heart rhythm, PEA
9 and SR, does that have to be entered by a person or is
10 that --

11 A. Yeah, because a lot of times, there is --
12 that's one of them that I know that we can edit.
13 The -- a lot of times, there's artifact on the EKG, and
14 it may pick it up as some type of arrhythmia, which it
15 is not. It may, in fact, just be sinus rhythm and
16 somebody's -- somebody's moving or something, and it
17 picks it up as an arrhythmia, and you would go back in
18 and, you know, correct that if you needed to if it was
19 picking it up differently, so.

20 Q. Can you do that in real time as you're sitting
21 there?

22 A. You absolutely can, uh-huh.

23 Q. Okay. Now, but those other values, are
24 those -- are you supposed to leave those alone? Those
25 are what the machine says they are?

1 A. As I understand it, yes.

2 Q. Well, let me ask you, do you change those
3 numbers?

4 A. No. No.

5 Q. Now, one thing about this particular chart is
6 it's divided into 15 minute intervals, but we know --
7 we know that those values are measured how often?

8 A. Okay. So they are measured like every
9 second -- every second, they are -- they're being
10 monitored.

11 Q. So when you're sitting in the room monitoring
12 the patient, are you looking at this chart, or are you
13 looking at some other monitor as to the continuous
14 numbers?

15 A. No. Because the computer chart is right here,
16 and the actual patient monitor and patient are right
17 here. So once we get started, I'm keeping my eye on
18 the monitors.

19 Q. Right. But I mean what are you -- are you
20 actually working with as you are -- you're monitoring
21 the patient? In a few minutes, I'm going to -- in a
22 little while, I'm going to show you the picture of the
23 room. But are you looking at this 15 minute chart to
24 assess the patient, or are you looking at other
25 indicators -- or monitors? Do you understand my

1 question?

2 A. Not really. Not really.

3 Q. We are sitting here looking at this chart as
4 it records these numbers every 15 minutes.

5 A. Correct.

6 Q. But I think you testified that you're actually
7 monitoring it on a continuous basis?

8 A. Oh, yes. Oh, yes, like beat to beat.

9 Q. All right.

10 A. And you have the pulse -- you have the pulse
11 tone, obviously, on your O2 stat. That's an ASA
12 standard. So it defaults, and it comes on at a pretty
13 good volume level so everybody can hear it.

14 Q. So, when I -- when I look at these numbers, I
15 see the first entry as under the number that says 7:45,
16 does that -- does that represent the 15 minute interval
17 between 7:45 and 8:00?

18 A. As I understand it, yes.

19 Q. Okay. Do you know how the machine decides
20 which of those myriad of numbers that it -- that it
21 detected between 7:45 and 8:00 get put in that box?

22 A. Okay. So I have come to understand that it's
23 a result of an average.

24 Q. Okay.

25 A. That is a result of the average of 15 minutes

1 worth of beat-to-beat monitoring.

2 Q. Some kind of average?

3 A. Correct.

4 Q. So if we go down to the bottom of this, what
5 is that?

6 A. So this is supposed to be your real time data
7 graph of your SP02, your systolic and diastolic, the
8 blood pressure. Your mean blood pressure, your O2 sat,
9 and your heart rate.

10 Q. What do you use that for?

11 A. What do I use the real time data graph for?

12 Q. Yes.

13 A. Nothing. It is printed out with the record.
14 I'm -- I'm watching my patient and I'm watching the
15 numbers on the monitor. This is what's printed out
16 later.

17 Q. For somebody looking at the chart afterwards,
18 is that intended to give them an idea of the trends
19 that took place over time?

20 A. I would say so.

21 Q. And are those in color, normally, when you get
22 the original chart?

23 A. Yes, yes, they are.

24 Q. So they would be different colors for
25 different things?

1 A. Yes, sir.

2 Q. So do those -- on this particular version of
3 this chart, are those numbers intended to roughly line
4 up with -- with the graph below it?

5 A. So I believe they are intended to roughly line
6 up with -- with the numerical values that are at the
7 top.

8 Q. When the patient is actually in the hospital
9 and you're taking care of them, do you print out a
10 version of this to go in his chart?

11 A. Yes. So, generally speaking, after anesthesia
12 is finished with the chart, and they go to the recovery
13 room or they go to the unit, if you turn -- if we turn
14 them over to recovery room, generally, recovery room
15 continues the record and prints the record that goes
16 with the patient on the chart.

17 If you're in DDC, again, you go to a recovery
18 area and they're supposed to finish the chart as it is
19 like a procedural anesthesia and postop chart, printed
20 and it goes on the -- on the chart as complete for the
21 procedural areas.

22 Q. And which version of that -- of this chart do
23 you normally print for the record, is it the 15 minute
24 version or the one minute version, or some other
25 version?

1 A. I'm -- I'm not sure. It may -- it may have to
2 do with whoever is printing the chart, and what their
3 -- what their default settings are. You know, when we
4 are monitoring and looking at it, you know, when we
5 were using PICIS, we could opt to look at a one minute,
6 a five minute, a 15 minute chart in numerical values
7 and everything is -- we could kind of decide what our
8 default was, that we were looking at, as the case was
9 going on.

10 When it gets printed, I'm not certain. Because
11 when PICIS was in its infancy, like the first year or
12 two, it would print out a lot of pages that didn't need
13 to be, like 200, and some of them were blank. So I
14 believe they eventually tried to kind of pare it down,
15 if they could to to the -- to the 15 minute version was
16 my understanding from other people just in general.

17 Q. But in your experience, by the time it's
18 printed out, you're done; right?

19 A. Oh, absolutely, yes.

20 Q. I'm going to show you -- hand you a stack of
21 papers that's been marked as Defendant's Exhibit 6, and
22 ask you to look at it, and tell us if that appears to
23 be the one minute version printout?

24 A. It appears to be the one minute version, yes,
25 uh-huh.

1 MR. COOKE: Your Honor, we would offer this into
2 evidence.

3 THE COURT: What's the number?

4 MR. COOKE: Defendant's Exhibit 6. And it's the
5 one minute version of the section of the chart.

6 MR. RANSOM: No objection.

7 THE COURT: Exhibit 6 admitted without objection.

8 (WHEREUPON, Defendant's Exhibit No. 6 was
9 admitted into evidence.)

10 BY MR. COOKE:

11 Q. Now, all of that was a long winded
12 introduction to one question that I just wanted to ask
13 you about. When I look at a page that has a lot of the
14 same data; do you see that?

15 A. Yes.

16 Q. And this one is broken up in one minute
17 intervals; correct?

18 A. Yes, I see it.

19 Q. But do you see that that graphic part of it
20 down there, looks exactly the same as the version
21 that's in the 15 minute chart?

22 A. Yes, yes, I do.

23 Q. And do the numbers -- do the times match up on
24 the one minute version with the -- with the -- with the
25 actual data?

1 A. They do not.

2 Q. Do you have any idea why that happens when
3 they try to print this thing in a one minute version?

4 A. I do not.

5 Q. Am I right when I look at that and say, it
6 looks like that software somehow just takes the exact
7 same graph and sticks it on the -- on the one minute
8 chart?

9 A. That's my thought, exactly.

10 Q. So would it be a good idea to rely on this
11 chart down here when you're looking at the one minute
12 version?

13 A. No, it would not.

14 Q. Is it even each possible for this chart to
15 have been created, given that there's no data above it?
16 In other words, do you see there's a thing there that
17 says one of those lines is for oxygen saturation?

18 A. Yes.

19 Q. But when you go above that, there's no number
20 at 7:35 in the oxygen saturation?

21 A. I see that, yes.

22 Q. You see that?

23 A. I do.

24 Q. And is that consistent with your recollection
25 that the machine, although -- although it was showing

1 you what the saturations were --

2 A. Yes.

3 Q. It was not recording them to this chart at
4 that time?

5 A. Absolutely.

6 Q. And does that show that it began recording,
7 all that -- data looks like at 7:48?

8 A. Yes.

9 Q. And that SR, is that -- is that because you
10 were able to enter that, or some human being was able
11 to enter that data manually?

12 A. Yes. So part of the assessment and position
13 checks, as I recall it from PICIS, is that you --
14 depending on how often things change, you can do it
15 every one minute, every five or every 15. Most of us
16 did every 15. A rhythm, you would enter. A patient
17 position, it was kind of like a -- a way to
18 electronically record check patient position, very
19 important.

20 Because when you have an anesthetized patient,
21 you're checking on their position, making sure the
22 pressure points and everything are good. And this is
23 part of the record that we could actually manually
24 enter along the way, still in sinus rhythm, still in
25 left lateral, oxygen being delivered via nasal cannula.

1 So it's a -- it's kind of like an assessment check
2 however often you deem it necessary.

3 So as I understand it, sometimes it will be --
4 the assessment will kind of back populate to -- to the
5 time that the anesthetic was started.

6 Q. And we'll get into -- we'll get into the
7 anesthesia starting in a few minutes. When you're
8 sitting in the room, and you're watching your monitors,
9 is there any audible information coming to you as well?

10 A. Absolutely. So it's an ASA standard that the
11 tone be on pulse ox, so that everyone can hear it at
12 all times. Obviously the anesthesia provider is the
13 one that needs to hear it. Our machines now default to
14 volume level of three, which is pretty normal. Three
15 when you hear actually in the room -- in the procedural
16 area or in the OR. So sometimes I'll turn it down a
17 little bit because it's very quiet and I really need to
18 hear it. And, you know, it doesn't need to be blaring.

19 Q. And those are the things -- you're supposed to
20 check those before you start the procedure to make sure
21 that they're all working; right?

22 A. Oh, absolutely, yes.

23 Q. The lines --

24 A. Oh, yes, uh-huh.

25 Q. I want to ask you about another record that

1 Mr. Ransom asked you about. And he was suggesting to
2 you, I believe, that sometime between two -- October of
3 2010 and 2013, that somebody had monkeyed with the
4 narrative notes. And I believe you said that it wasn't
5 you, if anybody did that. But I want you -- I want to
6 look at the records for a second, and just see what, if
7 anything, was actually changed in that interval of
8 time?

9 A. Yes, sir.

10 Q. And he was looking specifically at what
11 occurred at 7:48; do you remember that?

12 A. Yes.

13 Q. I'm going to put these boards up here so you
14 can see them. And I'm going to show you what he showed
15 you, this is -- this was a printout of the anesthesia
16 record -- it was printed out on October 2nd, 2010; do
17 you see that?

18 A. Yes, sir.

19 Q. And I know it's a little hard to read back
20 there, but the 7:48 entries are right here?

21 A. Yes.

22 Q. 7:48, 7:48, 7:48 --

23 A. Yes.

24 Q. -- 7:48 and 7:48 and a 7:48; do you see that?

25 A. Yes, I do.

1 Q. These are all -- these are all entered by
2 human beings; right?

3 A. Yes. Uh-huh. They are narratives, uh-huh.
4 They're narratives where -- in Eric's case, his
5 attestations that are the first four entries, I think,
6 are automatic. He -- yes, I was available. Yes, I
7 was -- you know, right. But, yes, otherwise, you type
8 in your narrative.

9 Q. And then this was the version that was printed
10 out on April 2nd of 2013, according to that; do you
11 remember seeing that?

12 A. I remember seeing that date.

13 Q. Okay. Now, this is actually -- can you tell
14 that this is actually a different record that -- the
15 one up here is called an anesthesia record, and this
16 one here is called an anesthesia PACU record?

17 A. I did not notice that the first time, when I
18 saw it before.

19 Q. Are those different records?

20 A. What it probably means is that PACU has added
21 to it. They've added to the record that has been
22 finalized or printed out.

23 Q. Well, let's look at 7:48. And what we have
24 here are -- it's printed out a little differently, but
25 there's 7:48, 7:48, 7:48, 7:48, 7:48 -- so there are

1 five entries?

2 A. Right.

3 Q. At 7:48. On this -- this one, there are five
4 entries for 7:48 on that entry?

5 A. Okay.

6 Q. Are any of those entries different in the 2010
7 version from the 2013 version; do you want me to hand
8 this to you?

9 A. No, sir. I can see them. I can see them.
10 Not on the 48 entries, other than -- other than they
11 are like in a different order. It looks like my -- the
12 7:48 entry that I made, about the nasal airway, is in
13 the middle of Eric's attestations is the only
14 difference I see.

15 Q. So is it fair to say that each one of those
16 five entries that Mr. Ransom pointed out to you on the
17 2010 version versus the 2013 version, has the same time
18 and the same information in it?

19 A. Correct. It appears to, yes.

20 Q. Just in that -- just in the computer, when
21 they printed it out, they printed it in a different
22 order?

23 A. It must have been, yes.

24 Q. Well, did you go into that computer and
25 scramble it, so that it would print these in a

1 different order?

2 A. No, sir. Not -- not -- whenever the later
3 record was, no, sir.

4 Q. Does it look -- does it look, based on your
5 knowledge and your examination of these entries, does
6 it look like anybody changed anything in those entries?

7 A. No, sir, not in the entries you're talking
8 about. I see that times have popped up, that weren't
9 in the previous, so there are things that are populated
10 that...

11 Q. At 7:48, everything is exactly the same?

12 A. That's correct. It appears to be, yes.

13 Q. When somebody prints the record, prints a
14 chart, how do you do that?

15 A. On the computer, you go into the patient's
16 record, and hit -- with your mouse, you hit a print --
17 a print button.

18 Q. Does -- does -- does the act of printing a
19 record change the record in any way?

20 A. No, sir, not that I'm -- not that I'm aware
21 of. It just prints what's been generated
22 electronically up until then.

23 Q. And this is going to be a silly question --
24 but if you print it, then shred it, that doesn't change
25 the record either; does it?

1 A. No, sir.

2 Q. The record remains what it is in this
3 computer?

4 A. Absolutely.

5 Q. And you could print it out a thousand times
6 and it's still going to say what it says? The data is
7 going to be the same?

8 A. Absolutely.

9 Q. Did you discard anything out of Mr. Mikell's
10 chart?

11 A. No, sir.

12 Q. I'm going to show you an audit trail. Have
13 you ever seen one of these things before this
14 litigation started, an audit trail?

15 A. Before the litigation started?

16 Q. Yeah. I mean, is this something you work with
17 in your normal daily life?

18 A. I cannot recall actually looking at one prior
19 to this case.

20 Q. Okay. Were you shown this before your
21 deposition?

22 A. I do not recall being shown that prior to my
23 deposition, no, sir.

24 Q. I'm going to show you what Mr. Ransom showed
25 you. All right. Do you see that?

1 A. I do.

2 Q. This -- this refers to the notations about Dr.
3 Nelson being in the room; do you see that?

4 A. Yes.

5 Q. And it looks like at 1535, which I think is
6 5:35, you went up and you created an entry, and then
7 you modified the entry?

8 A. Yes.

9 Q. Do you see that?

10 A. I do.

11 Q. And then he asked you about the last one there
12 that says 4:18:24 seconds, do you see that?

13 A. Yes, I do.

14 Q. And you couldn't figure out why you would have
15 been in there at 4:18 working on it? And do you think
16 that you and Mr. Ransom might have missed something on
17 the date of that number? Take a look at the date.

18 A. I see the date that I -- that I modified -- it
19 was the next day.

20 Q. Okay.

21 A. But I'm -- I'm looking at it, and it says
22 modified, but I didn't -- I didn't change anything
23 though. Do you follow?

24 Q. Yeah.

25 A. So nothing is changed. I printed a record to

1 look at it visually on Saturday, but I -- I do not
2 recall editing any of narrative.

3 Q. But according to that, at least, you at least
4 went into the system, into that entry?

5 A. I did.

6 Q. On the second day?

7 A. I did.

8 Q. So -- so just for clarification, it was not at
9 4:18 on the 1st, it was at 4:18 on the 2nd?

10 A. Correct.

11 Q. That you looked at that entry?

12 A. Yes.

13 Q. All right. I'm going to ask you to look at a
14 couple of other things in here. You were challenged
15 about your assertion that Dr. Nelson was in the room at
16 7:48; do you remember that?

17 A. Yes.

18 Q. And was he in there at 7:48?

19 A. He was, because he made his attestations on
20 the computer. And at the time you had to -- you had to
21 -- when a case was on-going, it was my recollection
22 that you had to be actually present in the case and on
23 the same computer that was being charted on with the
24 patient.

25 Q. All right.

1 A. So the anesthesiologist would frequently log
2 you off, log on, do their thing, and then they were
3 done, to cover for their attestations for medically
4 directing and supervising the case.

5 Q. So, do you see Dr. Nelson's name up there at
6 the right?

7 A. I do, I do, yes.

8 Q. And do you see what time he was logged into
9 the computer?

10 A. Yes.

11 Q. Just for clarification, the numbers -- the
12 date and the time on the right hand are when the person
13 was typing into the computer; correct? The -- the
14 numbers on the left hand column are the -- are the time
15 that appears on the chart; correct?

16 A. Correct, yes.

17 Q. So, do you see there that at 7:49, Dr. Nelson
18 created an entry that begins with "anesthesiologist
19 assessed patient" and so --

20 A. Yes. Yes.

21 Q. Are those things there his attestations that
22 you referred to?

23 A. Yes, they are.

24 Q. And where would he have to be to make those
25 entries?

1 A. In -- in the room, in the procedural area.

2 Q. Okay.

3 A. In the procedure area that the -- that case
4 was going on.

5 Q. So does this audit trail prove, to your
6 satisfaction, that Dr. Nelson was in fact in the room
7 exactly where you said he was at 7:49 a.m. that
8 morning?

9 A. Yes. Yes.

10 Q. Ms. Embrey, there's been a lot of talk about
11 changing records, adding to records, and that -- for
12 lawyers, that's -- that's a pretty dangerous term,
13 "changing records"?

14 A. Yes, sir.

15 Q. I'm going to ask you, is a part of your job to
16 go in after a case is over, when you have time to
17 review everything, is it your job to change that record
18 if there are omissions or inaccuracies in that record?

19 A. I'm very -- I'm very meticulous and take a lot
20 of pride in what I do in the -- in my anesthesia work
21 area, and what I do for patients in the OR and in the
22 procedural areas. So if there has been a lot going on,
23 I try to -- even if it's noncontemporaneous, as in not
24 at the time of the occurrence, I try to make sure that
25 everything is accurately reflected that we gave and did

1 for a patient.

2 Q. But to answer my question specifically, is it
3 part -- is it part of a CRNA's job to go in and make
4 sure that the anesthesia record is correct?

5 A. I mean, I think -- I think it is to the best
6 of my ability.

7 Q. Well, who's going to do it if you don't do it?

8 A. Possibly no one.

9 Q. I mean, is this the only case that you've ever
10 gone in after the case was over, and added information
11 and corrected information?

12 A. No, sir.

13 Q. Is this something that you do day in and day
14 out?

15 A. No, sir, I wouldn't say day in and day out,
16 but a lot of times if there's critical occurrences in
17 the ORs, and you may have helped in the OR or the
18 procedural area, and you have a very unstable patient
19 and five, six, seven of you are busy doing for the
20 patient, and no one is charting for 20 or 30 minutes,
21 then that begs maybe going back and taking a look at
22 it. And usually collaborating with whoever -- someone
23 else that was on the case, or you know using what
24 references you have at your disposal, so.

25 Q. All right. I'm going -- I'm going to bear

1 down on you a little bit here. Mr. Ransom called you
2 to task because when your deposition was taken in
3 August of 2014 --

4 A. Yes.

5 Q. -- you told him that Dr. Nelson had charted
6 under your name?

7 A. Yes.

8 Q. Do you remember that testimony?

9 A. Yes.

10 Q. All right. And I'm going to show you some
11 things from that record, and I'm going to ask you to
12 explain them. Okay?

13 A. Yes, sir.

14 Q. So let me start -- what Mr. Ransom showed
15 you -- this is -- this is the entry we're talking
16 about. Do you see right down there, it says 7:56,
17 "Memo, came into room, patient hypoxic with junctional
18 rhythm, and no palpable pulse"?

19 A. Yes.

20 Q. "ACLS protocol initiated, Mayday team called"?

21 A. Yes.

22 Q. And that's the one, is it not, that in your
23 deposition in August of 2014, you told Mr. Ransom that
24 that was Dr. Nelson charting under your log-in?

25 A. Yes, I believe so, yes.

1 Q. And why did you think that in August of 2014?
2 What was it about that entry that made it look like he
3 was charting under your name?

4 A. Because it says "came into room" at the time
5 that he actually did, and that means he was charting in
6 first person. He thought -- I guess, maybe, you know,
7 under -- under his name -- under his log-in at the
8 time -- do you follow -- he said, I'm logged in.

9 Q. Yeah.

10 A. Inferred that I came into the room, meaning --
11 meaning Nelson.

12 Q. Okay. So in other words, the context of that
13 note makes it clear that it's him writing it, right?
14 Because you're already in the room?

15 A. Of course, yes, yes.

16 Q. So you wouldn't write "came into the room" if
17 he's talking about you?

18 A. Correct.

19 Q. All right. And -- and -- but DBE is you?

20 A. Yes, yes, sir.

21 Q. So does it -- does it look to somebody looking
22 at this record, who doesn't know any better, that it --
23 that it was Dr. Nelson writing about himself or
24 somebody writing about Dr. Nelson, but it's under your
25 initials?

1 A. Correct, yes. Unfortunately, like I said,
2 when it was -- right when Eric charted it, I believe
3 that he wanted to convey that it was in first person.
4 "I came into the room", meaning Nelson.

5 Q. All right. Now, did you know, when you were
6 sitting there in August -- it was August 24, 2014,
7 wasn't it, that your deposition was taken?

8 A. Yes, sir.

9 Q. Did you remember, as you were sitting there in
10 that room under oath, did you remember having gone in
11 at 5:30 p.m. on October 1st of 2010, almost four years
12 earlier, did you remember having gone in and changing
13 that particular entry yourself?

14 A. I'm not certain if that particular entry was
15 brought up or I confirmed it at that time.

16 Q. In your deposition, when you were shown this,
17 did Mr. Ransom first show you what's been marked as
18 Plaintiff's -- Plaintiff's Exhibit 2, the PACU note
19 showing that same notation being at 8:00?

20 A. I believe so.

21 Q. When did he show that to you?

22 A. I can't be certain.

23 Q. Do you think you -- do you think you saw that
24 note at all before he asked you that question in August
25 of 2014?

1 A. Well, I edited the time on it the very next
2 day. I edited the time narrative.

3 Q. I'm talking about -- we know that. But I'm
4 talking about -- I'm talking about what you knew, as
5 you were sitting there under oath, being questioned by
6 Mr. Ransom in -- August 24, 2014, did you remember at
7 that time that Dr. Nelson had originally written that
8 note at 8:00, and you had changed it to 7:56? Did you
9 remember that as you were being asked that question by
10 Mr. Ransom?

11 A. I can't be certain.

12 Q. Do you remember him -- did he show you the
13 audit trail at that time, to remind you that you had
14 gone in the next day and changed that entry?

15 A. I can't recall.

16 MR. RANSOM: Your Honor, I'm going to object on
17 that point. Because as Mr. Cooke well knows, my office
18 had not yet been provided the audit trail when I took
19 her deposition in August of 2014.

20 THE COURT: What -- what is your legal objection?

21 MR. RANSOM: That he's misrepresenting the record
22 with this witness.

23 THE COURT: All right.

24 MR. COOKE: I think the question was, did he show
25 you the audit trail -- I'll rephrase it.

1 BY MR. COOKE:

2 Q. Did you -- did you see the audit trail before
3 you were asked that question?

4 A. Not before I was asked the question, I don't
5 believe.

6 Q. So here's our dilemma, you testified earlier
7 that you used the Mayday sheet to help you come up with
8 some of the information that you put into the record?

9 A. Yes.

10 Q. But we don't have that Mayday sheet anymore.
11 So the jury sometime is going to have a problem,
12 they're going to have to decide whether you're telling
13 the truth or not about those times. And one of the
14 pieces, or least materials, that you relied on is not
15 anywhere to be found. Do you have any idea of where we
16 might look in this chart to find some objective data
17 that you couldn't have changed, that corroborates your
18 testimony here?

19 A. Only the numbers and the variables on the
20 anesthesia record.

21 Q. Well, why don't we look at some of those. I'm
22 going to show you the one minute chart. And this is
23 the one that's now been marked as Defendant's Exhibit
24 6, And if you'll remind us what this is.

25 A. Yes, sir. That is the one minute record

1 reflecting numerical variables and EKG rhythm.

2 Q. Now, what numbers would you see change on
3 there once you start bagging a patient?

4 A. Peak inspiratory pressure, end tidal, and
5 FIO2.

6 Q. So that would be this number down there?

7 A. Correct.

8 Q. And the FIO2, those two numbers there?

9 A. Yes, sir. And probably your expired tidal
10 volume in mills --

11 Q. Okay.

12 A. -- as well. Once the patient was -- well,
13 you're manually bag masking them, those definitely
14 would -- would convey at a minimum.

15 Q. So what we see here is this pit number is
16 zero, all the way up to 7:54; is that right?

17 A. Yes, yes.

18 Q. And this FIO2 number, there's a 99 there, but
19 there's a 35, a 26, a 29 --

20 A. Yes.

21 Q. -- 26, 29, what does that indicate to you
22 about the way that the air and oxygen is being provided
23 to Mr. Mikell?

24 A. Via nasal cannula. Because you're only
25 speaking -- again, it's a general range. It's not an

1 exact number like you're going to get the FI02 on an
2 anesthesia ventilator -- on the machine delivering a
3 set inspired oxygen concentration, via an endotracheal
4 tube. This is a nasal cannula, so it's kind of a
5 genral range. And usually it reads anywhere from 25 to
6 40.

7 Q. And I'm going to show you what looks to be the
8 continuation. We are now looking at 7:55?

9 A. Uh-huh, yes, sir.

10 Q. And 7:56?

11 A. Yes, sir.

12 Q. And what happens to this PIP number between
13 7:55 and 7:56?

14 A. Yes, sir. So it's registering on a -- a
15 fairly high number.

16 Q. Okay.

17 A. That means you're -- you're -- you're bagging
18 air into the lungs.

19 Q. And then what happens to that FI02 number?

20 A. It's almost 100 percent.

21 Q. It goes -- it goes from -- what was it in the
22 last sheet that I showed you it was?

23 A. Twenty something, 30 something.

24 Q. Yeah, 20s, and then all of a sudden at 7:55,
25 7:56, it goes to 95?

1 A. Correct.

2 Q. And stays 98, 99, 100?

3 A. Correct.

4 Q. And, again, tell the jury why does it do that?

5 A. Because it's more accurately being read as
6 inspired and expired through -- through either a manual
7 bag mask, a closed system versus a nasal cannula where
8 a lot of it escapes.

9 Q. All right. Then in your -- Dr. Nelson's
10 notes.

11 (PAUSE.)

12 Q. Can you tell me -- tell the jury what,
13 according to these notes, was happening at that time;
14 7:55, what does that say?

15 A. "Patient turned supine from lateral."

16 Q. Okay.

17 A. "To establish better assisted bag mask
18 ventilation."

19 Q. All right.

20 A. "Nasal airway out, oral airway in."

21 Q. And then below that?

22 A. "Memo, came into room. Patient hypoxic with
23 junctional rhythm and no palpable pulse. ACLS protocol
24 initiated. Mayday team called."

25 Q. And so who was in the room doing this at 7:55

1 and 7:56?

2 A. Myself, Mark Payne, and whoever the nurse was
3 that day that I cannot recall, were all turning the
4 patient when Eric walked into the room and assisted us.

5 Q. Eric would be Dr. Nelson?

6 A. Yes, I'm sorry. Yes, yes.

7 Q. So based on that objective record that you
8 cannot change, right, those numbers we just looked at?

9 A. Correct. As I understand it, yes.

10 Q. Those are put in by the machine -- well --

11 A. Yes.

12 Q. -- did you ever change those -- did you ever
13 try to change --

14 A. No, no, not the -- not the O2 data, or any
15 data from the -- from the machine coming over, no,
16 absolutely not.

17 Q. So according to the computer at least, you
18 switched from the nasal cannula to bagging at 7:55 or
19 7:56?

20 A. Correct.

21 Q. Based on that objective data?

22 A. Correct, yes.

23 Q. All right. Let's go to part two. We're going
24 to talk about something that we really haven't talked
25 about much today, have we, and that is what did you

1 actually do that day -- but before we do that, I want
2 to talk about who you are and what your job is.

3 A. Yes, sir.

4 Q. You live in Charleston?

5 A. I do.

6 Q. How long have you lived here?

7 A. We have been in Charleston since 2007.

8 Q. Do you have family?

9 A. I do. My husband, Hans, and my older daughter
10 is outside of Atlanta, with her husband and two boys.
11 And Dillon is now 15 and a freshman at Wando High. And
12 Sara is a third grader Pinckney Elementary.

13 Q. Where did you grow up?

14 A. I grew up mainly in Columbia, South Carolina
15 from fifth grade on. And then went to USC there,
16 nursing school.

17 Q. And when did you graduate from nursing school?

18 A. Yes, sir, in 1987.

19 Q. What did you do after that?

20 A. I stayed in the Columbia area for a while. I
21 met my husband. We moved up to Charlotte and then down
22 to Florida. And when we were living in Vero Beach
23 around '93, '94, I became interested in furthering my
24 education -- you know, I've done just about everything
25 I could in the cardiac cath lab, and I was ready for

1 something else. And my college roommate actually was a
2 CRNA student at -- at UCLA. And she's like you should
3 see what I'm doing. You would love it. And I'm like
4 it sounds great. I'm going to apply.

5 Q. So what did you have to do?

6 A. I did -- so I made out applications for three
7 or four schools. And I was accepted luckily to Barry
8 University, which was in Miami, and kind of a new
9 anesthesia school at the time.

10 Q. How long did you have to go to school there?

11 A. So our program was 28 months. And you
12 graduated with a Masters of Science in Anesthesiology,
13 and eligibility to sit for the nurse anesthesia boards.

14 Q. Did you do that?

15 A. Of course.

16 Q. Did you pass the boards?

17 A. I did.

18 Q. How long did you practice as a CRNA up until
19 now?

20 A. So I've been practicing since '96, so
21 November -- October, November will be 20 years.

22 Q. Where did you practice?

23 A. My full time job was at Memorial Regional in
24 Hollywood, a level one 800 bed trauma center. And I
25 hit the ground begging to do open hearts, because I

1 just love cardiac being in a cath lab. And about a --
2 about eight or nine months later, they gave me the
3 opportunity because one of the CRNAs was going on
4 vacation. And it was a CRNA MDA model, no residents.
5 So I got to do a lot. I did only open hearts for about
6 four years, which I loved. A lot of central lines. A
7 lot of -- a lot of different things. And after about a
8 year in that room, I wasn't afraid of anything.

9 Q. How did you wind up back here?

10 A. So we lived in Hollywood until 2004. And by
11 then, I had Dillon. He was a couple of years old. We
12 needed to inch a little closer to the grandparents.
13 Both sets were in South Carolina, and so we moved up to
14 Flager Beach. I practiced at a Florida Hospital,
15 Memorial Orman there, and loved it. Full time there.
16 But the flexibility and the schedule wasn't anything
17 that I absolutely loved.

18 So when I had Sara, I said, Hans, I think we
19 have to get in the same state as both sets of
20 grandparents and all of the aunties. And so if we're
21 going to go up there, let me look along the coast,
22 Hilton Head, Myrtle Beach, Charleston. Let me
23 interview there and we'll see what we can find.

24 Q. Did you get a job at the Medical University?

25 A. I did. I actually interviewed at Grand Strand

1 to do open hearts alone, but they would not budge on
2 flexibility. And, of course, when I interviewed at the
3 Medical University, they were just about to open Ashley
4 River Tower in 2008, and they had a very flexible shift
5 coming up that would be manning the entire Ashley River
6 Tower Hospital. Unless there was a case going on, and
7 your attending anesthesiologist was coming in, and
8 present for the case, the CRNA -- whoever that was --
9 be it 24 hour overnight, once cases were done, or on a
10 Saturday, which I did, you were it as far as airway
11 management, intubations, et cetera. You were on your
12 own. You were manning the entire hospital for that.

13 So I did that for -- from '08 until '13, and
14 they decided to kind of restructure and get the
15 residents a little piece of that pie on the emergency
16 intubation and airway management, so.

17 Q. In 2010, were you still doing heart related
18 cases?

19 A. Oh absolutely, oh yes, uh-huh.

20 Q. What types of procedures were you doing?

21 A. Open, you know, just routine open hearts,
22 three and four vessel bypasses. We did arches. We did
23 -- we became transplant eligible, so we were doing
24 heart and lung transplants; valves as well with or
25 without the bypasses and arch work. So a little bit of

1 everything. A little bit of everything.

2 Q. Did you do some colonoscopies?

3 A. Oh, absolutely. So everybody -- everybody has
4 to kind of -- on Saturday, we did only emergencies.
5 And usually the emergencies, be it a general or
6 cardiac, were pretty emergent and pretty sick. But
7 then on my other one day a week that I did staffings --
8 other people, obviously, there were -- you know, 10 or
9 15 other CRNAs, I had to take -- we kind of worked out
10 a rotation that we would have to go down to DDC in the
11 procedural area. Not everybody loves doing procedural
12 work -- you know, everybody would prefer to be in the
13 OR doing the big cases, but we kind of made it fair,
14 and everybody kind of rotated in and out of that --
15 that area.

16 Q. How did you wind up on the team that was to
17 take care of Mr. Mikell on October 1, 2010?

18 A. I was assigned to Room D. I was assigned to
19 Room D that day with Eric Nelson.

20 Q. Now, Room D -- now, Dr. Guldan explained this,
21 but he talked a little fast and so -- it was a little
22 late in the day. Can you tell us what -- what these
23 NORA sites are? What's a NORA site?

24 A. Yes. So basically the NORA sites are
25 nonoperating room anesthesia sites. They're not the

1 nine ORs that we have. So we have now, I believe,
2 eight at Ashley River Tower, which include three rooms
3 in the cath lab for EPs and ablations, splitting it
4 with interventional radiology. We have five in the DDC
5 doing endoscopic ultrasounds, ERCPs in one room, really
6 sick inpatient upper and lower endoscopies in one room.
7 And then another two rooms to do just out patient,
8 upper and lower endoscopies. So those are our eight.
9 NORA sites that we have to staff, that are not in the
10 operating room.

11 Q. So how -- how is a NORA site, where you do a
12 colonoscopy in Room 4, different than a regular GI
13 suite in the -- in the Digestive Disease Center?

14 A. Well, all of the -- all of the DDC sites are
15 in -- are in there kind of grouped together, bunched
16 together, ERCP E West D, and now we have Room A and 3,
17 so.

18 Q. All right. Do -- do all of your colonoscopy
19 rooms have anesthesia service, the way that this
20 particular room did?

21 A. Absolutely, yes. They all have a computer for
22 charting and an anesthesia machine, a Phillips monitor,
23 and then a PICIS, which is your supplies, and your -- a
24 place for you to put your medication tray for the day.

25 Q. Who else -- who else was on your team that day

1 with Mr. Mikell?

2 A. Well, Dr. Nelson, was the supervising
3 anesthesiologist on the case that day.

4 Q. Did you know him?

5 A. Oh, absolutely, yes. Eric was a fellow at the
6 Med U, a cardiac fellow. And we worked together quite
7 a bit in the open heart room, and then an attending.

8 Q. And Dr. Payne was the gastroenterologist?

9 A. Absolutely. Yes, Mark Payne.

10 Q. Did you know him?

11 A. I did, yes. I've known Mark -- I've known
12 Mark since '07, when we started there.

13 Q. So I want you to walk the jury through what
14 you did for Mr. Mikell, how did you prepare for his
15 case, and what did you do different for him than you
16 would do for one of us if we came in for a colonoscopy?

17 A. Well, I looked him up in the -- in my
18 procedural area, to begin with, to see if I felt like I
19 needed anything -- anything special as far as what we
20 normally have, you know, to give maybe something for a
21 little low blood pressure or -- we have in that -- in
22 those areas especially, the off site areas, I tend to
23 be very prepared with my airway equipment. Because
24 there's such limited space as you saw on that
25 photograph, so I like to have everything readily

1 available to grab should I need it via -- as in ET
2 tube, oral airways, nasal airways. I like everything
3 to kind of be there. I don't like to struggle on
4 things that I can -- that I can fix easily, so.

5 But, I had looked him up. And actually I believe
6 that Eric had come into the room and said, hey, looked
7 at this guy -- ejection fraction is advertised as 30,
8 35 percent something -- you know, we just kind of went
9 over the thing. I said, you know, do you think we need
10 to use Etomidate? He's like, no, I think just an easy
11 Propofol drip --

12 Q. I'm sorry, use what?

13 A. Etomidate. I said, do you feel like we need
14 to use anything --

15 Q. You might not believe this, but I bet a lot of
16 these people in this room don't know what that is.

17 A. Right.

18 Q. Will you explain that?

19 A. So that's another induction agent that, in
20 fact, supports -- supports blood pressure. And, in
21 fact, usually raises it. And it's another induction
22 agent, hypnotic, that can essentially put the patient
23 to sleep.

24 Q. So, I'm sorry. I did interrupt you. What --
25 tell me about the conversation you had with Dr. Nelson.

1 A. So, we were discussing meds. You know, I
2 would have asked him do you feel like Versed is, you
3 know, a good idea. And, obviously, you know, we -- we
4 concurred. I usually -- with patients that have a
5 lower than normal ejection fraction, I'm kind of asking
6 what's your vive on it. Do you feel like he would
7 benefit from a little bit? You know, he's a younger --
8 you know, a younger man, so.

9 So we decided on Versed and just a -- just a
10 Propofol drip, just a Propofol drip starting at a much
11 lower rate than I would a healthy person --

12 Q. All right.

13 A. -- or with -- with a healthier heart.

14 Q. With -- with -- with a normal, uncomplicated
15 colonoscopy, is there a procedure where you don't
16 actually put the patient completely to sleep?

17 A. Okay. So if anesthesia is involved, the
18 endoscopists that are there -- there are many at the
19 Medical University -- okay. They do still many of
20 their cases with conscious sedation, meaning an RN is
21 giving the medication and the patient is maybe able to
22 verbalize or follow basic commands.

23 If anesthesia is employed, then they feel like
24 it is in our best interest to manage putting the
25 patient to sleep, as in them being sleepy enough not to

1 know anything is going on, but to manage that safely.
2 So it's very rare that we will do anything but a sleepy
3 IVGA -- IV general anesthetic. If we're employed,
4 that's why he's employing us. If he thinks he can do
5 it with somebody that's kind of talking, and kind of in
6 and out, then they will do it with their RNs.

7 Q. Now, just so we don't confuse terminology,
8 when you say they decided to employ anesthesia, you
9 mean you and Dr. Nelson? That's --

10 A. Yes.

11 Q. -- you're not talking about they used -- they
12 always use some anesthesia, I hope, for these
13 procedures?

14 A. Right.

15 Q. But when you say they use anesthesia --

16 A. Anesthesia personnel.

17 Q. Okay.

18 A. To manage the patient and medicate
19 appropriately.

20 Q. All right. So you don't necessarily have to
21 have a board certified anesthesiologist and an ACLS
22 trained CRNA to do a colonoscopy for most patients;
23 correct?

24 A. No. In other words, they do some of their
25 patients under conscious sedation, just with the

1 endoscopist and an RN. We are not involved at all.
2 And an endoscopist usually makes that call, who they
3 want anesthesia to manage, and who they want to manage
4 with an RN as a conscious sedation.

5 Q. I'm going to put this picture up, so we can
6 see what the room looked like, and have you give us a
7 little tour. All right. Now, there's some way that
8 you can make marks on that thing there -- how does --
9 how does she do point -- if you can point --

10 THE COURT: Use her finger. She can just use her
11 finger.

12 MR. COOKE: Just her finger -- permission to use
13 her finger. You can make marks on there. So why don't
14 you show the jury what --

15 THE COURT: James, why don't you show her how to
16 erase it while you're there. He's going to show you
17 how to use it. Okay.

18 (PAUSE.)

19 BY MR. COOKE:

20 Q. All right. So I'm going to let you do it the
21 way you want to. You just show us what the different
22 things are there, and where you would sit, and what you
23 would do?

24 A. So when you bring your patient in for a
25 colonoscopy, you have to reverse and back them in head

1 first. Because the door is over here. You go around
2 the boom that holds the scope. And you would bring the
3 head of the bed toward the anesthesia machine. Again,
4 this is for a colonoscopy.

5 Before I would put the brake on, and get him
6 settled, right here is your PYXIS machine with my
7 medications -- my routine medications, my first line
8 medication supplies that I might need. So I will bring
9 up his name, open it, and leave it open for the case so
10 I can get to everything with the stretcher. You can
11 see that the stretcher doesn't allow much room between
12 the actual PYXIS --

13 Q. All right. Now, when you said PYXIS, that's
14 not the same as PICIS, is it?

15 A. No, PYXIS, P-Y-X-I-S, it's what our supply and
16 med -- medication machine is -- is termed. That's what
17 it's called, so. So -- open the doors, get the patient
18 put in there. And then you'll see that this is kind of
19 my area that I -- that I stay in, chart from, monitor
20 on, et cetera.

21 This is obviously the anesthesia machine here
22 that includes the machine data -- if you'll come over,
23 you'll see right here -- you could see a little meter,
24 and that's your O2 cannula, meaning you can dial in
25 usually two, three, four liters you'll start somebody

1 on, and usually keep them there while they're sleeping
2 and -- sleeping and unaware of what's -- what's going
3 on.

4 This is the monitor. It has an arm so that you
5 can turn it. You can turn it and see the monitor as
6 you're working. So I can turn -- as you can see, the
7 charting screen and my keyboard. I can turn this to
8 look exactly at the data and the monitors and
9 Mr. Mikell. So you can position yourself where you can
10 kind of do a sweep. Everything is kind of in front of
11 you and kind of to your left, right there. Very --
12 very handy. It's very cozy.

13 So for somebody else to get back there sometimes
14 is a little bit of a challenge. They have to duck the
15 overhead monitor that the endoscopist is using -- is
16 usually along -- along this side of the stretcher, up
17 in the air about four feet. So, you know, it's a
18 challenge if -- if more than you are -- are involved
19 with a patient. But that's it.

20 The patient's head is here. Something that I
21 always do is I put the -- I kind of get ready to manage
22 the airway should I need to on any case before it
23 starts. I'll put the -- the IV pole -- the pole for
24 fluids that's on the stretcher down, and I'll undo
25 the -- the handles on the stretcher, so nothing is

1 impeding me to the patient. He's right there, whether
2 he's lateral or he's supine. I do that for every case.
3 I do that first thing. It's just like monitors that,
4 positioning, oxygen cannula, everything, check.

5 Q. What things are actually hooked up to the
6 patient -- or what things were actually hooked up to
7 Mr. Mikell?

8 A. Okay. So, you'll see on some things coming
9 off here, and the three things that we monitor
10 continuously are the O2 sat, which is a probe that goes
11 on your finger. It's either a probe that clips on, or
12 a peel-on that attaches to a cable that stays on the
13 anesthesia monitor; a blood pressure cuff, and then EKG
14 leads. And, again, we monitor two NV (ph) for
15 everybody, that Phillips falls to it, and we monitor
16 two NV for everyone. So you have a -- you have a two
17 lead perspective.

18 Q. Do you have to check your machines?

19 A. Yes, sir, uh-huh. You go in -- usually that's
20 what you're doing in the morning. Before your case is
21 started, you are checking your machine. I'm making
22 sure that my airway equipment is as handy as I want it
23 to be. Putting a cannula on the -- nasal cannula, you
24 know, just kind of getting it ready to get ready.

25 Drawing up drugs for the case. Opening the

1 chart and looking at it, seeing if I can ascertain if I
2 need anything special for that particular case.

3 Q. Can you -- can you point on your thing there
4 to which monitor you're looking at to get the data in
5 real time? What do you call it, the Phillips monitor?
6 Is that what that's called?

7 A. Yes. So this -- this is your Phillips right
8 here.

9 Q. Okay.

10 A. And that's what your -- your O2 sat, your EKG
11 and your blood pressure are coming across on. And then
12 this is your anesthesia machine data, FI02, respiratory
13 rate, tidal volume, things that are specific with how
14 the oxygen is being delivered. Peak inspiratory
15 pressure is if you -- you know -- again, more accurate
16 if you have a breathing tube in, et cetera, but that's
17 your oxygen delivery data.

18 Q. And then what's -- what's over -- that black
19 one on the right, what is that? Is that your computer
20 monitor?

21 A. The black one right here (indicated)?

22 Q. Yes.

23 A. Yes, uh-huh. That is my computer monitor,
24 uh-huh, that I chart from.

25 Q. So is that where your electronic chart shows

1 up?

2 A. Yes.

3 Q. And there's a keyboard right under there?

4 A. Yes.

5 Q. Is that where you enter data?

6 A. Absolutely, yes.

7 Q. And so jumping ahead a little bit, but is
8 that -- by comparing what you are seeing on the
9 Phillips monitor and your anesthesia monitor, with what
10 was showing up in the chart in that computer, is that
11 how you knew whether the data was going into PICIS?

12 A. Yes. Because looking at the timeline on the
13 narrative that -- it looks like, you know, we
14 transferred -- I transferred around 35. I got
15 Mr. Mikell to the procedure area, oxygen monitors
16 positioned, everything. And it looks like at 39 was
17 the first time that I was like, oh -- was the first
18 time that I looked at the -- at the computer chart, and
19 said, oh, look, nothing is coming across, but we're
20 about ready to start. So I put a page into work, and
21 then got my Propofol drip ready to go, and just kept --
22 kept going --

23 Q. All right.

24 A. -- kept going.

25 Q. Will Dr. Payne start a procedure if the

1 monitors aren't hooked up?

2 A. Absolutely not. So Mark Payne's wife is Kim
3 Payne, an anesthesiologist at the VA. And Mark is very
4 in tune, more so than most endoscopists, I think, with
5 anesthesia issues. He did a mellampati exam, which is
6 an airway exam. I don't see other endoscopists doing
7 that, to give him an idea if we're going to maybe have
8 a problem securing his airway. You can, generally
9 speaking, sometimes tell that visually.

10 He also is very -- he's very acutely aware of
11 tone, you know. He'll say, everything okay? He's
12 very, very in tune with everything that's going on in
13 the room.

14 Q. So as he starts the procedure, what drug did
15 you give first?

16 A. So I had -- I had given, according to my
17 chart, I had given a Versed on the way from the holding
18 area -- you know, once Mr. Mikell was good, and Dr.
19 Nelson and I talked to him, Mark Payne had come in and
20 had him sign his consent. He was the first case in the
21 morning so -- which is generally 7:30.

22 So after all was good, consents were signed,
23 generally speaking, we'll give to -- a Versed as you're
24 kind of rolling to the room, which usually takes about
25 a minute, a minute and a half to get from a holding

1 area -- this particular holding area to that procedure
2 room.

3 Q. And what does Versed do?

4 A. Versed is anxietlicitic. It's a benzo, as in
5 Valium, and kind of makes you not really give a rip.
6 And it also causes some retrograde amnesia. In other
7 words, you may be talking to me, but you may not
8 remember the conversation. So sometimes the amnesia
9 can be profound.

10 Q. Okay. And then what drug -- what anesthetic
11 agent did you decide to use?

12 A. Yes. So Dr. Nelson and I decided to use a
13 Propofol drip, and just started at a low rate and just
14 kind of -- just let it onset gently.

15 Q. Why Propofol?

16 A. Why Propofol, because it's our favorite drug.
17 It's the best drug anesthesia has come up with in the
18 last century. But besides that, it is a drug that you
19 can titrate on a dime. You can turn it on and it works
20 usually within 60 seconds to two or three minutes,
21 depending on what rate you got it on. You can turn it
22 off and the patient is awake and fairly clear four or
23 five minutes later, just depending on what rate you
24 have it at. So it's a perfect titratable drug for a
25 procedural area.

1 Q. You have been accused of spending your time
2 and attention texting and making phone calls when you
3 should have been paying attention to the patient; is
4 that true?

5 A. No, sir, not at all.

6 Q. Tell the jury what you did and how you dealt
7 with the issue of the chart, and how, if at all, that
8 affected the attention that you paid to Mr. Mikell that
9 morning?

10 A. Yes, sir. So I had texted or I had paged on
11 Simon page, is where you can put messages on pagers.
12 And so at 7:39, once I had Mr. Mikell hooked up and
13 positioned, and I was happy with all of that, I looked
14 back at my chart and realized the data was not coming
15 over. So I took a few seconds, and got on Simon page
16 -- Simon paging system -- S-i-m-o-n.

17 Q. You do that from your computer terminal?

18 A. I can, yes. Yes. So I minimized the chart,
19 got on Simon, says call me back -- or call me, NORA
20 patient not in -- not -- not able to transfer NORA
21 patient -- or however I put it. I can't recall
22 exactly.

23 Q. Where, in that picture, would the phone be
24 that they would call you back on, if they did call you
25 back?

1 A. Okay. So the phone is right next to -- is
2 right next to the PYXIS machine right here about
3 maybe -- maybe about three more feet from the PYXIS
4 machine.

5 Q. Can you answer that phone without losing your
6 attention on the -- on the monitor?

7 A. Oh, absolutely. Absolutely, yeah. You can
8 pick it up and, you know, you can still sweep and
9 you're just feet away.

10 Q. Did she call you back?

11 A. Okay. It appears that I paged her at 39. We
12 proceeded and I still wasn't getting results as far as
13 the chart coming across, and so I re-paged her. And I
14 believe she called me back then, got the chart up at
15 47, 48.

16 Q. Okay. According to our notes, your first text
17 went out at 7:39; does that sound about right?

18 A. Yes, it does.

19 Q. And then your second one, hey, can you
20 call/page me back, was 7:46; does that sound right?

21 A. It does. Because by the time Eric walked in
22 at 48 to do his at -- and everything -- everything was
23 good. I was no longer -- I was no longer, you know,
24 the chart wasn't an issue, so.

25 Q. Did you have any more communication with the

1 IT people after 7:46?

2 A. No, no, no.

3 Q. And they did do whatever they do --

4 A. Yes.

5 Q. -- remotely -- they didn't have to send an IT
6 guy in to --

7 A. No.

8 Q. -- monkey with your equipment?

9 A. Usually you have to get -- give them the
10 computer number, which is usually listed at the bottom
11 of the screen. You give them that number, and they
12 remotely capture and do the transfer that for some
13 reason didn't work for me.

14 Q. Going back to your -- your note here 7:48,
15 anesthesiologist assessed patient, reviewed chart and
16 formulated anesthesia plan, medically directing --
17 those are notes that he made; correct?

18 A. Yes. Those are his attestations, yes.

19 Q. Okay. Anesthesiologist present for induction,
20 you explained what that meant earlier.

21 A. It's a range --

22 Q. And then I or another attending was
23 immediately available -- throughout -- throughout and
24 present for all key and critical portions of the case.
25 And then you write the note at 7:48 also, "Memo, Nelson

1 MDA in; nasal airway in; O2 sat up to 94 percent;
2 patient remains lateral".

3 A. Yes.

4 Q. Now, you didn't actually type that in that
5 morning, did you? You typed that in later?

6 A. Correct. As I -- as I recall it, yes.

7 Q. Was that information correct?

8 A. Absolutely. Because I remembered that when
9 Eric came in to make his attestations, he's like, is
10 everything all right. I'm like, yeah, I put a nasal
11 airway in. He was obstructing a little bit, but
12 everything is fine now, you know, oxygen cannula. He's
13 still on cannula and sat is 94 percent.

14 Q. And just to remind you, when -- when the
15 machine started recording -- when the machine started
16 recording up there, what is your first reading for the
17 oxygen saturation?

18 A. So it appears to be 96.7.

19 Q. Okay. And but you're actually looking at it
20 in real time, even finer increments than that?

21 A. I absolutely was, yes.

22 Q. So based on -- was it based on your
23 observations of saturation that you wrote here that
24 the -- that the O2 sat was up to 94 percent?

25 A. Yes.

1 Q. Now --

2 A. Yes, I remember having a conversation, you
3 know, the conversation with Eric when he walked in, and
4 the number that I gave him, so.

5 Q. All right. Now, it's been suggested that
6 because you said O2 sat up to 94, that that implies
7 that it was less before, and therefore maybe Mr. Mikell
8 was in distress before when you were sending your text
9 messages; is that true?

10 A. His O2 sat after I had started the Propofol,
11 maybe five or six minutes earlier I believe -- it was
12 7:41-ish, and the procedure started at 42; so it had
13 dipped to the point that I felt like -- and he was
14 sleepy enough that I felt like that would be a good
15 intervention and to maintain it higher.

16 Q. You mean to put the nasal cannula in?

17 A. Nasal airway.

18 Q. Nasal airway.

19 A. Yes. You had the cannula breathing, but he
20 was obstructing, like snoring, and maybe completely
21 obstructing -- you know, somebody that snores and
22 doesn't take in air for, you know, a second or two.
23 He -- he had sleep apnea, so we knew that. So I knew
24 he might be airway amenable.

25 Q. So you were able -- you were able to actually

1 think about that even while you were texting with the
2 IT folks then?

3 A. So according to -- oh, what I was shown about
4 the times that I texted Annette --

5 Q. Right.

6 A. I texted her at 39, before anything had
7 started, the procedure or the Propofol. I said, hey,
8 got a problem. Call me back. So I believe that she
9 did not call me back. And then I sent another message,
10 I believe, at 7:46 -- correct -- so I had started the
11 Propofol, texted her, and then turned my attention to
12 Mr. Mikell. Two minutes later, I felt like a nasal
13 airway would be appropriate. So, yes, at no time was
14 my focus off Mr. Mikell, and what I needed to do with
15 his airway or his medication, his Propofol infusion.

16 Q. I want you to just -- in your own words, I
17 want you to look at this jury, and I want you to tell
18 them, under oath, do you believe -- looking back on
19 what happened on that day, do you believe that you were
20 concentrating on Mr. Mikell, and that you were properly
21 monitoring everything that you should have been
22 monitoring that day?

23 A. Absolutely. Absolutely. And, unequivocally,
24 I can say that, yes, yes.

25 Q. Do you think you -- could you have missed

1 something? Could you have missed a desaturation or
2 something wrong with these other vital signs? Is it
3 possible that you could have missed that because you
4 were busy on the phone or sending that text message?

5 A. No. No, not at all. Not at all. If it had
6 not been remedied by the second time, I would have just
7 let it go. And whatever is on the chart -- I mean, do
8 you follow what I'm saying? I mean, the patient is --
9 is always first. Charting can come later. Whether the
10 data can be repopulated or captured later accurately is
11 not my concern at the moment. My concern is the
12 patient.

13 If she can get the chart up and working, that's
14 even better obviously to reflect all the -- all the
15 monitor data that's coming across. Otherwise, I'm
16 looking at it, focusing on Mr. Mikell, and deciding
17 what I need to do with his airway management and
18 Propofol infusion management.

19 Q. And Dr. Nelson left room at what time?

20 A. So he -- you -- when he stepped in at 48 --

21 Q. Right.

22 A. And did his attestations, okay. So my -- my
23 estimate was -- he was in the room for about two to
24 three minutes. He came to talk to me and say, hey, is
25 everything good. I said, yeah. I put a nasal airway

1 in. He's back up to 94 percent, happy there. He's
2 like, okay. And so he would have come around behind
3 me, and done his computer work, et cetera. And so I
4 estimated about two to three minutes he was in the
5 room. It wasn't -- it wasn't less than that. It
6 wasn't less than that, but.

7 Q. So he would have left, according to your note,
8 at --

9 A. Correct.

10 Q. Nelson out --

11 A. Yes. I believe that's within a good 30 second
12 window, yes.

13 Q. Okay. One --

14 A. Yes. Yes.

15 Q. Did you feel comfortable allowing him to leave
16 the room under the circumstances?

17 A. Oh, absolutely. Absolutely, I would have told
18 him, listen, I need some help. I put the nasal airway
19 in and I'm not getting good results, or I'm -- I'm not
20 feeling -- or I would absolutely immediately let him
21 know if I -- if there was something that I felt like I
22 needed him to stay for or to help me with at the
23 moment.

24 Q. Did you know where he was going to be?

25 A. So not specifically and exactly, but I know

1 that he's within -- he's within quick access to me
2 should I page him or need him for any reason. Yes,
3 usually within the department, because he's
4 supervising, you know, depending on what's going on, at
5 least one CRNA. So he's kind of on a short leash for
6 the procedures.

7 Q. Tell us what happened after he left the room?

8 A. So, after he left the room, the Propofol
9 continued to infuse. And Mr. Mikell desaturated a
10 little more than I could make better as far as with the
11 nasal airway and the cannula.

12 Q. And so what did that mean to you?

13 A. So at I believe it was 55, I said to Mark
14 Payne, first, I said I'm having trouble keeping his
15 saturations up. I feel like I need to turn him over
16 supine where I can -- on his back and manage his airway
17 a little more -- a little more tightly than I can with
18 him in the lateral position.

19 So I'm going to do that now. I'm going to turn
20 the Propofol off. And I believe I said to the RN, will
21 you call Eric Nelson in, to come assist me and see what
22 it is we need to do. Can we give him a couple of bags.
23 He's a little bit better. And then he can support his
24 own airway with or without a nasal airway enough for us
25 to finish the procedure, so.

1 Q. And did you -- I think, according to the
2 chart, you turned the Propofol off at 7:53?

3 A. Correct, yes, uh-huh. Yeah. That was the
4 point at which I felt like there was an issue, and we
5 might have to -- number one, take a break from the
6 Propofol. And, number two, you know, manage his airway
7 concurrently, just to get him back to an acceptable
8 saturation level.

9 Q. And how quickly did Dr. Nelson arrive after
10 you determined that you needed help?

11 A. Like almost immediately, almost immediately.

12 Q. And is that what's reflected in your notes
13 here?

14 A. Yes. Yes.

15 Q. Tell the jury what happened once he got there?

16 A. Yeah. So as we were -- as me, Mark, and the
17 nurse were turning the patient, Eric walked in the
18 room. Helped us complete the turn of Mr. Mikell on to
19 his back. I took the nasal airway out. I put an oral
20 airway in, and began -- and began to manually mask him
21 with an ambu bag, and just deliver a big, hundred
22 percent oxygen breaths to him, to try and support that
23 sat --

24 Q. Then what happened.

25 A. -- his oxygen saturation. He became -- I

1 didn't -- Eric was looking at the monitor, and also
2 getting out first line drugs here. Because at first he
3 got -- he had a very slow rhythm. And then it got so
4 slow, a lot of people will go into what they call a
5 junctional rhythm, where it's just kind of the
6 ventricle contracting without the atria really
7 responding. And you can tell because you don't see a P
8 wave with it. So he got kind so slow, he kind of
9 started into a junctional rhythm, became hypertensive,
10 and then became unstable from there.

11 Q. And he -- did he -- did he actually digress
12 down to the -- what they call the PEA?

13 A. He did. He did. Yes. I would have to look
14 back at the record to see if Eric got any medications
15 in before he went into pulseless electrical activity,
16 meaning there's sometimes -- electricity on the EKG,
17 but it's not really pumping and not causing a pulse.
18 So you're seeing something on the EKG, but nothing is
19 really happening in the body.

20 Q. Then what happened after that?

21 A. So we initiated CPR. He -- either myself or
22 he told the nurse to call -- to call a Mayday. And
23 that brings a lot of people, including pharmacy if you
24 need extra drugs that you may not have in your initial
25 first line set up. And I -- I believe I intubated

1 shortly thereafter, put the breathing tube down and --

2 Q. What's -- what's the purpose of putting the
3 breathing tube in?

4 A. Well, obviously, he's -- he's -- he's in a
5 very unstable situation. So if nothing else, you
6 definitely want to have your blood pressure, airway,
7 and EKG stabilized. So that's just one of the first
8 things that you -- you need to do until he's more
9 stable and figure things out. Obviously, it is the
10 optimal way to manage an airway versus just bagging
11 someone for 20 or 30 minutes, you know.

12 Q. Are you certificate in advanced cardiac life
13 support?

14 A. Absolutely.

15 Q. What does that mean?

16 A. So that means you are certified to give drugs
17 and initiate CPR, and to direct defibrillation. If you
18 have Vfib or Vtac, if the heart is just quivering, and
19 it needs to be shocked into a normal rhythm. That
20 means that you can direct -- you can yourself do, or
21 direct other people to do all of those things together.

22 Q. And was he shocked -- did somebody have to
23 shock him to get his heart back --

24 A. Yes. So generally speaking -- uh-huh --
25 every -- every nursing unit in the hospital has a

1 Mayday card, and they have an defibrillator on it. And
2 it's checked every day to make sure that it's got power
3 and it functions well. And you can kind of dial it
4 into 200, and kind of test shock it into -- into the
5 machine itself which is grounded, and it shows that,
6 yes, you can deliver a safe shock. Nothing -- no
7 problems with this machine. So they -- they check it
8 every day in the OR or the procedural areas that we
9 work in.

10 Q. So how did -- how did the procedure end?

11 A. Well, actually, I believe shortly after we
12 turned him supine, we were starting to manage a bunch
13 of different things. Obviously Mark Payne took the
14 scope out. That was the end of the -- of the endoscopy
15 procedure itself.

16 We initiated -- we called a code, started giving
17 meds, CPR; intubated, defibrillated; got a lot of other
18 anesthesia help. Dr. Guldán, two other CRNAs responded
19 to help me put a larger peripheral IV in for access.
20 Put in an arterial line that measures beat to beat
21 blood pressure versus a blood pressure cuff that can
22 maybe read it every 45 to 60 seconds. A manual blood
23 pressure cuff -- so the arterial line is a good beat to
24 beat blood pressure manage for someone that's unstable,
25 or you anticipate to be unstable. We put that in.

1 We put a central line in which again is access
2 and great for drips and things that you think you will
3 be running for a while. So we did all of that for him
4 in the space of about 30 minutes, I believe -- or 30 to
5 40 minutes before we were happy enough with his
6 hemodynamics -- his stability to transfer him to the
7 PACU.

8 Q. Did he -- did he eventually return to
9 spontaneous respiration and heart beat rhythm?

10 A. Oh, absolutely. Yes, yes.

11 Q. Did his heart ever actually stop?

12 A. Not -- not completely. No, he was in -- you
13 know, he was in PEA, so he had some electrical activity
14 after the junctional. And then after the -- after the
15 CPR and meds, his rhythm came back spontaneously, so.

16 Q. Well, ever since this has happened, I assume,
17 that you have had a lot of opportunity to think about
18 what happened that day, and what you did that day. As
19 you think back on it, can you think of anything, being
20 self critical as you can possibly be, anything that you
21 didn't do that you should have done, or anything that
22 you could have done better that day to try to help
23 Mr. Mikell?

24 A. I have reflected on this a lot obviously. You
25 know -- I'm sorry.

1 (Witness pause.)

2 A. I kind of like to think that -- that I set the
3 bar very high for myself as far as the anesthesia that
4 I deliver, and my job that I do every day. And I like
5 to think that my judgment on an anesthetic plan,
6 especially when it's in collaboration, obviously, with
7 an anesthesiologist or whoever I'm working with that
8 day, is the absolute best plan, and the safest plan for
9 our patient or, you know, whoever we're -- we're
10 undertaking to get their procedure done with the
11 anesthesia.

12 I've looked back on it. I've gone over my
13 conversation with Eric, and I -- I -- I truly believe
14 that we had a good anesthetic plan for Mr. Mikell. I
15 think that he became unstable, and we did -- we did a
16 lot of things for him very quickly and very
17 efficiently. But I look back on the plan, and I -- I
18 would do it all the same again, as far as the
19 anesthetic plan. I really do not see anything
20 differently that I would do as far as the anesthetic
21 that we had planned for him.

22 I also look back on how we responded to him
23 becoming unstable. And during that period, and the
24 procedural room, I'm -- I'm -- I'm very pleased with
25 what we did for him, and how we reacted to him becoming

1 unstable. But I -- I wouldn't change anything about my
2 plan of Versed or the Propofol infusion; I can say that
3 without reservation.

4 MR. COOKE: Thank you very much. That's all I
5 have.

6 THE COURT: All right. Madam Forelady, ladies and
7 gentlemen of the jury, we'll take a break at this time.
8 I believe we've been going about an hour and 40
9 minutes. Please leave your notepads in your chair. If
10 you need anything, let the bailiffs know. And we'll
11 take an afternoon break. Please follow the bailiff to
12 the jury room.

13 (WHEREUPON, the jury leaves the courtroom at
14 3:30 p.m.)

15 THE COURT: All right. Anything from the
16 plaintiff before we take a break?

17 MR. RANSOM: Nothing, Your Honor.

18 THE COURT: Anything from the defendant?

19 MR. COOKE: Nothing. Thank you.

20 THE COURT: All right. We'll take an afternoon
21 break. Thank you very much.

22 (WHEREUPON, a brief recess was taken.)

23 THE COURT: Let me know when you're ready to bring
24 the jury; okay?

25 MR. RANSOM: Yes, sir. I believe we are ready.

1 THE COURT: Well, if you're ready, is the defense
2 ready?

3 MR. COOKE: We're ready.

4 THE COURT: Okay. Bring us the jury please.

5 (WHEREUPON, the jury enters the courtroom at
6 approximately 3:48 p.m.).

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

8 THE COURT: Thank you very much. Redirect.

9 MR. RANSOM: Thank you, Your Honor.

10 **REDIRECT EXAMINATION BY MR. RANSOM:**

11 Q. Ms. Embrey, you testified a little bit ago
12 about this number right here. And I'm pointing to page
13 504, down in the bottom. This number here at the top,
14 this 47 and a half, that's the blood oxygen saturation
15 value for the period between 7:45 and 8:00; do you
16 remember that?

17 A. Yes, sir.

18 Q. You said that that number was an average of
19 the blood oxygen saturation values during that period
20 of time?

21 A. As I understand it, and whatever the oxygen
22 saturation probe was able to pick up.

23 Q. Right. Okay. So that's the average between
24 7:45 and 8:00, and it's going to be 47 and a half.
25 Okay. And what we're talking about with respect to

DONNA EMBREY -- REDIRECT

1 this record that was marked as Defendant's Exhibit 6,
2 that's the one minute record, there are a couple of
3 pages -- the -- hold it -- okay. So 7:45 starts here
4 with an empty box; 7:46, 7:47 empty. And then we
5 actually get data for a number of boxes across there up
6 to 7:55?

7 A. Yes, sir.

8 Q. And a couple of pages later, in Defense
9 Exhibit 6, then we follow that along 7:56, 7:57, 7:58,
10 7:59, 8:00. And so what -- so what you're telling us
11 is that if we take the values that go in those 15
12 boxes, for 15 minutes, and we add them up, the average
13 is going to be 47 and a half?

14 A. My understanding as to what is actually
15 populated in the 15 minute record, I'm -- I'm -- I'm
16 guessing that that is what's happening. I mean, I see
17 higher numbers. I see lower numbers, obviously, during
18 the arrest and subsequent, you know, the PEA and --

19 Q. No, I'm just listening. So what we'll do then
20 is I just want to confirm with you that, I mean,
21 because this is -- this is your record. This is your
22 software. This is your institution, your job. You're
23 telling us that this number here is the average of the
24 values during that time, and I accept that. I just
25 want to make sure that I'm understanding you correctly.

1 A. That is my understanding of how on a 15 minute
2 record, one number is put there.

3 Q. Okay. So we'll come back later and do the
4 Math. Now, you had said, I think, Mr. Cooke had
5 pointed out with respect to the audit trail, which is
6 Plaintiff's Exhibit 10, that Dr. Nelson was over here
7 actually at the terminal keying in information at
8 7:48 -- I'm sorry -- at 7:49. And what he was putting
9 into the system at that time were these entries as to
10 what he was doing at 7:48?

11 A. All right, sir.

12 Q. And that was what -- that's what you and Mr.
13 Cooke talked about; right? So what I wanted to confirm
14 with you then, is if he's actually on the terminal at
15 7:49, we see that Mr. Mikell's oxygen saturation is 75.
16 All right.

17 Now, you had testified that when the patient's
18 oxygen saturation is less than 90, you need to be doing
19 something about it? Okay.

20 A. Yes, sir.

21 Q. Would standing at the terminal, entering
22 entries at 7:49 be the thing to be doing when your
23 patient's saturations are 75?

24 A. No, sir, but may I explain? There -- there
25 could have been some artifact on the O2 sat, because if

1 I had noticed that it was that low, or Eric had noticed
2 that it was that low, we would have done something very
3 differently than just leaving it at the nasal airway in
4 and the nasal cannula flowing at what it was, so.

5 Q. Well, I just want to make sure I understand
6 this because I'm gathering that your defense team is
7 basing your defense on the numbers up here. Okay. And
8 I want to know, can we rely on those numbers as being
9 accurate? Because if they're accurate for your
10 defense, they're accurate for my client, too. And it's
11 the same thing over here with this audit trail, if Dr.
12 Nelson is on the computer terminal at 7:49 --

13 A. Yes.

14 Q. -- when Mr. Mikell says are at 7 -- 75, that's
15 malpractice, isn't it?

16 A. I don't recall them being that low when -- you
17 know, until he started kind of becoming unstable a
18 little bit later and closer to the Mayday being called.

19 Q. Now, the next thing that you testified to was
20 over here on this board -- and this is page 494.
21 You've got this business here that Dr. Nelson at 7:51,
22 he's leaving the room at 7:51?

23 A. He was in there for two to three minutes,
24 right.

25 Q. Right. And this is the accurate rendition of

1 the record that you put together on the Mayday record?

2 All right.

3 A. On the anesthesia record, yes.

4 Q. Right. So what -- what's his oxygen
5 saturations at 7:50? It's 69.2. Okay. So you would
6 agree with me that during the times that you have
7 indicated --

8 A. Yes.

9 Q. -- and using the data that you're relying on,
10 Dr. Nelson is on the terminal when the patient is
11 desaturating, and he's leaving the room when the
12 patient is getting even worse?

13 A. I do not recall it happening that way, Mr..
14 Ransom.

15 Q. Now, I also want to ask you, to take a look
16 for me, if you will --

17 A. Yes.

18 Q. -- at this -- these real time graphs. And we
19 have this one that we marked on earlier this morning.
20 You said that it was at 7:55 that the patient was being
21 turned, and you were making an effort to do certain
22 things?

23 A. Yes.

24 Q. When we look at this downward trending graph,
25 all right, that you agree started at 7:45 or 7:46,

1 wouldn't you agree with me that 7:55 is going to be
2 somewhere right around there?

3 A. Again, I've seen that graph on several
4 different timelines. And I think the -- I think, if
5 anything, I think the variables and the numbers are
6 more accurate for whatever they were picking up than
7 the -- than the graph is. I've seen it on several
8 different timelines.

9 Q. Well -- and see this -- this is what we are
10 trying to figure out, Ms. Embrey, is -- you know, can
11 we rely on the real time graph, can we rely on the real
12 time variables, or do we just have to rely on you?

13 A. Good question, because as I recall it, after I
14 put the nasal airway in, his oxygen saturation jumped
15 back up to the mid 90s. I -- I said in my narrative 94
16 percent. The -- I think the number on that time
17 reflects even a better number than that. But I
18 intervened and it got better for a period of time.

19 I do not recall him having problems with his O2
20 sat while Eric was in the room. I cannot speak to the
21 fact if there was artifact on it. I -- but I can tell
22 you that there was no further intervention needed until
23 a little bit later when I felt like it was prudent to
24 turn off the Propofol. And then a of couple minutes
25 later, turn him on his back, manage his airway a little

1 more specifically.

2 Q. Ms. Embrey, can you be putting a nasal airway
3 in your patient when you're on the telephone?

4 A. No, sir.

5 Q. Can you be doing a chin lift to clear an
6 obstruction if you're on the telephone?

7 A. No, sir, absolutely not.

8 MR. RANSOM: Thank you. I don't have any other
9 questions.

10 THE COURT: Recross?

11 MR. COOKE: Just one, Your Honor.

12 **RECROSS EXAMINATION BY MR. COOKE:**

13 Q. Going back to the one minute. Mr. Ransom
14 circled these numbers here, and I don't know whether
15 you can see it from where you are. But your record --
16 your narrative record reflects that Dr. Nelson left the
17 room at 7:51; correct?

18 A. Yes. Yes.

19 Q. And can you see what the oxygen saturation is
20 up to at 7:51?

21 A. The number appears to be 90.1.

22 Q. And so is that what you're referring to when
23 you said that you recall it having increased
24 dramatically from the lower numbers before you inserted
25 the nasal airway?

1 A. Yes. Yes. Eric wouldn't have stepped out and
2 I wouldn't have let him if what I had done at 48 was
3 not effective -- an effective intervention for
4 Mr. Mikell. If it wasn't working then -- then I would
5 have had him stay or give me a hand or, you know.

6 Q. So at the time that he left, did it appear
7 that he had improved to 90.1 percent, and that that was
8 as a result of the insertion of the nasal airway?

9 A. Absolutely.

10 Q. Thank you.

11 A. Absolutely.

12 Q. That's all?

13 THE COURT: You may step down. Thank you very
14 much. May I see the attorneys up here just a second?

15 (WHEREUPON, a bench conference was had.)

16 THE COURT: All right. Madam Forelady, ladies and
17 gentlemen of the jury, we are going to take a break at
18 this time, and we'll start back in the morning at 9:30.
19 If you'll leave your notepads there.

20 And as I told you before, don't discuss the case
21 with anyone. And I'll see you in the morning at 9:30.
22 And, ma'am, you need to probably change your
23 appointment.

24 JUROR: Okay.

25 (WHEREUPON, the jury leaves the courtroom at

1 4:03 p.m.)

2 THE COURT: All right. Anything from the
3 Plaintiff before we take a break?

4 MR. RANSOM: No, Your Honor.

5 THE COURT: Anything from the defendant?

6 MR. COOKE: Nothing, Your Honor.

7 THE COURT: All right. I'll see you in the
8 morning 9:30. Thank you very much for your
9 cooperation.

10 (WHEREUPON, the hearing concluded.)

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1 * * * Thursday, April 21, 2016 * * *

2
3 THE COURT: We're still waiting on one juror. But
4 I -- is there anything that we need to talk about or do
5 before we bring the jury -- as soon as the other juror
6 gets here?

7 MR. COOKE: I can't think of anything. We've got
8 a lay -- lay witness, and then we've got Dr. Reeves
9 here.

10 THE COURT: You got? I'm sorry, what?

11 MR. COOKE: I think -- I think -- I think we have
12 our order of witnesses for the morning, so I think
13 we're set.

14 THE COURT: All right. Well, as soon as we get
15 the other jurors, we'll bring the jury in.

16 (PAUSE.)

17 THE COURT: Bring us the jury, please.

18 (WHEREUPON, the jury enters the courtroom at
19 approximately 9:39 a.m.)

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

21 THE COURT: Thank you very much. You can call
22 your next witness, please.

23 MR. APOSTOLOU: The plaintiff calls Mark Fielding.

24 MARK FIELDING, after having
25 been duly sworn, testified as follows:

1 THE CLERK: Please state your first and last name,
2 and spell your last name loudly and clearly into the
3 microphone.

4 THE WITNESS: Mark Fielding, F-i-e-l-d-i-n-g.

5 **DIRECT EXAMINATION BY MR. APOSTOLOU:**

6 Q. Good morning, Mr. Fielding.

7 A. Good morning.

8 Q. Where are you from?

9 A. I'm from Charleston.

10 Q. Did you know Charles Mikell?

11 A. Yes, I did.

12 Q. What did you call Charles?

13 A. Chuckie.

14 Q. Chuckie?

15 A. Yeah.

16 Q. All right. How did you get to know Charles
17 Mikell or Chuckie?

18 A. I met him at Shaw University in 1979. We were
19 freshman at Shaw University. We became life long
20 friends after that.

21 Q. Okay. He was from Charleston and you were
22 from Charleston, but y'all didn't know each other here?

23 A. No.

24 Q. Where was he from in Charleston?

25 A. The West Ashley area.

MARK FIELDING -- DIRECT

1 Q. And where are you from?

2 A. I was from Lincolnville at the time.

3 Q. Okay. And so y'all both ended up being
4 freshman at Shaw University?

5 A. Yes.

6 Q. And that's a school in Raleigh, North
7 Carolina?

8 A. Yes, it is.

9 Q. Okay. So y'all got to be friends at the
10 college?

11 A. Yes, sir.

12 Q. Okay. And were y'all in a fraternity at Shaw?

13 A. Yes. Omega Psi Phi, Inc.

14 Q. And Chuckie was in that same fraternity?

15 A. Yes.

16 Q. Okay. And did you see him after college?

17 A. Yes. I went to Atlanta -- I went to funeral
18 service school in Decatur, Georgia. And when I moved
19 back to Charleston, I -- we continued our
20 relationship -- or our friendship.

21 Q. And what -- what year basically ballpark?

22 A. 1985.

23 Q. 1985. And you saw him -- how often did you
24 see him up until he passed away?

25 A. Two or three times a week. I spoke to him

1 every day, multiple times a day.

2 Q. Unfortunately, we're not going to get a chance
3 to meet Chuckie. Can you tell us a little bit about
4 what kind of person he was?

5 A. Chuckie was just -- one of these -- one of
6 these kind of people that you just loved to be around.
7 He always had a joke on his heart. Very energetic,
8 very enthusiastic. As a matter of fact, I was just
9 telling Mr. Scott that -- and I had forget it -- but
10 Chuckie introduced me to my wife.

11 Q. Okay.

12 A. And I think I got married before he did. And
13 he got married and, you know, the kids started coming
14 after that. And he just loved his kids.

15 Q. Well, let's talk about that. What kind of
16 father was he?

17 A. As far as I could see, he was a great father.
18 You know, Madison and DaeDae and Shon, they were very
19 active in church in every aspect of family life.

20 Q. Did y'all ever go back up to Shaw University
21 for homecomings and those types of things?

22 A. Mostly every year, we'd go for homecoming.
23 There was a few times that I couldn't make it, but that
24 was one of the highlights, you know, going back to Shaw
25 University in Raleigh.

MARK FIELDING -- DIRECT

1 Q. And he enjoyed doing that?

2 A. Oh, very much so. We all did.

3 Q. What about socially, did he do anything?

4 A. Yeah. Well, he was a part of the Knights of
5 Pythagoras -- I think he was one of their leaders. And
6 that's with the Masons and the Shriners. And also with
7 the fraternity, he was very active with both, and his
8 church as well. I think he was -- he handled the music
9 and lighting and stuff like that for the church.

10 Q. Okay.

11 A. And for the fraternity, we have mandated
12 social programs that we have to be a part of.

13 Q. And what types of programs are those?

14 A. Mentoring programs, reclamation. I can't
15 think of all of them right now, but there is a number
16 of them, like 10 or 15.

17 Q. Was Chuckie involved in --

18 A. Yes --

19 Q. -- the mentoring?

20 A. Yes, he was.

21 Q. What did he do for a career? What was his
22 career?

23 A. He started out at WCBF. And then I think he
24 became -- he was also working part time with Rick
25 Hendrix. And then, you know, things happened. And I

1 think he had to stop working for a while. And then the
2 later years, prior to his death, he was working at the
3 Canterbury House as a driver for -- for the residents.

4 Q. You had mentioned that he had worked for a
5 television station?

6 A. Right.

7 Q. And is that what he studied at Shaw
8 University?

9 A. Yes, sir.

10 Q. And he graduated from Shaw?

11 A. Yes, he graduated.

12 Q. What did he do in the television business?

13 A. I think he was the night production person,
14 so -- but he used to go to work like 8:00 -- 8:00 at
15 night and don't get off until the next morning, things
16 like that.

17 Q. And you said some things happened, he had some
18 health issues?

19 A. Yes.

20 Q. Okay. Did you see him after those health
21 issues?

22 A. Yes.

23 Q. And did he go back to work after those health
24 issues?

25 A. Now, what are we talking about, from the

1 television station or --

2 Q. Yes.

3 A. -- from the Canterbury House?

4 Q. After the television station, you said he had
5 gone back to work at the Canterbury House?

6 A. Yes.

7 Q. Okay. What is the Canterbury House for folks
8 that might not know?

9 A. It's -- how do I say it?

10 Q. A retirement home?

11 A. A retirement home, yes.

12 Q. And what did he do there?

13 A. He drove the bus that, you know, when they had
14 to go to different functions, or needed to go to the
15 store, or anywhere the residents had to go, doctor's
16 appointments or whatever.

17 Q. And did he enjoy that job?

18 A. Yes, he did.

19 Q. Did he enjoy being around the old people?

20 A. He just enjoyed being around people, period.

21 Q. Okay. What type of things when -- did y'all
22 go walking or what type of things did y'all do
23 together?

24 A. We used to do things with the fraternity, with
25 the boys. I think -- I can recall -- I was just

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1 thinking about it, they lived on a dead end street, and
2 Chuckie bought a gocart for the kids. And he was
3 telling me about the neighbors, who would literally
4 park their car at the beginning of dead end so that the
5 kids wouldn't be affected. I mean, he just enjoyed
6 being around people. He loved his children like I said
7 emphatically.

8 Q. Okay.

9 A. Now me, I never did go walking with him. I
10 should have you know. But I didn't have the time
11 because I was, you know, trying to run a business.

12 Q. I understand. So he -- he had some health
13 issues, which he stopped working in the television
14 business. And then -- can you give us a timeframe on
15 how long, basically, he worked?

16 A. Honestly, I can't give you a timeframe, you
17 know, it's -- it's been over the course of almost 25,
18 30 years.

19 Q. Right.

20 A. So I mean, I -- I want to say he worked at the
21 WCBD up until the '90s. I can't recall honestly when
22 he stopped working there.

23 Q. Okay. You know at some point he ended up
24 having a -- going to MUSC for a colonoscopy in October
25 of 2010?

MARK FIELDING -- DIRECT

1 A. Right.

2 Q. Okay. And did you visit him -- obviously, he
3 had -- he was intending to come back that day, but
4 obviously he had a protracted stay in the hospital?

5 A. Yes.

6 Q. Did you visit him in the hospital?

7 A. Yes.

8 Q. What did -- can you describe the scene for us
9 that you saw?

10 A. I don't remember the timeframe, but I know
11 right after the colonoscopy, where there were
12 complications, they put him in MUSC and they had to
13 induce a coma to get his vitals back to where they
14 needed to be.

15 And at that time, you know, we -- we go by at
16 least two or three times, you know, when he was in the
17 induced coma, just to get up there and, you know, to
18 see how he was doing.

19 Q. How did you find out that things had gone
20 badly at MUSC?

21 A. Well, through -- through the family circuit.

22 Q. Okay. And can you just describe when you
23 first walked in, what -- what did you see -- visually,
24 what did you see?

25 A. I see my friend there with all these wires and

1 tubes and what not. And it -- it was a little
2 disheartening.

3 Q. A disheartening scene?

4 A. Yes, sir.

5 Q. Okay. Did he recognize you? Did he talk to
6 you?

7 A. Well, when he was in the coma, he didn't --
8 you know, he was in a coma. But afterwards, yeah.
9 Because one of the first things he said to me was
10 that -- the night before he went into the -- to have
11 the colonoscopy, I think, I was the last person to
12 speak to him that night.

13 Q. Okay.

14 A. Yeah.

15 Q. And did he -- what -- what was the basis of
16 that conversation?

17 A. You know, we prayed together and, you know,
18 hoping that everything went well with the colonoscopy.
19 But afterwards, you know, after the induced coma -- I
20 can't remember if that went on for like a week or two
21 weeks -- I'm not a hundred percent certain how long
22 that went on.

23 Q. But you visited him in the hospital?

24 A. Yes, sir.

25 Q. Okay. And there came a point where he got out

MARK FIELDING -- DIRECT

1 of the hospital; is that correct?

2 A. Right.

3 Q. Did you see him after that?

4 A. Yes, sir.

5 Q. And can you describe for us what kind of
6 condition he was in?

7 A. He -- he wasn't the same. I mean, you know,
8 he was a very energetic and enthusiastic person. And
9 you could just tell his demeanor was -- was down. And
10 he was trying to do everything that they were telling
11 him to do, the doctors, you know, as far as his weight,
12 which he had lost a significant amount of weight, and
13 eating more healthy. And he was just trying to find
14 his way back to where he was.

15 Because prior to him going for the colonoscopy,
16 I can remember him taking trips to Maryland to go to
17 DaeDae's and Madison's games, which was a lot for him,
18 you know, leaving from Charleston by himself going to
19 Maryland -- driving by himself. You know, I even
20 offered to go with him a couple of times, but he said
21 no.

22 Q. And DaeDae and Madison were his children?

23 A. Right. Those are his children.

24 Q. Okay.

25 A. That's what we call them. I'm sorry.

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1 Q. I understand. And it was important for him to
2 go see them?

3 A. Of course.

4 Q. To go over there. Okay. You said he wasn't
5 the same before as after -- can you put like a
6 percentage number on kind of what -- where he was?

7 A. I think before he went in, he was at 85 or 90.
8 And when he came back out, he was 25 or 30.

9 Q. Okay. And he was out about two, three months?

10 A. Yes.

11 Q. Did you talk to him -- how did you find out
12 that he passed away?

13 A. Mr. James Fordham called me at the house, and
14 said you need to come get Chuckie. And I -- I didn't
15 know what was going on. I thought he needed to go to a
16 doctor's appointment or something. I didn't know that
17 he was calling me professionally as a funeral director
18 and embalmer.

19 Q. Had you talked to him?

20 A. I talked to him the night before he died, yes,
21 just to see how he was doing.

22 Q. Can you tell us about that conversation?

23 A. You know, he wasn't the same, but he -- he
24 said everything was all right, that that day was a good
25 day.

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1 Q. And then you got the call that he had passed
2 away?

3 A. Yes, that morning.

4 Q. As a funeral director, you went and helped the
5 family with the body?

6 A. Right.

7 Q. Okay.

8 MR. APOSTOLOU: The court's indulgence.

9 BY MR. APOSTOLOU:

10 Q. You had mentioned that when you saw him at
11 MUSC initially, he was comatose?

12 A. Yes.

13 Q. Was he hooked up to a bunch of machines?

14 A. Yes.

15 Q. That kind of thing.

16 A. Yes, he was.

17 Q. And that lasted for a while?

18 A. Yes.

19 Q. And -- but then you were able to see him
20 afterwards -- and you saw him when he got back to his
21 house?

22 A. Yes.

23 Q. Can you -- can you speak to his quality of
24 life and his enjoyment of life before?

25 A. Well, before he went for the colonoscopy,

1 Chuckie was walking I know three, four, maybe five
2 times a week. He was still out there cutting his
3 grass. Because I even offered to come cut his grass
4 and his mother's grass, who lived behind him. And he
5 told me, no, that's how he gets his exercise -- one of
6 the ways he gets his exercise. It was just totally
7 different, you know, from where he was before he went
8 in.

9 Q. Did that impact his enjoyment of life?

10 A. I'm sure it did.

11 Q. When is Shaw's homecoming typically?

12 A. October.

13 Q. Okay. Did he go that year?

14 A. No, he didn't go.

15 Q. Was he disappointed about that?

16 A. Very disappointed. I was as well, because he
17 had just gotten me back into going to homecoming. And,
18 you know, re-acquainting with old friends. And it
19 was -- it was just sad.

20 Q. Is that the type of thing that he valued?

21 A. Oh, yes.

22 Q. Being with his friends?

23 A. Being with his friend and family, yeah.

24 Because I think normally he would leave Shaw, and he
25 would go with his children afterwards.

1 Q. Okay. His children lived in Maryland?

2 A. Right, in Maryland.

3 Q. Did they ever come to Charleston? Did you
4 ever see them down here?

5 A. Yes. Yes. He said they came a couple of
6 times a year. There were probably sometimes when I
7 didn't know about them coming to Charleston, but they
8 were -- Shon lived here at the time. He still -- did
9 you live here, Shon -- I'm sorry. I shouldn't be
10 asking the questions.

11 Q. That's all right. That's okay. So did he
12 look forward to like when his children would visit over
13 the summer, that type of thing?

14 A. Most definitely, yeah.

15 Q. And y'all tried to get the families together?

16 A. Oh, yeah. Have cookouts and, you know, eat
17 crabs and oysters, and just be around each other.

18 Q. Did you do any of that in between the period
19 when he got out of the hospital and before he passed
20 away?

21 A. No.

22 Q. He wasn't -- was he up to being able to --

23 A. No, he wasn't up to it, no --

24 Q. -- any of that kind of stuff?

25 A. No.

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1 MR. APOSTOLOU: No further questions.

2 THE COURT: Cross-examination.

3 MR. COOKE: Thank you, Mr. Fielding. I don't have
4 any questions.

5 THE COURT: Mr. Fielding, you may step down.
6 Thank you very much. You may be excused. Thank you,
7 sir -- unless want to stay, you are welcome to stay.

8 MR. APOSTOLOU: The Plaintiff calls Andre Scott.

9 THE COURT: Okay.

10 ANDRE SCOTT, after
11 having been duly sworn, testified as follows:

12 THE CLERK: Please be seated. Please state your
13 first and last name, and spell your last name loudly
14 and clearly into the microphone.

15 THE WITNESS: Andre Scott, S-c-o-t-t.

16 **DIRECT EXAMINATION BY MR. APOSTOLOU:**

17 Q. Good morning, Mr. Scott. Thank you for
18 coming.

19 A. Good morning.

20 Q. Did you know Charles Mikell?

21 A. Yes, sir, I did.

22 Q. Okay. Can you tell the jury how you knew
23 Charles?

24 A. I've known Charles Mikell -- Chuck Mikell --
25 Chuckie Mikell since we were kids, probably since about

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1 the age of six. We lived about less than a block from
2 each other in the Washington Park neighborhood.

3 Q. Okay.

4 A. We grew up together, Cub Scouts, Boy Scouts
5 Webelos. We went to different high schools. I was
6 slightly older than Chuck, but we were friends most of
7 our lives.

8 Q. Okay. And he went away to Shaw University?

9 A. Yes, he did. And I believe he left in -- that
10 would have to be 1979. I was already gone in the
11 military, and in the navy in 1977.

12 Q. And then you came back to Charleston?

13 A. I came back to Charleston 29 years later.
14 December 7, 2006, my father took sick and my mother had
15 already passed, and I came back to take care of my
16 father.

17 Q. Did you maintain your friendship with Chuck?

18 A. During the period -- during over the 29 years,
19 when I would come back home and he was in town, we
20 would get together and meet and talk, and things of
21 that sort, yes.

22 Q. Can you tell us what kind of person he was?

23 A. Well, Chuckie was an honest person. If all of
24 you have real friends, you know that you don't always
25 get along, but they will tell you the truth. We didn't

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1 always get along, but he always kept it legitimately
2 real. We didn't agree on everything, but he had his
3 points of views, and I had my opinions. And that's
4 what I enjoyed about him, being honest and being
5 truthful. That's how you know you have a real friend
6 to me.

7 Q. And you maintained your friendship since y'all
8 were six years old?

9 A. Yes, we did.

10 Q. Okay. And did you know what he did for a
11 living?

12 A. I was somewhat familiar that he had went to
13 college, and he had worked for the station. But as far
14 as I was -- I was still traveling the world and doing
15 other things for the military.

16 Q. Okay. What is the Knights of Pytharoras?

17 A. The Knights of Pytharoras is a mentorship
18 program that works through the Masonics through the
19 Masons. It's a mentorship program, not just about
20 masonry, but about life for young men. It tries to
21 prepare men to -- young men to become men and to become
22 better persons, to understand life and to develop a
23 point of view.

24 Q. Is that something that's important to you?

25 A. Yes, sir. I'm still a member. I was -- as a

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1 matter of fact, I was recruited by Charles. He was in
2 charge of Knights of Pythagoras for Lodge 51. I was
3 recruited by him to become a knight(ph), which I am
4 still today.

5 Q. And he was active in that?

6 A. He was the head of it. And, yes, he was
7 exceptionally active.

8 Q. It was a big deal to him, wasn't it?

9 A. Yes, it was. He took it personally.

10 Q. Okay. And it was a mentoring program?

11 A. Yes, it is.

12 Q. Okay. Was that something that was important
13 to Chuck?

14 A. I would say, yes, as far as that -- not only
15 with that, with the church and Bible school. He would
16 work with the kids. And in the summertime, Madison and
17 Dadrian would come down. He would put DaeDae in --
18 DaeDae would go to a fishing camp in the daytime
19 sometimes in the summer. Madison would have other
20 things to do, but that was Chuck's favorite time to
21 spend with his children, the summer when they would
22 come down for three months. As far as the mentoring
23 program, anything he could do or we could do, we would
24 do.

25 Q. He loved being around children, didn't he?

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1 A. Yes, he did.

2 Q. Okay. And -- and outdoors, did he enjoy going
3 outside and being outdoors?

4 A. Well, yes, we went outdoors. And well he
5 was -- we were in the Boy Scouts, so he had no choice
6 there.

7 Q. And he spoke a little bit about his family,
8 was that an important part of who Chuck was?

9 A. Exceptionally important. Not only his
10 children, but the rest of his family, his mother, his
11 aunt. We also looked after him. And in general, just
12 trying to make sure that everyone that we would meet,
13 we could put on a straight and narrow path -- not
14 always easy, but sending them in the right direction.
15 Life is filled with choices, and those you make of your
16 own, but we would like to give you an option.

17 Q. And that's something that he believed in as
18 well; right?

19 A. Yes, he did.

20 Q. Okay. Who was Jewel Mikell?

21 A. That was Chuck's mother.

22 Q. And was he close to his mother?

23 A. Yes, indeed.

24 Q. Did he -- was he protective about --

25 A. Well, I'll put it like this, he took care of

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1 his mother and his aunt until he passed. He was
2 responsible for doing what he could, and when he could.
3 His aunt became up in age, she is still living now.
4 She's in her late '90s. They moved her from where she
5 was living in with his mother, so she could be closer
6 and he could help the both of them at one time.

7 Q. Okay. His mother was alive when she -- when
8 Charles passed away?

9 A. Yes, she was.

10 Q. She subsequently has passed away?

11 A. Yes, she did.

12 Q. And his children would come visit you said
13 over the summers, is that something that Chuck would
14 look forward to, get excited about?

15 A. That was something he lived for. He would
16 usually count the days. "They'll be here in a couple
17 weeks, I'm ready". That's what he would say.

18 Q. Okay. You know at some point, he went to MUSC
19 and had a colonoscopy in October of 2010?

20 A. Yes, sir.

21 Q. Okay. And you know it didn't go well -- how
22 did you find out that it didn't go well?

23 A. Well, I, -- I know he went in. And I usually
24 check with him on a daily basis. He's about -- when
25 things -- I heard from his mother.

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1 Q. His mother called you?

2 A. Yes.

3 Q. Did you go see him in the hospital?

4 A. Yes, I did.

5 Q. Can you tell us what you saw when you got
6 there?

7 A. Well, what -- what I saw was a person that was
8 not the same person that I saw before he went in. He
9 was receiving medical help, I would say. He was -- he
10 was unable to speak or things of that sort. But he
11 just was laying there on a gurney.

12 Q. It's hard to see your friend in that
13 condition?

14 A. There are things that you think you can be
15 prepared for, and there's things you just don't really
16 prepare yourself for, and that was one of those things
17 for me.

18 Q. It stuck with you?

19 A. I guess it took me like a double blow, because
20 my dad just died and dealing with that. Then I come in
21 here and find one of my friends in that condition. It
22 was just difficult.

23 Q. All right. And it came to a point where he
24 got out of MUSC -- did you see him in the two months
25 that he was out?

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1 A. Yes, sir.

2 Q. In the interim -- and can you tell us what
3 kind of condition he was in?

4 A. Well, being -- living less than a block from
5 Chuck, I would try to see him three -- between three
6 and five times a week personally. If only for a couple
7 of hours, we'd sit down and watch the news, or watch a
8 show on TV. We'd talk a little bit. I would ask him
9 if he needed anything.

10 His activity level was different. I won't
11 say -- he didn't do the things he did prior to
12 entering. He was trying to get into better health. We
13 were walking together in the afternoons and things like
14 that. His walks became shorter, less frequent, and
15 things of that sort.

16 I started checking on him more periodically.
17 I'd ask him if he wanted to do something, and I'd tell
18 him I would drive and things of that sort. And I just
19 was trying to offer any assistance I could.

20 Q. Okay. And how would you say that his -- the
21 diminished abilities that you just talked about, how
22 did that affect -- how would you say that affected his
23 enjoyment of life?

24 A. Well, number one, he stepped down as the
25 leader of the Knights of Pythagoras. We had to assign

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1 someone different. He would attend some meetings, but
2 he was never in -- in the position of authority as he
3 was. He was just in an observance position. He would
4 help with what he could and when he could.

5 As far as the church, I knew he still went to
6 church on Sundays. I don't know if he did as much as
7 he did, because we didn't go to the same church. I
8 would visit periodically to check -- to see the person
9 that I knew -- because I knew some of the people there.
10 But as far as that, I didn't know them. As far as the
11 fraternity, I'm not a member, so I wasn't familiar with
12 that.

13 Q. Okay. But he stepped down from the Knights of
14 Pytharoras?

15 A. Yes, he was in charge and he stepped down from
16 that and just moved to an observance position where,
17 you know, he could just basically oversee and see what
18 was going on.

19 Q. How -- how did you find out that he passed
20 away?

21 A. His mother called me at home on Sunday morning
22 and told me that --

23 Q. I'm sorry. Who called you?

24 A. His mother.

25 Q. His mother.

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1 A. And she said -- all she would repeat was
2 "Chuckie's gone", and that's all I remember. I walked
3 to the house, which is not that far. And she met me at
4 the end of the driveway, and I tried to console her,
5 and I tried to keep myself together.

6 MR. APOSTOLOU: Okay. The court's indulgence.

7 (PAUSE.)

8 BY MR. APOSTOLOU:

9 Q. So, in your friendship with Chuckie, family,
10 community, his church and support, are those the type
11 of things that were important to Chuck?

12 A. Yes, sir.

13 MR. APOSTOLOU: I don't have any further
14 questions.

15 **CROSS EXAMINATION BY MR. COOKE:**

16 Q. Good morning, Mr. Scott. I believe in your
17 deposition, you said that you actually did speak to
18 Chuck on Saturday -- Friday and Saturday before he
19 passed away?

20 A. The Saturday, I called him. I work with
21 youths in sports. I called him to let him know that we
22 had won the game, and I asked him how he was.

23 Q. And he said "pretty good"?

24 A. He said "pretty good".

25 MR. COOKE: That's all. Thank you -- no, I'm

1 sorry.

2 BY MR. COOKE:

3 Q. And that was the last time you spoke to him?

4 A. Yes, sir.

5 MR. COOKE: No further questions, Judge.

6 THE COURT: Any reply?

7 MR. APOSTOLOU: No, Your Honor.

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

10 THE WITNESS: Thank you, Your Honor.

11 MR. APOSTOLOU: The plaintiff calls Louann Arthur.

12 LOUANN ARTHUR, after having been
13 duly sworn, testified as follows:

14 THE CLERK: Please state your first and last name,
15 and spell your last name loudly and clearly.

16 THE WITNESS: Louann Arthur, A-r-t-h-u-r.

17 **DIRECT EXAMINATION BY MR. APOSTOLOU:**

18 Q. Okay. Hey, Louann, you knew Chuck, didn't
19 you?

20 A. Uh-huh.

21 Q. Can you tell us how you knew him?

22 A. Chuck was my husband, my friend, and the
23 father of my children.

24 Q. Okay.

25 MR. APOSTOLOU: Your Honor, may I approach the

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1 witness?

2 THE COURT: Yes, sir.

3 BY MR. APOSTOLOU:

4 Q. So, you were married to Chuck?

5 A. Yes.

6 Q. When did you first meet him?

7 A. I met Chuck when I was like 15.. He actually
8 is the best friend of my first cousin.

9 Q. So, you were 15 years old?

10 A. Uh-huh.

11 Q. All right. And what -- when -- how old were
12 you when you all got married?

13 A. I was 29, going on 30.

14 Q. And did you already have a child at that
15 point?

16 A. Yes, I did.

17 Q. And who was that?

18 A. That was Shon.

19 Q. The plaintiff in the case, Shon?

20 A. Shon, uh-huh.

21 Q. And then you got married to Chuck?

22 A. Yes.

23 Q. Okay. What kind of father was he to -- I know
24 you had -- subsequently y'all had children together,
25 but what kind of father was he to Shon? Was he a

1 father to Shon?

2 A. Yes, he was.

3 Q. What did Shon call him?

4 A. Daddy, yeah. Chuck -- Chuck and I had been
5 friends for -- since I was 15. So when I had Shon at
6 25, Chuck would come around, and he would go get me
7 cheeseburgers and french fries, because I was craving
8 them with Shon. So at the time, we were just friends.
9 And then a year -- a year or so afterwards, I wanted to
10 go to Oregon, and I was going to leave Charleston and
11 take Shon. And Chuck asked me not to go.

12 And I -- I said why? He said, "Because I don't
13 want y'all out of my life". So -- and he said, "I've
14 fallen in love with Shon". That's what he said. So
15 that's when we started dating. Three years later, we
16 got married.

17 Q. And did you subsequently have children?

18 A. Yes, we had two.

19 Q. Madison and --

20 A. Madison and Dadrian.

21 Q. And was that -- how did Chuck enjoy being a
22 father?

23 A. Madison was planned. We planned Madison. We
24 were excited and we, you know, he wanted -- his dad was
25 still living, and he wanted -- we wanted to have

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1 children together. Dadrian our little -- on the way
2 out, but he was so excited. He just -- he loved him.
3 He loved him just like he loved Shon.

4 Q. He didn't love Shon any differently than --

5 A. Oh, no.

6 Q. What did he do for a living?

7 A. He was a Master of Production Specialist at
8 WCBD TV.

9 Q. Okay. He graduated from Shaw University?

10 A. Yes, he did.

11 Q. Okay. And what type of things -- do you know
12 what he did at the TV station?

13 A. Yes, actually he did the news. He did the
14 technical aspects of the morning news, and running
15 commercials, editing, that sort of thing.

16 Q. And that's what he had studied at Shaw?

17 A. Yes.

18 Q. And he ended up stepping down from that
19 because he did have some health issues?

20 A. Yes, in about 2003. Yes, he was no longer
21 able to work.

22 Q. Okay. And did he get his health issues
23 straight?

24 A. Well, he was -- he was doing really, really
25 well with his -- with his heart condition. And he was

1 at least able to go and find a full time job working at
2 the Canterbury House. He couldn't go back to WCBD with
3 the hours and that sort of thing, but he was able to
4 work at the Canterbury House.

5 Q. And he worked?

6 A. Yes.

7 Q. At the Canterbury House up until the incident
8 in October?

9 A. Yes.

10 Q. Why did he get a job at the Canterbury house?

11 A. Well, Chuck is -- Chuck is -- was always a
12 people's person. Chuck loved children and he loved old
13 people. He -- he just thought they were the funniest
14 things. So he liked working with them, and it gave him
15 something to do, that he felt like he was -- where he
16 was helping people.

17 Q. Was it important to him to get back and to
18 contribute --

19 A. Oh, yes.

20 Q. -- to something that he valued?

21 A. Yes, very much.

22 Q. How about with children in general, not just
23 his children?

24 A. He just liked -- he just liked helping
25 children. He just loved them so.

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1 Q. And how about with his mother, was he close to
2 his mother?

3 A. Very, very close, yes.

4 Q. At a certain point, you and Chuck got
5 divorced?

6 A. Yes.

7 Q. Okay. Did y'all maintain a friendship?

8 A. Well, we got divorced in 2001, 2002. And, you
9 know, the first years of -- during separation, I don't
10 think we liked each other that much. But, you know, we
11 maintained a really good relationship. Because one
12 thing we had promised each other was that regardless of
13 what was going on with us, that the kids always would
14 come first. So even if the -- the conversations were
15 short, and only about the kids, they were frequent
16 because we had to deal with things like Dadrian not
17 meeting up to speed, and stuff like that.

18 So I would say gradually, I got my friend back,
19 you know. It took some time, but we became very close
20 again.

21 Q. And y'all talked fairly often?

22 A. Yeah. At least two to three times a week.

23 Q. Okay. Did Chuck ever come up to Maryland --
24 I'm sorry -- what do you do for a living?

25 A. I'm sorry -- I'm a senior financial analyst

1 with the Navy.

2 Q. With the Navy?

3 A. In Washington, DC at the Naval Shipyard.

4 Q. Okay. Do you still work for the Navy?

5 A. Yes.

6 Q. And you've basically -- you moved up to
7 Maryland because of the job?

8 A. I moved up to Maryland as a contractor,
9 working for Future Technologies Incorporated, and
10 recently took on another civilian position with the
11 Navy.

12 Q. With the Navy. And did Chuck ever come up
13 there and visit?

14 A. Yes.

15 Q. What type of things would he come up for?

16 A. Madison's basketball game, Dadrian's football
17 games, graduation, and stuff like that.

18 Q. That's a long way to go for a sporting event?

19 A. Yeah, but not for his children.

20 Q. Can you tell us what he would do?

21 A. I mean, he just -- he would come up and, you
22 know, and come to the event or he'd fly in or take the
23 train or, you know, he drove. We met each other a lot
24 of times. And he would come up and whatever event --
25 attend that event, and spend some time with them, and

1 then turn around and drive back to Charleston.

2 Q. Okay. And that's in the interim after you've
3 been divorced?

4 A. Uh-huh, yes.

5 Q. And did the children ever come to Charleston?

6 A. Yes, the children came to Charleston regularly
7 every summer, at least for Spring Break -- every Spring
8 Break. And I had -- we had decided that since we were
9 so far away, you know, it was easier if -- instead of
10 trying to get them to -- to him every other weekend,
11 you know, they would just spend like Spring Break and
12 Christmas, or Thanksgiving, and we would swap out, you
13 know, the holidays unless they wanted to go and kind of
14 pressure me about going home, you know, for both
15 holidays. But all -- every summer.

16 Q. Okay. And is that something Chuck looked
17 forward to?

18 A. Oh, yeah.

19 Q. And y'all had conversations about that?

20 A. (Nodded affirmatively.)

21 Q. I'm going to --

22 MR. APOSTOLOU: May I approach the witness, Your
23 Honor?

24 THE COURT: Yes, sir.
25

1 BY MR. APOSTOLOU:

2 Q. Just thumb through those. Do you recognize
3 what those are?

4 A. Uh-huh.

5 Q. Are those some photos?

6 A. Yes.

7 Q. And accurately and clearly depict the subject
8 matter of Chuck and his family?

9 A. Yes. Yes.

10 (PAUSE.)

11 MR. APOSTOLOU: Your Honor, we move to introduce
12 into evidence Plaintiff's Exhibit 45.

13 THE COURT: Any objection?

14 MS. FLEMING: No objection.

15 THE COURT: All right. Plaintiff's 45 admitted
16 without objection.

17 (WHEREUPON, Plaintiff's Exhibit No. 45 admitted
18 into evidence.)

19 BY MR. APOSTOLOU:

20 Q. Louann, I'm going to publish some photos up
21 here, and if you could just tell us kind of what they
22 are? Who is that on the left there?

23 A. That's Chuck and Dadrian.

24 Q. And obviously that's football?

25 A. Yes.

LOUANN ARTHUR -- DIRECT

1 Q. And can you tell us what we're seeing in this
2 exhibit?

3 A. This is around Christmas time when Chuck --
4 this is Chuck's family, extended family. His mother is
5 here and --

6 Q. Where is his mother -- his mother is there?

7 A. This is his mother (indicated). And this is
8 his grandaunt that he is helping to care for. And then
9 he has his two cousins, and their husband, and his
10 uncle.

11 Q. Is Chuck in that photo?

12 A. Yes. This is Chuckie.

13 Q. You've seen this a few times, but go ahead and
14 clear the screen. And who is in that photo?

15 A. This is -- that's me, Shon, and Chuckie. And
16 I think we were at Chuckie Cheese celebrating his
17 birthday.

18 Q. Shon's pretty young there, isn't he?

19 A. Yeah. He's maybe about four or five.

20 Q. And how about this photo?

21 A. That's Madison and Chuck. Actually on that
22 other photo, Shon must have been about five because I
23 was pregnant with Madison.

24 Q. In the photo before?

25 A. Uh-huh.

LOUANN ARTHUR -- DIRECT

1 Q. In that one. And this was -- this is Madison
2 here?

3 A. Uh-huh, yes, it is.

4 Q. And how about this?

5 A. That's Madison, Shon, and Chuck. And I had
6 just had Dadrian. I had just come home with Dadrian.
7 And that was -- yes, we were celebrating -- I don't
8 know -- it was somebody's birthday. It had to be
9 Madison's birthday because they were born -- Madison's
10 birthday is the 28th and Dadrian was born on the 22nd.

11 Q. And that's Dadrian in your arms right there?

12 A. That's Dadrian.

13 Q. And obviously that's Chuck in the red shirt?

14 A. Uh-huh.

15 Q. And how about this family photo?

16 A. Yeah. I don't know what time, but Dadrian had
17 to be about one, so maybe a year after.

18 Q. How about that photo?

19 A. I think that was either at Carowinds or when
20 we went to -- no, I think that was Carowinds when we
21 went -- because she wanted to keep riding the bumper
22 cars, and Chuck had trouble getting in and out of that
23 car, but he got in.

24 Q. And how about that?

25 A. I think we -- that was -- we had gone to

LOUANN ARTHUR -- DIRECT

1 Disney World. And we were in a hotel. It was actually
2 Chuck's birthday and Super Bowl Sunday that weekend.

3 Q. And who were the children there?

4 A. Madison and Dadrian -- I mean, Shon. Madison
5 and Shon.

6 Q. And how about that photo?

7 A. That's Madison and Chuckie. I think Madison
8 was running for Ms. T. Rose with the Alpha Kappa Alpha
9 sorority. And she was running for that little pageant.

10 Q. A little tiara?

11 A. Uh-huh.

12 Q. How about this photo?

13 A. We were definitely in Disney World with Shon
14 and Madison.

15 Q. And that's Chuck doing the maneuver?

16 A. Yes. That's Chuck. That's like the Omega Psi
17 Phi.

18 Q. And how about that?

19 A. That's Madison and Chuckie.

20 Q. Where was that taken?

21 A. In our bedroom.

22 Q. That's in your bedroom. And how about that?

23 A. And that's another picture of us -- actually,
24 we bought that cake for him that -- when we were in
25 Disney World, and it was Super Bowl Sunday as I said.

1 And we had driven down. So the kids and I kind of
2 snuck off and bought this cake to celebrate his
3 birthday.

4 Q. And there he is. When is that photo?

5 A. This is a photo of when Chuckie got promoted
6 to being the chief with the knights of Pytharoras.

7 Q. We heard about the knights of the Pytharoras
8 earlier, can you tell us what sort of role that had for
9 him and --

10 A. Oh, he loved that. He loved -- he -- he had
11 been in that since Shon was a little boy. And then
12 when Dadrian, he came along, you know, he pushed
13 Dadrian in it as well. And it was basically a
14 mentoring group for young African American boys, to
15 help instill in them some self confidence and respect
16 for growing up and endeavoring to be better men, so.

17 Q. And that's something (that was obviously
18 important to him?

19 A. It was -- yeah, he loved -- he loved those
20 little boys.

21 Q. How about his church, we heard about his
22 church a few times --

23 A. Yeah, he -- actually he was over the
24 production side, you know, taking care of the lighting,
25 the speakers, videography in the church.

1 Q. And you didn't get a chance to see him after
2 the colonoscopy, did you?

3 A. I did when he was in the hospital.

4 Q. Right. You saw him in the hospital?

5 A. Yes.

6 Q. Can you tell the jury what basically you --

7 A. Actually I received a call from his God sister
8 saying that something had happened. I was actually at
9 work, and it was a little after eight. And she said
10 that something had happened with the colonoscopy. And
11 the kids and I drove down the next day.

12 And when we got there, of course, he was in, you
13 know very, very grave condition. He was hooked up to a
14 lot of machines, and had a lot of things. He was
15 comatose. He wasn't speaking. He looked -- he looked
16 really, really bad.

17 Q. And you went back to Maryland with the kids
18 after that, but you didn't get a chance to see him once
19 he had been out?

20 A. No, I didn't.

21 Q. Did you have plan to come visit?

22 A. Oh, yes. We had plans. Actually the day he
23 was able to speak, I was -- I had just picked Madison
24 up from basketball practice, and we were waiting at a
25 light and the phone rang. And I saw -- I was, like,

LOUANN ARTHUR -- DIRECT

1 oh, my God. And then I could barely hear him. And the
2 first thing he said was -- I said, oh, Chuck, I said,
3 I'm so glad. And he said, "Let me speak to my baby
4 girl". And Madison -- we just started praying and you
5 know. We were just so happy that at least we could
6 hear him again.

7 And then, you know, we were -- just from that
8 point on, once he went home, we talked a lot, maybe two
9 or three times a week.

10 Q. And had you made plans to come visit him?

11 A. Yes, we did.

12 Q. He actually passed away, as we can see, on
13 January 2nd?

14 A. Right.

15 Q. The day after New Years Day?

16 A. Yes. That weekend --, the week prior to the
17 New Years, I had had surgery -- minor surgery. And I
18 had -- we had planned on coming home for New Years.
19 Because we usually would come for Thanksgiving, but
20 Chuck had just gotten out of the hospital, and he said
21 he didn't want the children. He wasn't feeling good.
22 So he didn't want me to bring the kids until he felt
23 better.

24 So, I said, okay. So Christmas, he said, "No, I
25 want them to enjoy -- I'm still -- I'm still not, you

1 know, a 100 percent." So he said, "Let's plan -- give
2 me a little bit of time. I'm seeing the doctors. Give
3 me a little bit of time and then we'll bring -- bring
4 them for New Years." So I said, "Okay".

5 But the week before, I had had a D&C and I
6 wasn't feeling good. So I called him that Thursday.
7 And I said, "Chuck", I said, "I'm not going to be able
8 to come." I said, "Because I'm not -- I'm not feeling
9 good." So he said, "Oh, well, don't worry about it."
10 He said -- he said, "Don't worry about it. He said, "I
11 want you to get better." He said, "As long as I get to
12 see my babies", he said, "It don't matter when. So I
13 said, "Okay". I said, "I'll bring them the week of
14 Martin Luther King holiday". And he said, "I can't
15 wait" and that was it.

16 Q. And that was the last conversation you all
17 had?

18 A. No. We actually spoke on New Years Day
19 because I had spoken -- we had called and the kids had
20 wished him, you know, Happy New Years. And then about
21 11:00, me and the kids were all in -- we were just
22 joking around, me and Madison and Dae. And I was
23 teasing her about her love for shoes. And Chuck had a
24 love for shoes. So we called him and we were just --
25 and he was coughing, you know -- he had been coughing

LOUANN ARTHUR -- DIRECT

1 that Thursday, but he was coughing a lot that day.

2 And I asked him, I said, "You all right?". He
3 said, "Well, I'm all right, you know." He said, "but I
4 want to -- I want to check on this cough when I go to
5 the doctor on Tuesday". So I said, Okay.

6 So we spoke to him and we were just -- you know,
7 talking to him, and he was so happy. Because he was
8 like, "Yeah", he said, "you know, Shon moved his stuff
9 in." He said, "So Shon is going to be back". And he
10 said, "Shon was nervous." Shon had a show tonight.
11 Shon was nervous." And he said -- I told him, "Don't
12 be nervous. Don't be nervous." And that was the last
13 time we spoke to him.

14 Q. Okay. And he had mentioned a doctor's
15 appointment, what -- that was Tuesday?

16 A. I think he said Tuesday.

17 Q. And he had planned to go back to the doctor?

18 A. Uh-huh.

19 Q. Did he make it to the doctor on Tuesday?

20 A. No, he didn't.

21 Q. What day did he pass away?

22 A. He passed away, yeah, that night.

23 Q. Which was what day of the week?

24 A. January 2nd.

25 Q. Which was a Sunday?

1 A. Yes.

2 Q. Okay. Just, finally, can you tell us what
3 you're going to miss about your friend?

4 A. You know, I think the biggest thing is raising
5 my children or having -- because they are pretty big
6 now. And I wish he could see how wonderful they really
7 are, especially how good a kids we have. I think he
8 would be really proud. So I missed -- I missed having
9 him around for certain things, Madison's graduation;
10 Dadrian is getting ready to graduate, and Shon's first
11 baby.

12 Q. Madison is getting ready to graduate from
13 where?

14 A. Madison will be graduating next year from
15 Bowie State University.

16 Q. And where is that located?

17 A. In Maryland.

18 Q. Okay. And you said DaeDae is getting ready to
19 graduate. Where is he graduating from?

20 A. From Woodpark High School.

21 Q. And what's his plans?

22 A. He's going to Bowie State. He says he wants
23 to be a teacher.

24 Q. Okay.

25 MR. APOSTOLOU: The court's indulgence. I don't

1 have any further questions.

2 THE COURT: Cross-examination.

3 MS. FLEMING: No questions. Thank you.

4 THE COURT: You may step down. Thank you very
5 much. Call your next witness.

6 MR. RANSOM: Your Honor, at this point in time,
7 we'd like to publish some of the Medical University's
8 answers to plaintiff's first requests for admissions.

9 (PAUSE.)

10 MR. COOKE: May we approach?

11 THE COURT: Yes, sir.

12 (WHEREUPON, a bench conference was had.)

13 THE COURT: You are talking about the ones that
14 are circled; right?

15 MR. RANSOM: Yes, sir, numbers four, six, 16 and
16 17.

17 THE COURT: Let me see you up here just a second,
18 please.

19 (WHEREUPON, a bench conference was had.)

20 MR. APOSTOLOU: Your Honor, the plaintiff calls
21 Dadrian Mikell.

22 THE COURT: I'm sorry. Calling who?

23 MR. APOSTOLOU: Dadrian Mikell.

24 DADRIAN MIKELL, after
25 having been duly sworn, testified as follows:

DADRIAN MIKELL -- DIRECT

1 THE CLERK: Thank you, sir. Please be seated.
2 Please state your first and last name, and spell your
3 last name loudly and clearly into the microphone.

4 A. Dadrian Mikell, M-i-k-e-l-l.

5 **DIRECT EXAMINATION BY MR. APOSTOLOU:**

6 Q. Good morning, Dadrian.

7 A. Good morning.

8 Q. You are known to have a very good smile, don't
9 you?

10 A. Yes, sir.

11 Q. How do you come by that smile?

12 A. I got it from my dad, you know, when...

13 Q. Dadrian, you're going to have to talk pretty
14 loud --

15 A. Oh, I'm sorry.

16 Q. Can you tell us about your smile?

17 A. Yeah, I mean, I got it from my dad. He was
18 the one that smiled. He really liked to laugh and
19 smile a lot, too.

20 Q. Okay. Your dad obviously is Chuck Mikell?

21 A. Yes, sir.

22 Q. Okay. And where do you live?

23 A. Where do I live?

24 Q. Huh-uh.

25 A. Accokeek, Maryland.

DADRIAN MIKELL -- DIRECT

1 Q. And you attend high school?

2 A. I attend high school --

3 BY COURT REPORTER: I'm sorry. What high school?

4 A. Gwynn Park.

5 MR. APOSTOLOU: If you would speak into that, you
6 would make her life much easier.

7 BY MR. APOSTOLOU:

8 Q. So you are a high school student?

9 A. Yes, sir.

10 Q. What grade are you in?

11 A. I'm a senior, 12th grade.

12 Q. Okay. Do you have any plans for the future?

13 A. Yes, sir.

14 Q. What are your plans for the future?

15 A. I plan to attend Bowie State University and
16 study primary education.

17 Q. What do you want to do?

18 A. A teacher.

19 Q. Do you know anybody at Bowie State currently?

20 A. Yes, sir. My sister and a couple of her
21 friends.

22 Q. Have you gone up to visit?

23 A. Not a lot, but I know a little bit about it.

24 Q. And that's where you want to go?

25 A. Yes, sir.

DADRIAN MIKELL -- DIRECT

1 Q. Does that make your dad proud?

2 A. Yes, sir.

3 Q. Can you tell us a little bit about your
4 father?

5 A. To me, my father was an amazing man. You
6 know, he -- he was always there for me, my brother, and
7 my sister. And he just loved to talk to us, keep in
8 contact, keep up just a family oriented person, you
9 know. He never -- I felt like he never did anything
10 wrong to us and he just tried to do as great as he
11 could.

12 Q. You said family, did you include the
13 plaintiff, Shon?

14 A. Oh, yeah. Yes, sir. He's my brother.

15 Q. Okay. He's not your half brother?

16 A. No, sir.

17 Q. How about Charles Mikell -- or Chuck, did --
18 was he -- he wasn't Shon's biological father; was he
19 his father?

20 A. Yes, sir.

21 Q. Did you treat him any differently than you
22 all?

23 A. No, sir.

24 Q. And did y'all -- how much -- what time -- how
25 much time did y'all get to spend with your dad, and

DADRIAN MIKELL -- DIRECT

1 tell us about the time spent with him. What type
2 things did y'all like to do?

3 A. Normally, the summers, and then Spring --
4 Spring Breaks and all that, every -- you know, holidays
5 every now and then. But the holidays like
6 Thanksgiving, we may spend with him. We'll go to New
7 York and spend some time with his family up there. And
8 sometimes, you know, during the summers, we would come
9 down there. He would -- I would sometimes go to a
10 fishing camp and Madison would go to the basketball
11 camp. But when my camp ended, I would normally spend
12 time with him while he was working at the Canterbury
13 House, and we would do that together.

14 Q. You would go with him to the Canterbury House?

15 A. Yes, sir.

16 Q. On his job?

17 A. Yes, sir.

18 Q. Tell us what he did over there.

19 A. Well, he would come -- he would come, he would
20 -- there was always a little pamphlet with names of
21 people that he was supposed to have for day, the thing
22 he was supposed to do. So I believe like normally
23 Mondays, Tuesdays, and all that, it would be to certain
24 shopping destinations like Wal-Mart. And I think
25 Friday was -- Friday was swimming. He would take them

DADRIAN MIKELL -- DIRECT

1 to the -- to go swimming. And I think Tuesday was --
2 like not arts and craft, it's like ceramics. Yeah,
3 ceramics. Yeah, he would take people to go do
4 ceramics. And I would go with him. He would -- he
5 would have me make sure certain people were on the bus,
6 make sure certain people were -- you know, talk to
7 people just as like a kid figure around them.

8 Q. He put you to work?

9 A. Basically, yeah.

10 Q. Okay. And did he enjoy his job?

11 A. Yes, sir, he really did.

12 Q. Did he enjoy being around the senior citizens?

13 A. Yes, sir.

14 Q. Okay. And so you would -- you said a fishing
15 camp?

16 A. Yes, sir.

17 Q. Did you look forward to those visits?

18 A. Of course, yes, sir.

19 Q. Did he look forward to those visits?

20 A. Yes, sir.

21 Q. Did he ever come visit you in Maryland?

22 A. Yes, sir.

23 Q. What type of things would he come to visit?

24 A. He -- he came down for my football games. He
25 came down for a couple of Madison's basketball

DADRIAN MIKELL -- DIRECT

1 tournaments. He came -- sometimes he came down just to
2 get us, you know. He would meet my mom half way to
3 pick us up, and then we would go back to South
4 Carolina. But a lot of the times, he came for
5 Madison's basketball tournaments.

6 Q. Okay. And what year were you born?

7 A. I was born in 1998.

8 Q. So basically for most of your life, it was the
9 period where he had stopped working for the television
10 station?

11 A. I believe so. I wasn't really into the
12 television thing. I didn't know about that.

13 Q. You didn't know about that?

14 A. Yeah.

15 Q. Okay. All right. And what type of -- your
16 grandmother lived here?

17 A. In South Carolina?

18 Q. Uh-huh.

19 A. Yes, sir.

20 Q. Charles' mother?

21 A. Yes, sir.

22 Q. What was that relationship like between them?

23 A. It was amazing. You know, he would always
24 tell me, don't kiss my mom, boy. And, you know, he
25 just really loved his mother. He was always around

DADRIAN MIKELL -- DIRECT

1 her, always checking on her. She would always call him
2 and be like, I need this and that. He would go and get
3 it. And, you know, he would -- he would complain, but
4 you know, you are going to do your stuff here
5 basically. So he would get anything his mom asked
6 done. He loved her.

7 Q. And were sports important to Chuck?

8 A. Sports, as in like super important for our
9 sports -- the sports we were into, yes, sir, it was.
10 But like watching basketball games and stuff, he was
11 kind of into it. He was really -- I think he -- he
12 loved Duke, yeah, I believe so. It was Duke.

13 Q. And when y'all were together, what type of --
14 did y'all talk? What sort of things --

15 A. Yeah, we talked all the time. We did errands,
16 just did things, hung out. Always going around to
17 grandmother's house -- going to Mr. Adre's house. Just
18 really active around the house, talking to each other,
19 playing games together and watching movies.

20 Q. And at a certain point, you know that he
21 got -- went to MUSC and things didn't go well?

22 A. Yes, sir.

23 Q. All right. How did you find out about that?

24 A. My mother set me and my sister down and told
25 us.

DADRIAN MIKELL -- DIRECT

1 Q. She sat you down and told you?

2 A. Yeah.

3 Q. All right. And what did y'all do after that?

4 A. After that, we packed our stuff and headed to
5 South Carolina to see him.

6 Q. Okay. And what -- what was the scene when you
7 saw him? Where did you see him?

8 A. The first time I saw him, they allowed me and
9 my brother to go in the back and see him. And he
10 was -- he was on the bed and kind of opened his eyes
11 and looked at me and my brother. And he -- my brother
12 said, "Dad, we need to pray". And he closed his eyes
13 and held my brother's hand. And we all prayed
14 together. It was really, really hurtful to me to see
15 my dad in that type of situation.

16 Q. And you stayed -- how long did y'all stay down
17 here?

18 A. I'm not sure of the amount of time, but I
19 think we stayed for -- I guess, maybe a week, maybe a
20 little longer. I'm not sure.

21 Q. Did your dad recognize you, you think?

22 A. I believe he did. When he opened his eyes, I
23 guess he knew -- to me, I think he knew that it was me
24 and Shon that he saw, and that he knew his family was
25 here.

DADRIAN MIKELL -- DIRECT

1 Q. And then after that, you went back up to North
2 -- I mean, back to Maryland?

3 A. I'm not -- I don't remember. I'm not sure.

4 Q. Did you have an opportunity to talk to him
5 after he got --

6 A. I think so. I don't really remember talking
7 on the phone to him. I think I may have. I do know
8 that he had left a voice mail on my cell phone at the
9 time, and that -- that's when I knew that he was
10 contacting me, trying to get in contact with me.

11 Q. How did you find out he passed away?

12 A. My mom told me.

13 Q. And y'all came back down?

14 A. Yes, sir.

15 Q. Okay. What are you going to miss the most
16 about your dad?

17 A. Probably just the joking around, making fun of
18 each other, making fun of -- the others in our family,
19 talking, you know. Calling him when I'm having
20 problems with mom or Madison, females -- other girls,
21 other people in my life, you know. Not -- not being
22 able to get -- allow him to see the things that he
23 wanted me to do when I graduated high school, getting
24 jobs, getting accepted to Bowie, stuff like that.

25 Q. Is that the person that you would go to talk

1 about girl problems?

2 A. Yes, sir.

3 Q. Is that what your dad --

4 A. Yes, sir.

5 Q. Was he always there for you?

6 A. Yes, sir.

7 Q. Was his family important to him?

8 A. Of course, yes, sir.

9 Q. Okay. How about the mentoring and all that
10 kind of stuff?

11 A. The mentoring was very important to him. You
12 know, he was -- like they said, the Knights of
13 Pytharoras, he would -- he would wake up and go to
14 the -- he called it the clubhouse. The club -- I don't
15 know where it is specifically, but it was a place that
16 he would go. All the boys would meet. They would have
17 fish fries, just all be around for each other, talk,
18 you know. It was like 18 of us when I was in it, and
19 we would all just talk. They would talk to us. They
20 would keep us going straight, ask us about what we're
21 doing, school and stuff like that.

22 Q. Did you talk to him about your career choice?

23 A. I never got to tell him that, I was going to
24 -- that I was going to get to -- try to be a teacher.
25 I never really told him that.

MADISON MIKELL -- DIRECT

1 Q. You think he'd like that?

2 A. Yes, sir.

3 MR. APOSTOLOU: I don't have any further
4 questions.

5 MS. FLEMING: I have no questions. Thank you.

6 THE COURT: You may step down. Thank you very
7 much.

8 MR. RANSOM: I call Madison Mikell.

9 MADISON MIKELL, after
10 having been duly sworn, testified as follows:

11 THE CLERK: Please state your full and last name,
12 and spell your last name loudly and clearly into the
13 microphone.

14 A. Madison Mikell, M-i-k-e-l-l.

15 **DIRECT EXAMINATION BY MR. APOSTOLOU:**

16 Q. Madison, you've been in the courtroom, tell us
17 about your dad.

18 A. To me, my dad was amazing. I couldn't
19 describe what he meant to me or -- he was a larger than
20 life figure to me.

21 Q. Well, let's talk about you. You are in
22 school?

23 A. Yes, sir.

24 Q. Okay. Where do you go to school?

25 A. Bowie State University.

1 Q. And what are you studying?

2 A. Business with a concentration in marketing.

3 Q. Okay. Are you graduating next year?

4 A. Yes, sir.

5 Q. Congratulations. And so did you come to
6 Charleston a lot?

7 A. Yes, sir.

8 Q. Did your Dad look forward to those trips --
9 well, tell us what kind of things y'all did together.

10 A. We would count down the days until summer
11 until we would be able to spend a lot of time with each
12 other. Before we moved to Maryland, I played a lot of
13 sports, tennis, basketball, softball. I was really bad
14 at softball my first year. I was really terrible. And
15 the summer, he said, "Baby girl, I'm going to make sure
16 that you're better, so that you could play the position
17 that you really want to play." And all that summer, we
18 worked hard, hard outside every day, just hitting
19 balls, catching balls, just trying to make me better.

20 He helped me with basketball. He taught me how
21 to shoot. He helped me with tennis. He just -- he
22 taught me so much. We had a great relationship.

23 Q. So pretty much, most every summer y'all would
24 come down here for the holidays?

25 A. Yes, sir.

1 Q. And he would come up for your sporting events
2 up there?

3 A. Yes, sir.

4 Q. And did y'all talk on the telephone?

5 A. Yes, sir. We talked all the time.

6 Q. Tell us about that.

7 A. We would talk a couple of times a week. As I
8 got older, we would talk more and more. Because I was
9 in high school, and we talked all the time, he was --
10 he was my friend, and then he was my father. He always
11 made sure, you know, I was doing the right thing, and I
12 took care of my little brother, and that he was doing
13 fine, you know. We just had a regular conversation.

14 Q. Okay. And how did you find out that he had
15 had trouble -- was in trouble at MUSC?

16 A. My mother had told me.

17 Q. And you came down to visit with him?

18 A. Yes, sir.

19 Q. Can you tell me -- what you saw when you
20 walked in there? What that experience was like?

21 A. (Witness pause). He -- he wasn't the same.
22 He wasn't the same. I wasn't -- I wasn't really
23 expecting him to be in that predicament, because he
24 never really -- I didn't even know that he was going to
25 have a colonoscopy done. So when -- whatever happened

1 after the incident, I didn't -- he wasn't the same. I
2 -- just to see him there -- like a little lifeless, was
3 very scary.

4 Q. And y'all ended up going back -- did you talk
5 to him while he was -- when he got out?

6 A. Yes, I talked to him.

7 Q. Okay. How -- can you tell us a little bit
8 about that?

9 A. Our conversations, they weren't necessarily
10 exactly the same as before. They were a little
11 shorter, but we didn't talk too much about his health.
12 He didn't want to make -- he never made that -- he
13 never dwelled on it -- he didn't dwell on it. He never
14 dwelled on it or made it seem like, you know, it was a
15 big issue. He always wanted to make sure that, in our
16 mind, that he was okay and that he was strong. He
17 didn't want to show that he wasn't doing well. But our
18 conversations, they got a little shorter and it was
19 just the basics.

20 Q. Y'all were planning to visit him?

21 A. Yes.

22 Q. Y'all talked pretty soon before he passed
23 away?

24 A. Yeah.

25 Q. So you ended up coming for his funeral?

1 A. (Nodded.)

2 Q. Can you just tell us what you're going to miss
3 most about your dad?

4 A. I'm going to miss our laughs and our -- the
5 friendship we had. It's a lot (witness pause) -- I've
6 grown so much since then as a person, as a lady. It
7 hurts me to know that he's not going to be able to see
8 me excel in life. And I know it's going to make him
9 proud, but he's not going to be there on some of my
10 best days, and some of my great days, some of my most
11 memorable days. So that's what I'm going to miss the
12 most, the experience that we would have together.

13 Q. When he passed away, you weren't in college,
14 you were in high school?

15 A. Yes, sir.

16 Q. So he didn't get to see you?

17 A. No, sir.

18 Q. Okay. We don't have any further questions.

19 MS. FLEMING: I don't have any questions. Thank
20 you very much.

21 THE COURT: You may step down. Thank you very
22 much.

23 MR. RANSOM: Can I call my next witness, Your
24 Honor?

25 THE COURT: Yes, sir.

1 MR. RANSOM: The plaintiff calls Dr. Scott Reeves.

2 THE COURT: I'm sorry. Who are you calling next?

3 MR. RANSOM: Dr. Reeves.

4 THE COURT: Hold on, let me see -- we've been
5 going about an hour and a half, why don't we take a
6 break at this time.

7 Madam Forelady, leave your notepads. Don't
8 discuss the case among yourselves. If you need
9 anything, let us know and we'll take a morning break at
10 the time.

11 (WHEREUPON, the jury leaves the courtroom at
12 10:58 a.m.)

13 THE COURT: All right. We had some conversation
14 at the bench concerning some requests to admit, and the
15 objection was it was not relevant. And I ruled at the
16 bench, sustained the objection.

17 Mr. Ransom, if you want to put that on the
18 record, then we can put the defense's response to it on
19 the record, so there'll be a record as to that request
20 and Court's ruling.

21 MR. RANSOM: May it please the court, Your Honor.
22 First, I'd just -- we got it marked for identification
23 purposes, all the answers to the first requests for
24 admission are marked as Plaintiff's Exhibit 35.

25 (WHEREUPON, Plaintiff's Exhibit No. 35 marked

1 for identification only.)

2 THE COURT: And you want to introduce the ones
3 that were circled; right?

4 MR. RANSOM: Yes, sir.

5 THE COURT: And what numbers are those?

6 MR. RANSOM: Those are numbers four, six, 16 and
7 17.

8 THE COURT: Okay. You want to mark as -- that's
9 what plaintiff's number?

10 MR. RANSOM: Yeah, they've been marked as
11 Plaintiff's Exhibit 35.

12 THE COURT: Mark it as a court's exhibit, so it
13 doesn't get mixed up with the plaintiff's exhibits.
14 Okay. Court's exhibit as to your -- the motion.

15 (WHEREUPON, Court's Exhibit No. 4 was marked and
16 made a part of the record.)

17 MR. RANSOM: And just for the record, judge, in
18 terms of the plaintiff's position in tendering this
19 evidence -- these submissions rather -- the Medical
20 University was asked to admit certain things relative
21 to the impact that the events of this case had on Mr.
22 Mikell. And they, in large measure said, that they
23 didn't have sufficient information to admit or deny.
24 We think that their responses to these requests to
25 admit are simply another piece of the puzzle in showing

1 that -- their whole defense narrative in this case has
2 no credibility whatsoever, and that their answers to
3 these discovery responses tend to undermine the
4 credibility of the defense narrative in this case.

5 THE COURT: Okay.

6 MR. COOKE: Thank you, Your Honor. We opposed it
7 for exactly the reason that Mr. Ransom just described
8 they wanted -- these are discovery responses. We, as a
9 rule, provide -- denied knowledge of things that we
10 didn't have access to the knowledge about, specifically
11 the effects that this had on the -- on the decedent --

12 THE COURT: I think the question was "any adverse
13 effect".

14 MR. COOKE: Correct. And we -- we responded that
15 in our -- in our -- that we admitted that he had a
16 transient event, but denied that it had lasting
17 effects. Of course, we deny to this day that it caused
18 his death. But those are discovery responses --

19 THE COURT: Why -- why do -- what's your legal
20 reason that you think it's not admissible?

21 MR. COOKE: That they're not relevant. And to the
22 extent that they could be relevant, Rule 403, the
23 prejudicial effect outweighs the relevance.

24 THE COURT: All right. I sustain the objection.
25 Even -- the court's position is even if they are

1 relevant, I think the prejudicial effect far outweighs
2 any probative value that you may have as far as proving
3 your case in chief. Okay.

4 MR. RANSOM: Understood, Your Honor.

5 THE COURT: All right. We'll take a morning
6 break. Thank you very much.

7 MR. COOKE: Your Honor, could we pass up -- we did
8 a little brief anticipating our directed verdict
9 motions later, even though it's premature, I don't mind
10 sharing them with the court and counsel if that would
11 be helpful.

12 THE COURT: I'll be glad -- anything you want to
13 hand to me, I'll be happy for you to give it to me.

14 MR. COOKE: Well, just -- it always puts you at a
15 disadvantage when I hand it to you as I mark it. So I
16 thought I'd hand it to you in advance.

17 THE COURT: Do y'all have any requests for charge?
18 Maybe that's a little premature. But if you do, I'd
19 like to try to get it tomorrow if we could. That's --
20 that's what I want to tell you. Assuming I don't have
21 a direct summary judgment -- I mean, directed verdict.
22 I'm not prejudging you on that. Okay.

23 MR. COOKE: I understand.

24 THE COURT: Assuming you -- they survive that, I
25 would like to get the request to charge that y'all may

1 have tomorrow sometime.

2 MR. COOKE: We'll do that.

3 THE COURT: Now, I've got a standard -- I'll
4 probably just use the standard charge. And Mr. Ransom
5 I -- I don't need any of this on the record. Okay.
6 You go ahead and take your break.

7 (WHEREUPON, a brief recess was taken.)

8 THE COURT: Are you going to read this deposition
9 now, or am I going to have an opportunity to look at it
10 before you do it?

11 MR. RANSOM: Judge, the proposal is, that there's
12 actually a technology where the edited portions of the
13 audio could be pulled off of the original recording.

14 THE COURT: Do I need to do that now?

15 MR. RANSOM: No. No. So once we come to an
16 agreement about what it is that the jury is going to be
17 permitted to hear, then I've got a technical guy
18 that'll need about an hour and a half to edit the audio
19 itself.

20 THE COURT: Okay. All right. Okay.

21 MR. RANSOM: Assuming he's available.

22 THE COURT: Are you going to call your next
23 witness? Who is your next witness?

24 MR. RANSOM: Dr. Reeves.

25 THE COURT: You're calling Dr. Reeves?

1 MR. RANSOM: Reeves.

2 THE COURT: Okay. All right. Bring us the jury
3 please.

4 (WHEREUPON, the jury enters the courtroom at
5 approximately 11:45 a.m.)

6 THE COURT: You can call your next witness,
7 please.

8 MR. RANSOM: The plaintiff calls Dr. Scott Reeves.

9 DR. SCOTT REEVES, after
10 having been duly sworn, testified as follows:

11 THE CLERK: Please state your first and last name,
12 spell your last name loudly and clearly into the
13 microphone.

14 THE WITNESS: Scott Reeves, R-e-e-v-e-s.

15 **DIRECT EXAMINATION BY MR. RANSOM:**

16 Q. Good morning, Dr. Reeves. Thank you for
17 coming down to the courthouse today. You are an
18 anesthesiologist employed by the Medical University?

19 A. That's correct.

20 Q. And you've been over there for, I think, about
21 24 years?

22 A. Correct.

23 Q. And for the last eight years, you have served
24 as the Chairman of the Department of Anesthesia?

25 A. For the last 11 years.

1 Q. Okay. The last 11 years. I want to show you
2 what's been previously marked as Plaintiff's Exhibit 8,
3 and these are some policies and basic standard of
4 anesthesia care at the Medical University. And if you
5 look at the second page, I want to ask you, is that
6 your signature up there at the top?

7 A. It is.

8 Q. All right. So these are -- tell us what these
9 are?

10 A. This is just our policies and basic standards
11 from our anesthesia manual.

12 Q. Okay. And when we talk about basic standards,
13 would it be fair to say that those are the safety rules
14 for providing anesthesia at the Medical University?

15 A. They cover a wide range of topics.

16 Q. But including the circumstances under which
17 anesthesia is to be provided to patients?

18 A. Correct.

19 Q. Both by physicians and by the nurse
20 anesthetist that they supervise?

21 A. Correct.

22 Q. If I might have that. We're going to go
23 through some parts of this on the overhead. All right.
24 So this first part is page 1 of 6. And there is a
25 definition section. Can you see that on the screen

1 there, Dr. Reeves?

2 A. Yes.

3 Q. Excellent. So it says, "During the elective
4 surgical schedule, all anesthetics in the operating
5 room will be the responsibility of anesthesiologist
6 assigned to the case and/or his designate"; is that
7 accurate?

8 A. Yes.

9 Q. Okay. Now, would a colonoscopy like the one
10 that Mr. Mikell have be considered elective surgery?

11 A. Yes.

12 Q. All right. And would the area of the
13 hospital, I think they call it, the Digestive Disease
14 Center where this procedure was performed, would that
15 be considered an operating room for purposes of this
16 definition?

17 A. Yes.

18 Q. And so what we see here is, it says that the
19 certified registered nurse anesthetist -- that's
20 commonly abbreviated CRNA?

21 A. That's correct.

22 Q. Okay. And in Mr. Mikell's case, Donna Embrey
23 was the CRNA?

24 A. Correct.

25 Q. Okay. So the CRNA and house staff will be

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1 under his/her direction and supervision -- that's under
2 the direction and supervision of the anesthesiologist?

3 A. Correct.

4 Q. And in this case that was Eric Nelson?

5 A. That's correct.

6 Q. Okay. On page 2 of Exhibit 8, we also see up
7 here, it says these standards apply for any
8 administration of anesthesia involving the Department
9 of Anesthesia personnel and it includes the DDC
10 locations where Mr. Mikell's colonoscopy took place?

11 A. That's correct.

12 Q. And there's another section here that sort of
13 restates what we have already seen, "Anesthesia care
14 will be provided by the attending anesthesiologist and
15 the nurse anesthetist may perform anesthesia under the
16 supervision of an attending anesthesiologist."

17 A. That's correct.

18 Q. Now, we see that in a couple of different
19 places here in this -- in these standards, and it's
20 because that's important; right?

21 A. That's correct.

22 Q. Okay. Under South Carolina State Law, a nurse
23 anesthetist isn't actually allowed to administer
24 anesthetic agents like Propofol, for example, unless
25 she's being supervised and directed by a medical

1 doctor; right?

2 A. That's correct.

3 Q. And that's why we see that provision, that
4 standard, is in these policies and guidelines several
5 different times because it's so important?

6 A. That's correct.

7 Q. Now, if we turn to page 4 of 6, one of the
8 important responsibilities that the anesthesiologist
9 and the nurse anesthetist has is to make sure that all
10 of the equipment is working properly before they start
11 the procedure; correct?

12 A. Correct.

13 Q. And you would agree with me that if a nurse
14 anesthetist or an anesthesiologist, as the case may be,
15 administered an anesthetic agent to render a patient
16 unconscious when they hadn't checked to make sure all
17 of the equipment was functioning properly, that would
18 be a breach of these standards of care?

19 A. Yeah. This -- this particular thing is
20 talking specifically about monitoring equipment, but
21 that's correct.

22 Q. Okay. So -- and we can agree that with
23 respect to these standards that are set forth in
24 Exhibit 8, if they aren't followed that's -- that's --
25 that's a breach of the standard of care?

1 A. It's our policy, correct.

2 Q. Okay. And it indicates up here that "The
3 practitioner administering the anesthesia will check
4 and document the readiness, availability, cleanliness,
5 sterility, when indicated, working condition and alarm
6 system of all equipment to be used"; that's right,
7 isn't it?

8 A. Correct.

9 Q. Okay. And the working condition would be
10 anything that might prevent some piece of equipment
11 from functioning as properly intended; right?

12 A. Correct.

13 Q. Okay. So this would require, for example,
14 that before you began administering the anesthetic, you
15 would need to check the anesthesia machine, the
16 Phillips monitor and the PICIS anesthesia record
17 recording system, to make sure that all those things
18 are working correctly?

19 A. So the anesthesia machine has the ability to
20 do a precertification checklist, so it's designed
21 specifically to be able to check it for each case,
22 because it's probably the most important equipment that
23 we have in the machines, having to deliver oxygen and
24 et cetera. The Phillips monitor have a similar
25 capability in that they -- when they boot up and turn

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1 on, they have the ability to show that they're
2 functional. The PICIS monitor does not have a pre-way
3 to know that it's actually functioning until it's
4 hooked up to somebody.

5 Q. Well, let's -- let me ask you this: If --
6 if -- if an anesthesia provider knew that the PICIS --
7 what do we want to call it -- the PICIS system was not
8 functioning properly, should they that fix that before
9 or after they knock the patient out?

10 A. They should fix it before.

11 Q. Okay.

12 A. I would like to make one more comment. This
13 particular guideline that you're talking about was
14 signed in 2009, which is before we had electronic
15 record systems.

16 Q. All right. Well, do these standards apply,
17 though, to new systems that are implemented in the
18 hospital?

19 A. Yeah. We've modified it since then. I'm not
20 sure what the exact wording is currently. But, you
21 know, we try to maintain standards as we -- as new
22 technology gets developed, yes.

23 Q. Well, you would agree with me these standards
24 that we got marked as Exhibit 8 are the ones that apply
25 to Mr. Mikell's colonoscopy in October 2010; right?

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1 A. I'm not aware of whether or not there's a 2010
2 version or not.

3 Q. Well, I mean, the reason that they were
4 provided to us in this case by the Medical University
5 is because this is the part -- or these are the
6 standards that apply to his procedure? Why would you
7 give us standards that don't apply to his procedure?

8 A. Well I'm assuming that's correct.

9 Q. All right. Now -- so you got to check the
10 working condition of all the equipment, and that would
11 include the PICIS anesthesia equipment?

12 A. I think I've answer this question. That's --
13 there's really no way to know whether or not it's going
14 to be functional until it's actually hooked up to a
15 patient.

16 Q. Okay.

17 A. There's not a precertification type checklist
18 for that monitor -- or it's a recording system. It's
19 not a monitor like there is with an anesthesia machine
20 or the Phillips monitors.

21 Q. And if knew that it wasn't working correctly,
22 it would be a breach of the standard of care to
23 administer an anesthetic agent to your patient before
24 you got that fixed?

25 A. Ideally, we would like it working before we

1 started the case, correct.

2 Q. Well, let's not split hairs about this. You
3 would agree with me that it's a breach of the standard
4 of care to administer the anesthetic agent to the
5 patient if you know that there's a problem with the
6 system and you haven't gotten it fixed?

7 A. No. Because I would switch over to paper. So
8 if I had a problem with the monitor -- I mean the
9 recording device, and I knew it didn't work, I would
10 switch to paper. We frequently, still even in 2016,
11 have to use paper fairly frequently for events around
12 our electronic systems. For example, when we -- when
13 we have a time change, which we just had, the machine
14 doesn't know how to recognize that one hour overlap
15 that occurs when you fall back or spring forward. So,
16 for example, during those periods of times, we would be
17 using paper.

18 Q. Okay. Well, do you remember I took your
19 deposition about two weeks ago and we had this
20 discussion about the standards of care and whether or
21 not you should be working to try to fix some problem
22 with the PICIS system after putting your patient to
23 sleep?

24 A. I'll be happy to -- if you have a specific
25 question.

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1 Q. This is on page 19, and we were talking about
2 to get the proper context to the jury, we were talking
3 about the computer linkage problem that Nurse Embrey
4 encountered during Mr. Mikell's procedure; do you
5 remember that?

6 A. Correct.

7 Q. And that's why it says, should this sort of
8 linkage problem -- we were talking about the computer
9 linking with his chart -- that's why we call it a
10 linkage problem during our discussion, right?

11 A. Correct.

12 Q. And I asked you, I said, "Shouldn't this sort
13 of linkage problem be checked out and corrected before
14 a patient is put to sleep?" And you said, "I'm sure if
15 she knew it wasn't working, she wouldn't have put the
16 patient to sleep, but that's -- but that's not the
17 sequence of events that happened here". All right. So
18 you agreed with me that if she knew that the system
19 wasn't working properly, she shouldn't have put the
20 patient to sleep; right?

21 A. I'm sure she wouldn't have, yes.

22 Q. Okay. You're sure she wouldn't have because
23 that would be a big mistake, wouldn't it? That would
24 be a breach of the standard of care if she did that,
25 correct, Dr. Reeves?

1 A. It's a recording system. I mean, like I said
2 before, you could have easily have done the whole case
3 on paper.

4 Q. Okay. Now, back to these policies, Exhibit 8,
5 the proper functioning of the recording system is also
6 included as one of the basic standards that we see on
7 page 5 of 6, it says "All information is to be
8 accurately recorded on the anesthetic record. This
9 shall at least include monitoring data", that means
10 things like blood, oxygen saturation levels?

11 A. That's correct. And specifically when this
12 policy was written, that would have been on paper.

13 Q. Okay. And at the time of Mr. Mikell's care,
14 are you aware of any of his blood oxygen saturation
15 levels having been recorded on paper by any of the
16 people who were there in the room with him that day?

17 A. I don't believe that occurred, no.

18 Q. No. That's not what happened, is it. Instead
19 what happened was, there was a problem with the PICIS
20 system. And during the period of time that she -- that
21 Nurse Embrey was trying to fix that, she administered
22 the Propofol to the patient; right?

23 A. Propofol is infused in the room, correct.

24 Q. Okay. And this was while she was sending text
25 messages and making phone calls to try to fix the

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1 problem -- this linkage problem that we discussed?

2 A. That's correct. But the patient was being
3 completely monitored. I think we need to be very clear
4 about that in the way -- the way the electronic system
5 works, is that in front of -- the patient is on a
6 stretcher in front of us. There's two monitors with
7 his vital signs being recorded continuously on a
8 monitor called the Phillips monitor. His blood
9 pressure, his saturation, his heart rate are all on
10 those monitors working properly. The anesthesia
11 machine is to -- to Ms. Embrey's right. That's where
12 oxygen is being delivered, and the saturation monitor.

13 And behind is the electronic record that's
14 designed to capture data coming from the monitors that
15 we are see in front of us. So all -- from --
16 everything that's in the -- so the monitors that we use
17 to actually take care of the patient are functioning.

18 Q. Okay. Now, one of the things that I had asked
19 you at your deposition a couple of weeks ago, we were
20 looking at the real time graph of Mr. Mikell's
21 anesthesia record, and we were trying to identify when
22 certain things were happening relative to the time of
23 the desaturation that's shown in the real time graph;
24 do you remember that?

25 A. Correct.

1 Q. So we've got some boards here that have these
2 real time graphs on them. I'm going to try to set this
3 up where everybody can see it. And the one that I'm
4 putting on the easel, this is page 36 of 99 for the
5 record. Do you see this real time graph right here?

6 A. I do.

7 Q. All right. And we had a discussion where I
8 was asking you if you would please tell me when you
9 believe it is that that downward sloping oxygen
10 saturation line began; do you remember that?

11 A. Yes.

12 Q. All right. And do you recall what your answer
13 was?

14 A. Well, when we were actually talking a couple
15 weeks ago in my --

16 THE COURT: Doctor, the question was, do you
17 recall the answer. That requires a yes or no, and then
18 you can give an explanation. Listen to the question,
19 be responsive, please, sir. Okay.

20 A. I'm sorry.

21 THE COURT: Or he'll keep asking you the same
22 question over and over. Okay.

23 THE WITNESS: I do know that, Judge. Thank you.

24 A. Yes, I remember the question.

25

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1 BY MR. RANSOM:

2 Q. Okay.

3 A. Now, can I elaborate please, sir?

4 Q. Well, we were -- we were asking about -- I was
5 -- I think I actually had an exhibit, and I drew an
6 arrow right about where I'm drawing it right now. And
7 my question to you was, what time corresponds to that
8 point that I've just identified on that graph; do you
9 remember that discussion?

10 A. Yes, I do.

11 Q. Do you remember what your answer was?

12 A. Yes, I do.

13 Q. Okay. What was your answer?

14 A. So during my deposition, the chart that you
15 showed me was not that chart. The chart that you
16 showed me was in 15 minute increments. That chart is
17 in one minute increments. So, I did not specifically
18 talk about that chart.

19 Q. Oh, all right. Well, let's go look over here
20 then. This is this 15 minute record over here on page
21 499. We can put that up if you prefer to the question
22 with respect to that graph. All right.

23 So I'm going to use -- this has already been
24 indicated right here in orange, but I'll go ahead and
25 the purple marker will indicate your answer. When do

1 you say it is -- what's the time that corresponds to
2 that point on the graph? Do you remember what you told
3 me at your deposition?

4 A. Yeah, I think I said 7:45ish.

5 Q. Okay. Well, actually you said 7:40 to 7:45,
6 somewhere around there; do you remember that?

7 A. Yes, sir. But then, if you recall, I drew it
8 on the back of the exhibit, hash marks on how I think
9 it's actually recording it. Since that time, I've had
10 the opportunity to read one of the IT people's
11 depositions that show that no information was coming
12 from the electronic system before, I believe, 7:48.

13 Q. Okay.

14 A. Which would make this information a lot
15 different as well.

16 Q. Well, let's confine ourselves to -- for a
17 moment, not what someone else told you after I had
18 taken your deposition; but what you actually testified
19 to yourself. Now, you've been there at the Medical
20 University, as we said earlier, 24 years in the
21 Department of Anesthesia; 11 years as the department
22 chairman. Certainly this is not the first time that
23 you've ever looked at one of these real time graphs?

24 A. No, it's not.

25 Q. Okay. And as we look up on the board, all

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1 right -- up on the screen rather, when I asked you, can
2 you tell me when that downward slope -- yes, sir. This
3 is at pages -- goodness, my eye sight is failing me.
4 It looks like it's about at page -- 31 and 32, "Can you
5 tell me when that downward slope begins, at what time?"
6 And you said, "It looks like around 7:40." That's what
7 you told me then, right?

8 A. That's what I said on here. But I think I did
9 go on and clarify further in my testimony when I drew
10 what I thought was occurring on the back page, showing
11 more definitively what I think the timelines are.

12 Q. That's right. We -- we got into a little bit
13 of a disagreement about what the scale is here for
14 these boxes. Do you recall you were telling me that
15 this line right here was not 7:30, you were telling me
16 that it was this line right here that's 7:30. That was
17 what the discussion was where you were writing on the
18 back of the exhibit; correct?

19 A. That's correct.

20 Q. Okay. And it was after you told me that this
21 line was 7:30, that we then confirmed that you believed
22 that this downward slope began at 7:40. And you're
23 right, you said between 7:40 and 7:45. All right. And
24 that was what the discussion was, that's what your
25 testimony was two weeks ago under oath; right?

DR. REEVES -- DIRECT

1 A. Correct.

2 Q. Okay. Now, as the chairman of the department,
3 when Mr. Mikell's cardiac arrest occurred, you did --
4 you appointed some people to do an investigation to
5 find out what had happened; correct?

6 A. That's correct. It's called peer review.

7 Q. And as a result of that investigation, no
8 action was taken by the Medical University or by you?

9 A. Correct.

10 Q. Nobody was reprimanded. Nobody was
11 sanctioned. No policy changes. Absolutely no action
12 of any kind was taken?

13 A. We felt that the two reviewers on that peer
14 review who were -- one was Dr. Cal Albert, who's had
15 over 40 years of experience in our department. And the
16 other one was Kelly Grogan, who was a person who
17 trained at John Hopkins, who was board certified in
18 anesthesia critical care and cardiac anesthesia, and we
19 felt that -- that the report that I was given said that
20 he -- that they felt that the standard of care was
21 maintained.

22 Q. Okay. No action taken. Thank you. I don't
23 have any other questions.

24 THE COURT: Cross-examination.

25 MR. COOKE: Thank you.

CROSS EXAMINATION BY MR. COOKE:

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Q. Doctor, just to make it clear, you did not participate in the care of Mr. Mikell yourself, did you?

A. I did not.

Q. Would you tell the jury a little bit about your educational background?

A. So I went to Clemson. I hope that's not held against me. I went to medical school here at MUSC. I went to Baylor College of Medicine in Houston, and did an internal medicine in anesthesia residencies. I did advanced training in pediatric anesthesia and echocardiography. I came back to the university in 1993, and I've been here ever since.

Q. And you are, for the last 11 years, chairman of the Department of Anesthesiology?

A. That's correct.

Q. That's not specific to cardiac anesthesiology or neuro anesthesiology, it's all the anesthesiologists; is that correct?

A. That's correct. We have roughly 250 people that work for me.

Q. And that would --

A. That includes residents, nursing anesthetists and faculty doctors.

1 Q. I want to clear up just one thing, maybe --
2 once and for all. Maybe it's not once and for all, but
3 we've got two version of this chart here; correct?

4 A. Right.

5 Q. Explain to me why it is that we can have two
6 different versions of the same -- what's supposed to be
7 the same information?

8 A. So I think that what's important is that when
9 we are taking care of Mr. Mikell, we were implementing
10 a new medical record similar -- called PICIS. It's an
11 electronic record, and that was mandated by the federal
12 government.

13 And so we are working on how that implementation
14 occurs. And so what we are seeing here is seeing the
15 machine printing out a record. And you ask it to do
16 two things -- and this might be better to talk to the
17 IT guys about this, than me. And I think you will have
18 an opportunity to --

19 Q. We'll get to that. Just tell us what you
20 know?

21 A. But -- so the machine is -- we've asked it to
22 print the data in 15 minute and one minute increments.
23 And so on the top part is the information being filled
24 out in 15 increments. That's where you see 7:30, 7:45,
25 8:00. And on the other side, you see it in one minute

1 increments, 7:34, 7:35, 7:36. That was accurate.

2 The stuff below it is the machine is just
3 printing the running, monitoring data -- it's almost
4 like it's copying, and pasted it on to this record
5 because they're identical, even though the timelines
6 are completely different.

7 Q. Right. And so -- on on this -- on this one
8 here to cover the same ground that's in one box, you go
9 from -- let's just say 7:40 is right here to 7:45?

10 A. Well, you've basically got to go to the 15
11 boxes. Because each box on here is 15 minutes --
12 excuse me -- each box on here is five minutes, so you
13 have to go five boxes on the one on the right.

14 Q. Right. These boxes -- these boxes are 15
15 minute increments, right, 7:30, 7:45, 8:00, 8:15?

16 A. Right. You have to go 15 boxes on the one on
17 the right.

18 Q. So if you were going to compare the two graphs
19 this -- this graph looks and is shaped just like that
20 graph; right?

21 A. Correct.

22 Q. But if it were really going to print out
23 accurately on this, it one would have to have been
24 stretched out 15 times as long as that one; is that
25 what you're saying?

1 A. Correct.

2 Q. Okay. So do we go by these graphs down here
3 if we're looking for information from these charts?

4 A. No. I mean the most -- the accurate data is
5 what's on the -- in the boxes, and --

6 Q. What's -- I'm sorry. Go ahead.

7 A. And, you know, again in this particular
8 incident, we've learned that the machine is not even
9 recording information to a defined time period.

10 Q. In this particular case, we now know that it's
11 7:48?

12 A. That's correct.

13 Q. So would it be even possible for this machine
14 to start creating a graph before 7:48?

15 A. No.

16 Q. And then on this 15 minute version, are we all
17 in accord as to whether the -- where the 7:30 is,
18 whether it's there or here or there, do -- do we know
19 for sure?

20 A. I don't know if we really know for sure to be
21 honest. But the standard way that we report -- and,
22 again, this is us going through -- this is one of the
23 earlier records, and we're going through a process to
24 try to make it look like an anesthesia record. Right
25 now, it's just a bunch of computer stuff in a server.

1 The -- the classic way that we would do it is at
2 the beginning of a line is where the time starts, so
3 7:30 -- kind of like the plaintiff's attorney put in
4 arrows down there.

5 Q. All right. So he wrote --

6 A. You can see where he put 7:30 on --

7 Q. Yeah.

8 A. The first 7:30 is where we would put 7:30.

9 And then 7:45 would be the next one.

10 Q. And then looking at this 15 minute interval,
11 if there's data under the one that says 7:45, and we
12 know that there's no data before 7:48, we -- we can
13 conclude from that -- that that data must have come
14 after 7:48?

15 A. Correct.

16 Q. Do you happen to know what number the computer
17 chooses to put in this box -- of all the -- we now know
18 that in any 15 minute interval, it's got at least 15
19 data points. Do you know how it chooses which one to
20 put in the 15 minute box?

21 A. I do not.

22 Q. The IT people might know that?

23 A. I mean, maybe.

24 Q. So if we wanted to go back and make a minute
25 by minute analysis of what happened, which -- which

1 version would you suggest that we look at?

2 A. We would look at the version on the right,
3 starting at 7:48, in that tabular format.

4 Q. What is a -- what is a NORA unit?

5 A. So NORA is -- is an acronym that we use for
6 Non Operating Room Anesthesia locations. So for us,
7 anything that is not in the operating rooms, it's
8 called a NORA location. So that would be digestive
9 disease where this gentleman has his colonoscopy. It
10 could be pediatric cath lab, MRI CT suites, for
11 example.

12 Q. And how is -- how is a NORA unit -- are
13 colonoscopies all done in NORA units?

14 A. They are.

15 Q. Okay. And that's -- that's to designate that
16 it's a nonoperating room, but it has anesthesia
17 capability?

18 A. That's right. We provide coverage in all the
19 NORA sites. So, for example, we do approximately
20 44,000 anesthetics a year currently, this year. I'm
21 not quite sure how many we were doing back in 2009 and
22 in 2010. And about 24,000 of them are in the operating
23 rooms, and the remaining 20,000 are done outside of the
24 operating rooms.

25 Q. All right. Now, when we spoke earlier, you

1 seemed right proud of your NORA units. Do you want to
2 tell the jury what you have done to try to make that
3 standard of care one of excellence?

4 A. Yeah. I mean we -- we provide the same type
5 of care there. We have very highly specialized
6 individuals. And our Digestive Disease Center is one
7 of our centers of excellence. We get patients from all
8 over the state that comes to us. So when individuals
9 are having a colonoscopy out in the community, it's
10 usually the healthiest patients. When they have them
11 from us, it's usually the very sick people, and the
12 people in the community don't particularly want to do
13 or can't do.

14 You know, Dr. Nelson, I know you haven't met him
15 yet, but I recruited him specifically because he's
16 cardiac trained. And one of the things that we do in
17 these locations now is we take care of patients that
18 are on artificial hearts, so they don't even have the
19 pulseless kind of blood pressures and -- which means --
20 you know, we all have a systolic and diastolic blood
21 pressure. But if you're on an artificial heart, you
22 just have a mean pressure, a very complicated patient
23 to take care of. And so I -- and we do hundreds and
24 hundreds of them.

25 So a year, on an average year, we do about 5,000

1 patients in the DDC Center. So we get really adapted
2 to taking care of very sick people in a -- in a
3 challenging environment.

4 Q. Do you find that despite your best efforts,
5 that you -- that you do have bad results sometimes with
6 some high risk patients?

7 A. Yeah, unfortunately. I mean, this gentleman
8 was an ASA 3, which meant he had a two or three percent
9 risk of a major adverse event. And we do everything we
10 can to try to mitigate that risk, but we can't
11 eliminate it. And so if I do 5,000 cases a year, and
12 let's say 500 or 600 of them are ASA 3, it's just
13 mathematically we're going to have a bad outcome on
14 somebody. And it's sad, but it does happen.

15 Q. Does this -- you talked about the peer review
16 process, what's the purpose of having peer reviews in
17 your institution?

18 A. It's several fold. You know, the one
19 instance, it's a process where we have the ability to
20 evaluate and yet I'm a very, very liberal peer review.
21 We will review just about anything that is -- that's
22 didn't go the way we exactly expected it to go, to make
23 sure that there's not a -- primarily not a systems
24 problem, something that's occurring at the
25 institutional level that we can fix. And as well as a

1 performance issue with an individual practice. And
2 we've been doing it this way for decades, way before
3 even I was chairman. And I think it's -- it's served
4 us well.

5 Q. You've -- because of this litigation, I guess,
6 you have review the records of this case. And you
7 weren't personally involved in the peer review, were
8 you?

9 A. That's correct. I was not.

10 Q. And you've read the depositions of people that
11 have been involved?

12 A. Correct.

13 Q. So as chairman of the department, I want you
14 to look at the family here, and I want you to look at
15 the jury, and tell them how do you feel about the care
16 that Mr. Mikell was given at -- at your institution?

17 A. I mean, I realize your father had a bad
18 outcome, and I'm sorry for that. But I -- we did give
19 him extremely good care. You know, I think he was --
20 he was an extremely high risk patient for us. He had
21 an adverse event that was treated very promptly. And
22 he was -- had deep hypothermia to cool him after his
23 -- after his event. That's the technology that we use
24 to try to protect the brain after we have an event like
25 this.

1 And, you know, the family -- I think accurately
2 discussed what that looked like when they first saw him
3 in the intensive care unit. It's very scary. You are
4 in a coma, a drug induced coma that we've actually put
5 you in.

6 But I think the -- from my perspective, the
7 outcome was good in that even though he had a very bad
8 event with us, neurologically his brain was working.
9 We've heard testimony that, you know, he was talking to
10 family, et cetera. And so I think we -- I think we
11 really did a good job on him.

12 Q. Now, this week we've heard a scenario that
13 would have Donna Embrey -- do you know her by the way?

14 A. I do. I've worked with her for many, many
15 years.

16 Q. Okay. That would have been a scenario where
17 this is in the room. This picture is more recent, but
18 it's more or less what the room looked like. But the
19 scenario that we're envisioning is that she started the
20 Versed, and they were getting ready to start the
21 Propofol, and they got the monitors hooked up.

22 And then she notices that her chart is not being
23 populated. And then I believe you said that that does
24 not -- I don't want to put words in your mouth -- does
25 that, in any way, shape, or form affect the quality of

1 care that Mr. Mikell is receiving that morning?

2 A. No.

3 Q. And why not?

4 A. Because everything that we're doing to take
5 care of Mr. Mikell is in front of us. The machine is
6 just recording vitals behind us.

7 Q. Do you have an opinion as to whether the
8 process of -- of Ms. Embrey texting the IT support to
9 get this thing going again, would have prevented her
10 from being able to pay the kind of attention to Mr.
11 Mikell that he deserved to have?

12 MR. RANSOM: Your Honor, I object.

13 THE COURT: Hold on just a second. You got a
14 legal objection?

15 MR. RANSOM: I do, Your Honor.

16 THE COURT: What's your legal objection?

17 MR. RAMSOM: He's being asked to render an expert
18 opinion --

19 THE COURT: I'll sustain the objection.

20 MR. COOKE: I'm sorry. Sustain the objection?

21 THE COURT: Yes, sir.

22 MR. COOKE: Okay.

23 BY MR. COOKE:

24 Q. What are the -- what are CRNAs and other staff
25 instructed to do in the event that they find that

1 the -- the PICIS system is not recording the way it's
2 supposed to?

3 A. Again, you know, we're implementing a new
4 system. And so in the system was -- we have a bunch of
5 IT people that are assigned to help troubleshoot issues
6 that we -- that occur. And a lot of the things that we
7 wind up troubleshooting are things that we can't
8 predict that occur when we are creating a system or
9 beta testing a system. And so there are three, four,
10 five people that were available for pager that did work
11 on the system, so we don't have to. I mean, that's the
12 whole purpose.

13 You pass it off to people that are experts in
14 IT, so we can continue doing what we need to be doing,
15 which is taking care of the patient.

16 Q. Was it appropriate or was it within the
17 standard of your department for Ms. Embrey to contact
18 IT when she realized the machine was not populating her
19 chart?

20 A. Correct, yes.

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

22 THE COURT: Any redirect?

23 MR. RANSOM: Yes, sir.

24 **REDIRECT EXAMINATION BY MR. RANSOM:**

25 Q. Yes, sir. Dr. Reeves, you've said that the --

1 I think what you said is that the real time graph can't
2 start plotting until the data starts, and this is the
3 basis for which you're now telling us that it looks as
4 though this downward sloping trend begins at 7:48?

5 A. Correct.

6 Q. Okay. So I'll go ahead then, with the marker,
7 and I will write 7:48 down here. That's when Dr.
8 Reeves told us that the downward trend began.

9 A. Well, let me -- let me clarify that if I can.
10 My vision is not as good as it should be, but I think
11 there's a couple data points that are plotted on that
12 graph prior to the downward trend. So the first data
13 point plotted on the graph would correspond with 7:48.

14 Q. Okay. I mean -- well, I'm not quite sure I
15 understand you. But how can the machine plot data
16 that's not being captured? It can't, can it?

17 A. Let me -- let me re-clarify, because I don't
18 want to be confusing. The first -- the first data
19 that's being recorded to the electronic record is at
20 7:48 -- do you see that in the table up at the top
21 there. For example, the saturation is 98.7.

22 Then go up here, the line goes like this and
23 then goes down (indicated), so this first point before
24 we start seeing the downward slope is 7:48, is what I'm
25 saying.

1 Q. Okay. All right. And from -- I mean, the --
2 the -- let's see. This page 499 is part of what's been
3 marked as Plaintiff's Exhibit 3. Let me put that up on
4 the screen, both of us can see it on the real time
5 graph. So, now, you would agree with me as we sit here
6 and we look at this graph on the screen, from the point
7 where it first starts plotting data, what we've now
8 agreed is 7:48, it's doing nothing but heading down
9 until it gets there in the Death Valley at the bottom
10 of that V; right? That's a downward slope; right?

11 A. I think we're saying the same thing. I'm
12 saying the first data point is 7:48.

13 Q. Okay. The first data point is 7:48, and it
14 looks like it's trending decidedly downward?

15 A. Over the next four or five minutes.

16 Q. Four, five, six minutes. Okay. Thank you,
17 Dr. Reeves. I don't have any other questions.

18 THE COURT: Any redirect?

19 MR. COOKE: Yes, Your Honor.

20 THE COURT: I mean -- excuse me, recross.

21 MR. COOKE: Yes, sir, if I may.

22 **RECROSS EXAMINATION BY MR. COOKE:**

23 Q. All right. I'm going -- I'm going to try to
24 see if it's even possible to correlate this chart with
25 these numbers. This is really unfair to the jurors

1 sitting down at the end. Let's see. Let's see if we
2 can extrapolate a graph out of these numbers. Now
3 the -- the chart -- the graph that you're looking at
4 was on the 15 minute interval; correct?

5 A. Correct.

6 Q. All right. So would you even be able to tell
7 a minute by minute variation on that graph?

8 A. No.

9 Q. Okay. So what we have is the first data point
10 was 7:48; 96.7; correct?

11 A. Correct.

12 Q. The next one is at 7:49 is 75?

13 A. Correct.

14 Q. Correct. The next one is at 7:50, that's 62
15 -- 69.2; do you see that?

16 A. Right.

17 Q. At 7:51, it's 90.1?

18 A. Correct.

19 Q. So is there any possible way that that -- that
20 that change from 7:48, from starting at 96.7, going to
21 7:49, dropping to 75; 7:50, 69.2, and then coming back
22 up to 90.1 at 7:51, is there in way that that can be
23 reflected in this graph that purports to cover a 15
24 minute period? Okay. So this -- this is our 15
25 minute -- this is our 15 minute graph. And according

1 to that, this is 8:00; is that right?

2 A. Correct.

3 Q. Okay. So does this appear to be reflecting
4 all the changes between 7:45 and 8:00?

5 A. No. It's -- it's not showing all the data
6 points as this graph is, because it's not -- it's not
7 plotting in one minute increments.

8 Q. Okay. Do you think that this dip right here,
9 the one that Mr. Ransom has been pointing to, do you
10 think that that is -- what I just referred to, when I
11 said you went from 96 to 75 to 69, back to 90.1, in the
12 course of the four minutes, do you think that that
13 could possibly be what's being reflected in this 15
14 minute graph?

15 A. Probably not.

16 Q. Thank you. That's all.

17 THE COURT: You may step down, doctor. Thank you
18 so very much. All right. Next witness.

19 MR. RANSOM: Judge, at this point, we've got --
20 excuse me -- the Plaintiff has two exhibits which we
21 want to offer into evidence, as I understand without
22 objection. The first is Plaintiff's Exhibit 16, which
23 was Shon Turner's request for a copy of Mr. Mikell's
24 medical chart that was submitted to the Medical --

25 THE COURT: Is that without objection, Mr. Cooke?

1 MR. COOKE: No objection.

2 THE COURT: All right, 16, and what else?

3 MR. RANSOM: And then the other one is Plaintiff's
4 Exhibit 14, which is a summary of the medical expenses
5 that were incurred by Mr. Mikell during his
6 hospitalization.

7 THE COURT: Which one?

8 MR. RANSOM: Forty-seven.

9 THE COURT: Forty-seven, medical expenses -- no
10 objection; is that correct?

11 MR. COOKE: No. objection.

12 THE COURT: All right, 47 admitted without
13 objection.

14 (WHEREUPON, Plaintiff's Exhibit Number 16 & 47
15 was admitted into evidence.)

16 MR. RANSOM: And with the admission of those two
17 exhibits, the plaintiff rests. (Pause.) Bare with me,
18 Judge. I may have misspoken; because I was forgetting
19 Mr. Mikell's testimony. We want to get Mr. Mikell's
20 testimony in.

21 THE COURT: Well, that's what I was asking you.

22 MR. RANSOM: Let me speak with counsel --

23 THE COURT: I'm going to have to -- as far as that
24 is concerned, I need an opportunity to look at the
25 objections before we go through her deposition. I

1 assume you're going to want to put in Mrs. Mikell --

2 MR. RANSOM: We do, and I'm sorry. I misspoke,
3 Judge. And Mr. Cooke has said that it's agreeable to
4 him to play the audio out of order so that we can get
5 it ended.

6 THE COURT: Okay. Is that right, Mr. Cooke?

7 MR. COOKE: That's correct.

8 THE COURT: So we can go ahead and listen to
9 motions at this time, but give me an opportunity to at
10 least look at the objections before we play the audio?

11 MR. COOKE: Yes.

12 THE COURT: I've got -- finally got them marked,
13 but I haven't looked at them yet.

14 MR. COOKE: Okay.

15 THE COURT: All right. All right. Madam
16 Forelady, ladies and gentlemen of the jury -- let me
17 see the attorneys up here just a second please --
18 before I excuse them and tell them what time to come
19 back.

20 (WHEREUPON, a bench conference was had.)

21 THE COURT: All right. Madam Forelady, ladies and
22 gentlemen of the jury, we're going to take a lunch
23 break at this time. And I'm going to have to hear
24 certain motions that are required at this time also.
25 So I'm going to ask you to leave to the jury room. So

1 I'll go ahead and let you go to lunch. We're going to
2 be here for a little while.

3 So be back in the jury room at 2:30 and we'll
4 get started at that time. Please leave your notepads
5 in your chair. And please don't discuss the case
6 amongst yourselves. I'll see you at 2:30.

7 (WHEREUPON, the jury leaves the courtroom at
8 12:31 p.m.)

9 THE COURT: Let me see you up here.

10 (WHEREUPON, a bench conference was had.)

11 THE COURT: All right. The plaintiff does not
12 have any objection to the court hearing the directed
13 verdict motions prior to closing the case, i.e., you
14 got one more witness -- I believe the deceased
15 grandmother(sic); is that correct?

16 MR. RANSOM: I think that's correct.

17 THE COURT: And you're going to deal with that by
18 excerpts from her deposition?

19 MR. RANSOM: That's correct.

20 THE COURT: Okay. All right. I'll be glad to
21 hear you. Any motions from the plaintiff?

22 MR. RANSOM: I think I've got to move for a
23 directed verdict on the liability issues in the case,
24 judge. The testimony at least at this point in time
25 has been indisputable. There have been breaches in the

1 standard of care both by Nurse Embrey and by Dr.
2 Nelson. That this -- these breaches of the standard of
3 care resulted in the cardiac arrest, which led to the
4 hospitalizations. The testimony from Dr. Kofke ties
5 that in. I think his word was "inextricably linked"
6 with Mr. Mikell's death.

7 THE COURT: Denied.

8 MR. RAMSOM: Thank you, Your Honor.

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

10 MR. COOKE: Thank you, Your Honor. First, in the
11 second amended complaint, you know that there are some
12 new causes of action --

13 THE COURT: Yeah, there's negligent
14 misrepresentation, conversion -- why don't we do the
15 medical malpractice first --

16 MR. COOKE: Okay.

17 THE COURT: And then you can go to
18 misrepresentation and conversion. And I'll have to
19 listen to what he has to say about that. Okay.

20 MR. COOKE: All right. We're going -- we move
21 for -- respectfully move for a directed verdict as to
22 both the survival and the wrongful death cause of
23 action, both based on there's been a failure of proof
24 on breach of standard of care and on causation.

25 THE COURT: Can I -- can I interrupt you just a

1 second?

2 MR. COOKE: Yes, you may.

3 THE COURT: Do you have anything new you want to
4 add to your previous argument? I believe you've made
5 one argument one evening, and then came back with some
6 more argument the next day; is there anything else you
7 want to add to that argument -- new?

8 MR. COOKE: Can I just --

9 THE COURT: You can summarize it very briefly, but
10 I -- I remember basically what you said. I just don't
11 want to -- I'm not interesting in regurgitating the
12 whole argument.

13 MR. COOKE: I can't say I was completely coherent
14 when I argued before, so I just -- I thought about it
15 and we actually submitted a memorandum.

16 THE COURT: All right. Go ahead.

17 MR. COOKE: So -- so I'd like to incorporate the
18 memorandum that we handed up.

19 THE COURT: And incorporate your previous
20 arguments?

21 MR. COOKE: Right. And also I do want to add --
22 I'll make this very summary -- but on the breach of
23 standard of care, the testimony from the doctor was
24 that -- I think he used the word "goofy", that the
25 records were goofy, and he couldn't understand them.

1 And I think there are only about three times in the
2 record that he said he would rely on.

3 And he admitted that because of the complication
4 of the -- because of the morbidities that Mr. Mikell
5 had, that he could have an event like this even with
6 all due care being exercised. And so as to Nurse
7 Embrey, he said, nevertheless, I conclude that she was
8 negligent because she was distracted making text
9 messages; and, therefore, she missed the vital signs.
10 There's nothing in the record that reflects that.
11 That's pure supposition. And then likewise with Dr.
12 Nelson, he testified that --

13 THE COURT: I'm sorry. Run that by me again now.
14 What did you just say?

15 MR. COOKE: That -- that his -- his only
16 specification of negligence against Nurse Embrey was
17 that she was distracted on her cell phone -- texting
18 the IT support while she should have been monitoring
19 the patient. And -- but there's no evidence,
20 undisputed evidence in the record, is that after her
21 last communication with IT, and after the machine was
22 recording properly, Dr. Nelson was in the room and we
23 --

24 THE COURT: But didn't he dispute that based upon
25 the time she started giving the Propofol and the

1 colonoscopy? Because he said she couldn't be giving it
2 that fast to start the colonoscopy when they said they
3 started it -- if I remember correctly.

4 MR. COOKE: Well, they said --

5 THE COURT: I may be misquoting it, but I think he
6 said that. And that was the basis of making that
7 decision --

8 MR. COOKE: Well, except --

9 THE COURT: -- that it was impossible for her to
10 do that.

11 MR. COOKE: No, I think --

12 THE COURT: In other words, he couldn't start the
13 colonoscopy based upon when she says she started the
14 Propofol.

15 MR. COOKE: Well, Dr. Nelson was the
16 anesthesiologist, so he's not in the room when the
17 Propofol was started.

18 THE COURT: Right.

19 MR. COOKE: But we know he was there at 7:49
20 because you remember the audit trail showed that he
21 entered his attestations then.

22 THE COURT: It said he was in at 8:00, and that
23 was subject to the objection --

24 MR. COOKE: No, this was a different -- that was
25 when he came back after the emergency began.

1 THE COURT: Okay.

2 MR. COOKE: And when the induction of the -- the
3 anesthesia was being conducted, he -- we know for a
4 fact that he was there at 7:49. The record -- the note
5 that was added, that was entered, said that he left the
6 room at 7:51 --

7 THE COURT: Well, I guess -- maybe I
8 misunderstood. My understanding was he was saying that
9 when the colonoscopy was started, the Propofol had to
10 be administered prior to that time..

11 MR. COOKE: Right.

12 THE COURT: Because it didn't have time to react
13 to start the colonoscopy. And then he tied that into
14 the text messages time, is how he justified saying she
15 was doing texting and talking on the phone.

16 MR. COOKE: That's right.

17 THE COURT: All right. I just want to make sure
18 we're on the same wave length.

19 MR. COOKE: Right. And he's right about that, the
20 first text message was at 7:46, the Propofol was
21 started at 7 -- let's see -- 7:41.

22 THE COURT: 7:42, I think 41, 42.

23 MR. COOKE: At 41, 42.

24 THE COURT: One of the two. I think somebody said
25 41, somebody said 42.

1 MR. COOKE: The first text was 7:39. The Propofol
2 started at 7:41 or 7:42. The second text was at 7:46.
3 And the machine is operating at 7:48 -- I mean, the
4 machine is recording at 7:48.

5 So -- so that part is true. The Propofol was
6 started while the machine was not recording. But we
7 know that -- we know that 7:48, the first recorded --

8 THE COURT: Well, I thought he was saying -- he
9 thought it had to be started before that time because
10 the colonoscopy was started -- I don't remember the
11 time when it was started.

12 MR. COOKE: He did say that it -- he did say that
13 it didn't -- not seem right that there were only one
14 minute between the Propofol and--

15 THE COURT: Starting the colonoscopy, because he
16 didn't have time to react.

17 MR. COOKE: Right.

18 THE COURT: So it couldn't start -- the Propofol
19 had to be done prior to 41 or 42.

20 MR. COOKE: Right. Except the machine says it was
21 --

22 THE COURT: I understand. But I mean you want to
23 say, hey, the machine doesn't work then. But now you
24 want to take advantage of what the machine said. Which
25 is it, it's either working or not working?

1 MR. COOKE: Well, it was working -- I -- I agree
2 --

3 THE COURT: You're making it work for your
4 benefit, but not for his benefit.

5 MR. COOKE: No. I mean, I'm not quibbling about
6 whether -- if he wants to -- let's just say the
7 Propofol was started three minutes earlier. The -- the
8 -- his criticism of her was that he thinks that -- that
9 he was desaturating and was in an impending myocardial
10 -- I mean -- arrest -- cardiac arrest while she was
11 texting. And my point is, even if -- even if -- even
12 if there was some problem that she was supposed to be
13 monitoring, and wasn't -- and he's only speculating
14 when he says she couldn't be doing both.

15 We know for sure that Dr. Nelson, the
16 anesthesiologist, was there after all of that texting
17 was over with. Because the last communication was at
18 7:46. The machine started recording at 7:48. And we
19 know that Dr. Nelson was entering data in the computer
20 in that room at 7:49, because of the audit trail.

21 And the memo said that he left the room at 7:51,
22 at which time the saturation rate was 90 percent, 90.6
23 percent or something like that. So -- so as a matter
24 of law whatever distraction she might have had before
25 was superceded because everything was the way it was

1 supposed to be. And, Dr. Nelson, the anesthesiologist
2 was there after her last bit of distraction or whatever
3 it was. So -- so -- so whatever happened up to 7:46
4 could not have contributed as a proximate cause to the
5 ultimate arrest and demise.

6 Because if you remember, the criticism of her
7 was she should have -- she should have been monitoring
8 better and call the doctor if there was a problem. But
9 he was there. He was there, we know, at 7:49.

10 And so -- and so as to Dr. Nelson, the criticism
11 of him was -- I don't know when he was in the room, but
12 it wasn't enough, whatever it was. That testimony is
13 almost exactly like the testimony that was given -- may
14 have been on that very witness in Fletcher vs. MUSC.
15 There was an injury to a phrenic nerve. There were a
16 couple of complications during an operation. And the
17 doctor testified -- the expert said, you know, it's
18 true. It is possible those are known complications
19 that can happen in the absence of negligence, and I
20 don't know exactly what the doctor did wrong here, but
21 he shouldn't have cut the phrenic nerve. And Judge
22 Dennis granted a directed verdict.

23 It went to the Court of Appeals, and they
24 affirmed that part of it. They reversed the informed
25 consent part, but they affirmed that part, and said

1 that doesn't meet the plaintiff's burden of proof of
2 saying that a complication -- known complication that
3 occurred, occurred, and you that -- you think in your
4 expert opinion that it must have been the fault of the
5 health care provider. That's not good enough.

6 The same thing was true in the -- in the
7 Martison (ph) case. The same thing was true in the
8 legal malpractice case in the -- the -- the -- yeah,
9 the Harris -- Harris Teeter case where expert witnesses
10 said, you know, I think that they were -- they deviated
11 from the standard of care, and there was no
12 specifications to what it was. So that's the
13 plaintiff's burden.

14 Then going to proximate cause, we would move as
15 to the wrongful death cause of action, in particular
16 that there is no evidence to satisfy the plaintiff's
17 burden under Sherer vs. James, and the other cases that
18 say that it is not sufficient to say that your
19 negligent acts nearly made you a greater risk of
20 suffering the ultimate outcome.

21 In Sherer vs. James, that was actually a
22 stronger case for the plaintiff because we knew what
23 happened to the plaintiff in that case. We knew the
24 outcome. In this case, nobody knows even the cause of
25 death. And, therefore, how could you possibly say --

1 even if you said, you -- because of what you did, you
2 put him at a 75 percent risk of having a stroke.
3 Unless he had a stroke, it's doesn't -- it's not the
4 proximate cause. And that's exactly what Sherer vs.
5 James said, if you could not meet your burden of proof
6 simply by saying that you place the patient at greater
7 risk.

8 And in this particular case, the only things
9 that the doctor -- and I reserve my objection about him
10 being able to change his testimony without
11 supplementing the interrogatory, but that's already
12 passed.

13 But -- but the best thing he can say is that I
14 think that maybe as a result of his injury to his
15 kidneys, he was taken off blood thinner, and he was
16 taken off the antiarrhythmia. And that he was at risk
17 for a blood clot related death, either pulmonary
18 embolism or stroke, and he was at risk for, I think, an
19 arrhythmia. And, therefore, he was at greater risk of
20 those things because he had been taken off of those
21 medications.

22 And even if -- and I would submit to Your Honor,
23 that even if we had an autopsy that said he did, in
24 fact, suffer a stroke, the plaintiff under -- under --
25 under that case would still have to prove to a

1 reasonable degree of medical certainty, more probably
2 than not, that he would not have had that stroke but
3 for this change in his medications.

4 But in this case, we don't even know if he had a
5 stroke, or if he had a death from an arrhythmia. He
6 could have choked to death. He could have fallen
7 asleep without a CPAP machine and obstructed.

8 And it's -- it's very likely that whatever
9 caused him to be susceptible to the cardiac arrest on
10 the 1st of October was the same thing that made him
11 susceptible to the cardiac arrest -- to cardiac arrest,
12 if that's what he had, on January 2nd. The only
13 difference was he had a crack team of specialists to
14 rescue him on October 1st, but he didn't have that for
15 him unfortunately on January 2nd.

16 So with all that said, we would -- we would move
17 for a directed verdict as to -- as to both causes of
18 action.

19 THE COURT: Thank you very much. Mr. Ransom.

20 MR. RANSOM: Judge, on the issue of the breach and
21 standard of care, I think what I would like the Court
22 to keep in mind is we've heard testimony from three
23 different witnesses in this case, not just Dr. Kofke,
24 about what the standards of care are.

25 And Dr. Kofke was asked would it be a breach of

1 the standard of care for you to be fooling around on
2 the phone, sending text messages while your patient is
3 desaturating; yes. Would it be a breach of the
4 standard of care for the -- for the anesthesia care
5 providers to be distracted by these other things when
6 their patient is unstable or desaturating; he said yes.
7 All right. Likewise, Nurse Embrey, basically agreed
8 that look, if I wasn't paying attention to my patient
9 while he was in trouble, that would be a bad mistake.

10 The same thing from Dr. Reeves just now this
11 morning, would it be a breach of the standard of care
12 if they were fooling around, attending to these other
13 things instead of watching a sick patient.

14 And what Mr. Cooke wants to argue about is,
15 well, is there any evidence that any of those things
16 happened. And taking it all in the light most
17 favorable to the Medical University, I think it's quite
18 obvious that there's a great deal of disputed evidence
19 as to whether or not the standard of care was, in fact,
20 breached.

21 I don't -- I think that Dr. Kofke clearly
22 testified that he said to a reasonable degree of
23 medical certainty, he most probably found that they
24 both breached the standard of care. He also was asked
25 whether or not this led to Mr. Mikell's death, and his

1 words were he thinks that they're inextricably linked,
2 and to him it's obvious that the events of October 1st
3 caused his death.

4 So it's a dispute that Mr. Cooke wants to argue
5 to the jury, you shouldn't believe that evidence. But
6 I think the evidence has certainly come in through Dr.
7 Kofke, through Nurse Embrey, through Dr. Reeves, and
8 all of the evidence that we've had from these records
9 and so forth, that the jury would certainly be entitled
10 to reach the conclusion that both Dr. Nelson and Nurse
11 Embrey breached the standard of care. That that breach
12 of the standard of care caused the cardiac arrest,
13 which led to the hospitalization.

14 And that all of those things -- to use Dr.
15 Kofke's expression -- all of that stuff -- all right --
16 led to his death. So -- and, again, taking -- you
17 know, I'm trying to give him the benefit of the doubt,
18 that okay if it's -- you know, you denied my motion, so
19 it's not rock solid convincing evidence. But I think
20 there's certainly disputed evidence as to whether or
21 not the standard of care has been met by these medical
22 care providers.

23 THE COURT: Well, I mean other than -- other than
24 the doctors taking him off of those two medications, as
25 I assume they took him off as a result of this cardiac

1 arrest and trying to get him well, and your expert said
2 that increased the risk. And it's his opinion either a
3 stroke or a heart attack killed him as a result of that
4 increase in risk. How does taking him off the medicine
5 correlate to their actions?

6 MR. RANSOM: Correlate to their actions?

7 THE COURT: Yeah.

8 MR. RANSOM: Yeah, so -- as Dr. Kofke explained,
9 the reason that he had to have some of those
10 medications stopped was because he had suffered this
11 injury -- this acute injury to his kidneys that
12 resulted from the lack of blood supply during the
13 cardiac arrest. Some of those medications, as he
14 explained, are cleared by the kidneys. And so when
15 their function has been damaged, you don't want to over
16 burden them by having heart drugs and antiarrhythmia
17 drugs.

18 And I guess the -- well, the -- it was the
19 seeping wound from the tracheostomy that resulted in
20 stopping the Coumadin, the blood thinner. But what
21 he's saying is, look, these antiarrhythmia drugs are
22 important to protecting from having an arrhythmia is --
23 is this blood thinner, it's important to protect him
24 from having a blood clot that can cause a pulmonary
25 embolism or a stroke.

1 And my recollection was, as he was describing
2 and explaining the basis for his opinion, he says,
3 look, as a critical care physician, I see these
4 patients who are ventilated and spend lengthy periods
5 of time in the ICU all the time, and this is what
6 happens to them. They throw a clot. They have an
7 arrhythmia and that's what causes them to die.

8 And my recollection was that Mr. Cooke had a
9 lengthy discussion with him, and what Dr. Kofke was
10 saying is, look, what -- what else could it be? I
11 mean, sure, it could be a clot and it could be an
12 arrhythmia. And those are two things that they've
13 severely -- you know, they've removed the medications
14 that he had been effectively controlling it before, to
15 prevent those things from happening.

16 And, you know, again, his conclusion was as
17 you'll recall, we asked the question, and he objected.
18 And we asked the question, to a reasonable degree of
19 medical certainty, did the events of October 1st most
20 probably cause his death. And he said yes. And he
21 actually went on and said he believed, in his view,
22 that it was all inextricably linked. Mr. Apostolou
23 wrote that down. And it was obvious to him.

24 I mean that was his testimony, it's -- it's
25 obvious to me that the two things are -- that there's a

1 casual relationship. So, you know, we went through the
2 process and somewhat tortuously over objection, and we
3 got him to use the magic words --

4 THE COURT: I know, but you got to have some
5 substance to give to the magic words -- you got to have
6 some valid reasons behind it.

7 MR. RANSOM: Well, yeah, and that's what I'm
8 trying to explain --

9 THE COURT: And that's what we're arguing about.

10 MR. RANSOM: Right. And forgive me again, I mean,
11 I'm not a -- I'm not a critical care specialist. And,
12 you know, you heard all the testimony. But he did go
13 through this analysis of, you know, these are the
14 injuries that he suffered. These are the problems that
15 he had. These are the medications that he was taking.
16 These were the changes that they made, so that left him
17 exposed to the risk of these two things happening. And
18 based on my experience in my hospital, with my
19 patients, seeing this types of -- this patient
20 population, those are the things that kill these
21 people.

22 And so they have basically, as a result of the
23 hospitalization and the injuries, they removed the
24 drugs that were protecting him from the risk and the
25 thing that's most likely to happen, and that was on the

1 basis that he was concluding, well, this is the most
2 likely explanation in my mind. It's obvious.

3 THE COURT: Thank you very much. Let me hear you
4 on the negligence misrepresentation and the conversion.

5 MR. COOKE: Thank you, Your Honor.

6 THE COURT: Are you going to proceed on those two
7 causes of action?

8 MR. RANSOM: I'm going to withdraw the negligent
9 misrepresentation --

10 THE COURT: Okay. So I don't have to rule on
11 that?

12 MR. RANSOM: Yeah.

13 THE COURT: Because I -- what are -- are we going
14 to listen very long to his argument on that -- I mean,
15 what -- what he has converted other than a loss of --

16 MR. RANSOM: The -- the Mayday record.

17 THE COURT: What do they call them -- Mayday card.
18 The lost Mayday card. What have they converted?

19 MR. RANSOM: That's the Mayday -- that's it. I
20 mean, most obviously --

21 THE COURT: Then the question is, I mean -- okay.
22 It was -- so it was converted without his permission,
23 but what's the damages? I mean, what's -- what's the
24 loss of the piece of paper, how did that damage him?

25 MR. RANSOM: Well, as we heard from Donna Embrey,

1 her recreation --

2 THE COURT: I mean, the damages of the evidence
3 presented in this case -- but that's not the issue on
4 the conversion cause of action. You got to have some
5 personal damage. How did misplacing or destroying, or
6 whatever happened to it -- I don't know -- I don't
7 think anybody knows --

8 MR. RANSOM: Judge, I -- I concede that the loss
9 of that document didn't damage his kidneys, didn't make
10 his heart fail, didn't kill him. No question about it.

11 THE COURT: So, how is he damaged? I understand
12 damaged presenting the case because if you had it, then
13 you would know whether the nurse, when she looked at
14 that and changed the numbers, whether the numbers she
15 changed were correct or incorrect. That's the one
16 missing item in this lawsuit, that would tell whether
17 she's either truthful about it, or she's in error about
18 it, or she's lying about it. And I don't know which
19 one.

20 MR. RANSOM: Right. So, again, my concession
21 would be, I can't show some bodily injury that flows
22 from the loss of that record. I can't show some
23 economic harm --

24 THE COURT: Well, how are you going to move
25 forward with conversion?

1 MR. RAMSOM: But I think it would be wrong to
2 conclude that there was no harm. And part of the harm
3 is, the harm that is created in this case in trying to
4 figure out exactly what happened, and test people's
5 truthfulness and so forth. And that's why I just
6 think, Judge, at the end of the day, the reason we put
7 that cause of action in here is because we wanted to
8 try to establish in this case, if nowhere else, that,
9 look, you are not permitted to destroy, alter, and --
10 and fabricate evidence in a case, and get away with it.
11 And under the tort claims act, I don't know what other
12 cause of action we can bring in order to try to address
13 that conduct --

14 THE COURT: Well, I'm not saying it's not a bad
15 theory, I just have a problem with -- in this
16 particular fact scenario, where he was harmed.

17 MR. RANSOM: Mr. Mikell wasn't harmed, but his
18 estate was harmed. Mr. Turner was harmed. I was
19 harmed.

20 THE COURT: I don't doubt that, you would love to
21 have it. I understand that. Okay. But I'm sure --
22 I'm sure Mr. Cooke would love to have it. Okay.

23 MR. COOKE: I would love to have it.

24 THE COURT: Both of you would love to have it.
25 But that -- that doesn't affect his damage on a

1 conversion action. Let me hear from you, Mr. Cooke.
2 It's your motion.

3 MR. COOKE: First of all, the card didn't belong
4 to him, and it didn't belong to his estate. There's no
5 evidence that it was intentionally taken away.

6 But second of all, the best thing that has ever
7 happened to Mr. Ransom in this case was that card being
8 gone. Because we know from the other records that --
9 that are -- that are undisputable, that the time -- the
10 only thing she could have gotten off of that
11 information was when did the code begin. That's the
12 first piece of data on there. And she used that to
13 help her know when Dr. Nelson was back in the room.

14 But we now know because of a record that she
15 couldn't have changed and nobody could have changed,
16 which is when the bagging began. That's -- that's the
17 FIO2 and the PIP, that both went up dramatically right
18 between 7:55 and 7:56, which proves absolutely
19 positively that without any doubt whatsoever, beyond
20 any capability of even Ms. Embrey to go back and change
21 records, that that's when the bagging occurred and
22 that's when Dr. Nelson was there helping her do it.

23 But, let's put all that aside. The very best
24 thing that has ever happened to the plaintiff's case is
25 for that record to be missing. Because their entire

1 argument about everything has been that these people
2 are liars. They are cheaters. They've stolen this
3 record. They've -- they've changed data, and they
4 wouldn't be making that argument if that piece of paper
5 was still in the record.

6 THE COURT: I guess that argument goes along
7 whether you think -- you believe it's a coincidence or
8 not. But that's neither here nor there.

9 MR. COOKE: Correct.

10 THE COURT: All right. As far as the directed
11 verdict as to conversion, that's granted. As far as
12 directed verdict on the other cause of action, on the
13 medical mal, i.e., the wrongful death, the survival
14 action, that's denied.

15 Anything else before we break for lunch?

16 MR. COOKE: Just -- we don't have to be on record,
17 but I --

18 THE COURT: We don't need to be on the record.

19 (Discussion off the record.)

20 THE COURT: Anything else?

21 MR. RANSOM: Nothing from the plaintiff. Thank
22 you.

23 THE COURT: All right. We'll adjourn until 2:30.
24 Thank you very much.

25 (WHEREUPON, a lunch break was taken.)

1 THE COURT: All right. Anything before we bring
2 the jury from the plaintiff?

3 MR. RANSOM: Nothing, Your Honor.

4 THE COURT: Anything from the defense?

5 MR. COOKE: Nothing. Thank you.

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

7 (WHEREUPON, the jury enters the courtroom at
8 approximately 2:38 p.m.)

9 THE COURT: Thank you very much. Call your first
10 witness please.

11 MS. FLEMING: The defense calls Dr. Van Bakel.

12 ADRIAN VAN BAKEL,
13 after having been duly sworn, testified as follows

14 THE CLERK: Please state your first and last name.
15 And spell your last name loudly and clearly into the
16 microphone.

17 THE WITNESS: Adrian Van Bakel, V-a-n-B-a-k-e-l.

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

19 Q. Good afternoon, Dr. Van Bakel. Where are you
20 currently employed?

21 A. I'm currently employed at the Medical
22 University of South Carolina.

23 Q. And what is your position at the Medical
24 University?

25 A. I'm a professor of medicine in the Division of

1 Cardiology.

2 Q. And how long have you been employed at MUSC?

3 A. Twenty-five years.

4 Q. Can you tell the jury a little bit about your
5 educational background and your training?

6 A. I completed medical school at the University
7 of Louisville in 1981. I attended graduate school and
8 received a Ph.D. in Pharmacology in 1983, and came to
9 the Medical University as an intern in internal
10 medicine that same year. I progressed through
11 residency, cardiology fellowship. And in 1991, I
12 became a staff physician.

13 Q. And just so the jury understands, you are a
14 cardiologist at MUSC?

15 A. Yes, ma'am.

16 Q. Are you board certified?

17 A. Yes, ma'am.

18 Q. And what are your board certifications?

19 A. I'm board certified in interim medicine in
20 cardiovascular diseases, and in -- in advanced heart
21 failure and transplant medicine.

22 Q. And do you hold any -- or do you have any area
23 of specialty within the field of cardiology?

24 A. My area of specialty is heart failure and
25 heart transplantation.

DR. VAN BAKEL -- DIRECT

1 Q. Now, is it my understanding that you -- are
2 you the Director of the Heart Failure Clinic at MUSC?

3 A. I am currently the Medical Director of the
4 Transplant Program, previously the Director of Heart
5 Failure Clinic.

6 Q. Now, was Mr. Mikell a patient in the Heart
7 Failure Clinic?

8 A. Yes, ma'am, he was.

9 Q. And -- just a moment.

10 (PAUSE.)

11 MS. FLEMING: I would like to have marked for
12 identification Defendant's Exhibit No. 7, please.

13 (WHEREUPON, Defendant's Exhibit No. 7 marked for
14 identification.)

15 BY MS. FLEMING:

16 Q. Dr. Van Bakel, could you identify these
17 records, please?

18 A. These are my clinic notes in the -- during the
19 time that I took care of Mr. Mikell dating, I believe,
20 from sometime in 2009 through December 14th, 2010.

21 MS. FLEMING: The defense would move to admit
22 Exhibit No. 7 into evidence at this time.

23 THE COURT: Any objection?

24 MR. RANSOM: Yes, Your Honor. At least at this
25 point in time, I would object to the relevance of those

1 documents. If the witness is going to explain and
2 describe their content, I probably don't have any
3 objection. But to just put them all into evidence
4 without some explanation, I do object.

5 THE COURT: All right. Lay some type of
6 foundation as to why they are relevant, if you would,
7 please, ma'am.

8 BY MS. FLEMING:

9 Q. All right. Dr. Van Bakel, you mentioned that
10 these are your clinic notes from the time that you
11 cared for Mr. Mikell during the -- the heart clinic?

12 A. Yes, ma'am.

13 Q. And when did Mr. Mikell first become a patient
14 in the Heart Failure Clinic at MUSC?

15 A. It was sometime in '09. And going back
16 through these records, it appears to be March of -- I'm
17 sorry. The first record I have is in February of 2010,
18 so that would be February 2nd of 2010.

19 Q. And why was Mr. Mikell referred -- let me --
20 let me back up a minute. Was he actually a patient at
21 MUSC prior to being referred to you in the Heart
22 Failure Clinic?

23 A. Yes, ma'am. He was being cared for by Dr.
24 Michael Zile, also in the Cardiology Division.

25 Q. What was your understanding about why he was

1 referred to -- to your care?

2 A. Mr. Mikell's cardiomyopathy dates all the way
3 back to 2003, and Dr. Zile cared for him through most
4 of that period of time. During that time, his heart
5 function got better, got a little worse, got better,
6 got a little worse, oftentimes in relation to some
7 atrial arrhythmias he was having.

8 During 2009, his heart failure also got a little
9 bit worse and Dr. Zile was able to -- he basically did
10 everything that he could, and he thought he might
11 benefit from more intense management, not so much in
12 terms of expertise, but in terms of more frequent
13 clinic visits, and we were able to do that in the Heart
14 Failure Clinic.

15 Q. So you mentioned that had Mr. Mikell had
16 cardiomyopathy since 2003; what was his condition when
17 you first saw him in February of 2010?

18 A. Okay. Do you mind if I look through my notes
19 at that point?

20 Q. Please do.

21 A. So at that point, Mr. Mikell had a -- his
22 heart was dilated. His ejection fraction, which is a
23 measure of his heart's pumping ability, was moderately
24 decreased, but he was fairly stable. And we considered
25 him to be what we call -- consider NYHA class three,

1 which is that he would have difficulty with
2 predominately with -- with exertional shortness of
3 breath on moderate levels or little -- more than mild
4 levels of exertion. And at that point, we were just
5 beginning to titrate some of his medications to try to
6 improve that.

7 Q. So when you -- when you say that his "ejection
8 fraction", I think your note indicates that his --

9 COURT REPORTER: I'm sorry. I'm having trouble
10 hearing her.

11 BY MS. FLEMING:

12 Q. His ejection fraction was between 30 and 40
13 percent, can you explain to the jury what the ejection
14 fraction means?

15 A. Okay. So the ejection fraction is an estimate
16 of the percent of blood that the heart pumps out with
17 each beat. So we measure that in various ways. And
18 what we're trying to determine is -- so if -- when the
19 heart is completely relaxed, and it fills with blood,
20 and then it squeezes as hard as it can squeeze and pump
21 the blood out, the percentage of that blood is
22 considered the ejection fraction. Now, a normal
23 ejection fraction is considered anything above 50
24 percent.

25 So if his was in the 30 or 40 percent range,

1 someone who is -- whose heart failure is severe, who's
2 ejection fraction is severely reduced, would be in the
3 20 percent range, so he's kind of right in between.

4 Q. And you mentioned that he was the New York
5 Heart Association class three symptoms at that time --

6 A. Yes, ma'am.

7 Q. And what -- can you explain to the jury what
8 the New York Heart Association classification system is
9 used for?

10 A. It's -- it's a functional classification that
11 looks at or -- or actually measures or somehow
12 determines how functional someone is. So if someone
13 has a condition, such as heart failure, but there --
14 they have no restrictions in their activity, they're
15 considered class one.

16 If they have severe restrictions in their
17 activities, such that they have heart failure symptoms
18 even at rest and very very minimal exertion, they are
19 considered class four.

20 Class two is someone who is able to do usual
21 activities, that moderate levels of activity will cause
22 them to be short of breath, say, or have other symptoms
23 of heart failure.

24 Class three is when mild levels of activity
25 would cause shortness of breath.

1 Q. So the fact that Mr. Mikell was having class
2 three A symptoms, when you first saw him, what did that
3 tell you about his disease process?

4 A. Well, that told me that combined with the
5 ejection fraction, that we knew was in the 30 to 40
6 percent range, that he was considered to be -- I would
7 say -- you know, moderately affected by his heart
8 failure.

9 THE COURT: Do you have any objection to
10 Defendant's Exhibit No. 7?

11 MR. RANSOM: No objection.

12 THE COURT: All right. Admitted without
13 objection.

14 (WHEREUPON, Defendant's Exhibit No. 7 admitted
15 into evidence.)

16 BY MS. FLEMING:

17 Q. Now, Dr. Van Bakel, when was the last time
18 that you saw him prior to the colonoscopy in October of
19 2010?

20 A. That was in July 2010, July 27th.

21 Q. And how would you -- I'm sorry. I just want
22 to put your note out for the jury.

23 A. Yes, please.

24 Q. How would you describe Mr. Mikell's condition
25 in July of 2010?

1 A. At that point, from a functional standpoint,
2 he appeared to have improved. We considered him at
3 that point somewhere between class two and class three.
4 And he appeared to be what we call euthenics, meaning
5 that his that volume status was what we would consider
6 normal.

7 Q. And why, in heart failure patients, are you
8 concerned about volume status? I'm not sure the jury
9 understands that.

10 A. Okay. Heart failure is a condition where with
11 the decreased ejection fraction, and even in certain
12 instances when it's not decreased, the body retains
13 fluid. Part of the therapy of heart failure is a
14 reduced sodium diet and fluid restriction. And in
15 addition, we use diuretics to try to maintain an
16 appropriate fluid balance.

17 Excess fluid often causes significant symptoms
18 in heart failure, such as shortness of breath on
19 exertion, shortness of breath when you lay down or
20 swelling in the legs. So part of our therapy of heart
21 failure is to manage those symptoms.

22 Q. Now, did you know that Mr. Mikell was
23 scheduled to undergo a colonoscopy on October 1, 2010?

24 A. I did not know that.

25 Q. Would you have liked to know?

1 A. Well, I always like to know what's happening
2 with my patients. So from that standpoint, yes, I
3 would have liked to have known. I--

4 Q. Go ahead.

5 A. Based on my note previously, I would have had
6 no worries of him going through a colonoscopy.

7 Q. And that -- that was getting to my next
8 question, was there any reason why Mr. Mikell, from a
9 cardiac standpoint, could not undergo a colonoscopy on
10 October 1, 2010?

11 A. Based on what I saw in clinic on July 27th,
12 no. I would have had no qualms about him undergoing a
13 colonoscopy.

14 Q. When did you first learn that Mr. Mikell had
15 a -- had a cardiac arrest during the colonoscopy on
16 October 1st?

17 A. I ran into the gastroenterologist in the hall
18 and he told me about it.

19 Q. And that was Mark Payne?

20 A. Yes.

21 Q. And do you recall what he told you?

22 A. Just that he had had an arrest, and that he
23 was in the hospital.

24 Q. Now, did you see Mr. Mikell after he was
25 discharged from Kindred Hospital in November of 2010?

DR. VAN BAKEL -- DIRECT

1 A. Yes, I saw him one time, not in November, but
2 in mid December.

3 Q. Now, I think we can -- if you could look at
4 your note from that day, what was his condition at that
5 time?

6 A. Well, by history, as part of our history, he
7 had complained of being weak in the body, his
8 experience. He was not exercising and, you know, the
9 note says that he still feels weak and gets tired
10 easily, but he is able to do all of his things that he
11 usually does at home.

12 Q. So from a functional standpoint, would it
13 be -- was he improving, his condition?

14 A. Compared to when he got out of Kindred?

15 Q. Right.

16 A. By his history, yes.

17 Q. And now was it your understanding, based on
18 the medical records from MUSC that you've reviewed, did
19 Mr. Mikell have a cardiac consult at any time during
20 his inpatient admission at MUSC?

21 A. Yes, ma'am, he did.

22 Q. And what was -- what was the reason for that
23 consult?

24 A. The reason for the consult was that following
25 the arrest, he had a little bit more -- as he was

1 recovering in the Intensive Care Unit, he had a few
2 short runs of ventricular tachycardia.

3 Q. And was -- was there discussion about whether
4 or not he should have some type of internal cardiac
5 defibrillator at that time?

6 A. Well, the -- from what I can tell from the
7 notes, the -- the ventricular tachycardia that occurred
8 in the intense care unit was provoked by agitation
9 while he was still on the ventilator.

10 Q. I'm sorry. Just for the jury's benefit,
11 ventricular tachycardia, what is that?

12 A. That's an arrhythmia of the heart, or a rhythm
13 disturbance of the heart whereby the lower part of the
14 heart kind of takes over, and it's usually a very fast
15 rhythm, and can cause declines in blood pressure, and
16 can deteriorate into other arrhythmias, and cause death
17 eventually if it's not -- if it's not terminated.

18 Q. And when you say that his was not sustained
19 arrhythmia, what does that mean?

20 A. That means that he had short runs of it. So
21 he was still having short runs, particularly when it
22 was agitated. And --

23 Q. When you say "agitated", what does that mean?

24 A. Well, whenever someone is on the ventilator, I
25 don't know if any of you guys have had any loved ones

1 on the ventilators, but as -- they're usually sedated.
2 And as we're trying to wean them off of the ventilator,
3 we have to lighten the sedation, and sometimes people
4 become uncomfortable with that. And they become a
5 little bit agitated while we're trying to remove the
6 ventilator. And so it was that agitation that provoked
7 his ventricular tachycardia while he was in the unit.

8 Q. And so was he treated for that arrhythmia in
9 the hospital?

10 A. Yes, ma'am.

11 Q. And how was he treated?

12 A. He was given a drug called Amidoerum.

13 Q. And did he have any indications for an ICD?

14 A. Not at the time because so shortly after he
15 had the arrest, and during his hospitalization, he had
16 another echocardiogram. And that echocardiogram showed
17 that his ejection fraction had been stable. And, in
18 fact, was a little higher than that previously --
19 previously determined.

20 And every arrhythmia that he had, every
21 ventricular arrhythmia that he had was somehow provoked
22 by something else going on. So, you know, whenever he
23 had this initial cardiac arrest that was, you know,
24 provoked as well as what was happening in the unit;
25 that was provoked. And so we didn't have any reason to

1 think that once he was more stable, extubated, off the
2 ventilator, that he would continue to have any of these
3 arrhythmias.

4 Q. When you saw him on December 14, 2010, was he
5 having any arrhythmias?

6 A. No, not at all.

7 Q. Had he -- had he had any to your knowledge
8 from the time that he had been discharged from Kindred?

9 A. None that I know of, no.

10 Q. And you mentioned the echocardiogram that was
11 done on October -- sometime when he was in the hospital
12 at MUSC --

13 A. Yes.

14 Q. Did that show any -- was that -- was his
15 ejection fraction essentially unchanged from before the
16 colonoscopy?

17 A. The -- the entire echo was essentially
18 unchanged. The ejection fraction, every other part of
19 echo was unchanged.

20 Q. What does that indicate to you with regard to
21 whether he had suffered any type of injury to his heart
22 muscle as a result -- as a result of the arrest?

23 A. I -- I think that he had no permanent damage
24 from the arrest.

25 Q. And just to clarify, did he have a heart

1 attack as a result of the arrest?

2 A. No. No. And by heart attack, oftentimes the
3 term heart attack is bantered about by anybody who has
4 some sort of an arrhythmia. A heart attack is an
5 inclusion of a coronary artery, and -- which causes
6 part of the heart muscle to die, and he did not have
7 that.

8 Q. Now, as a cardiologist who treats patients
9 with heart failure, do you also monitor renal function,
10 kidney function?

11 A. Yes, very carefully.

12 Q. And why do you do that?

13 A. We do that because a lot of the medications we
14 use can change renal function. We also do it to -- we
15 not only monitor renal function, but also electrolytes.
16 Because the diuretics that I mentioned that we use also
17 cause -- can cause electrolyte depletion; so we monitor
18 all that very carefully.

19 Q. Did Mr. Mikell, before the colonoscopy in
20 October of 2010, did he have a history of chronic
21 kidney disease?

22 A. Yes, ma'am, he did.

23 Q. And do you recall what his -- his -- I'll call
24 it a baseline creatinine, is -- is that the right term?

25 A. Yes. Yes. So it's -- baseline creatinine

1 runs anywhere from 2.2 to 2.5. And that's what we
2 would consider moderate chronic kidney disease. And so
3 from the very first time I started taking care of him,
4 he already had some impairment of his kidney function.

5 Q. So when you saw him on December 14th of 2010,
6 what was his creatinine on that day; do you recall?

7 A. It was 2.5.

8 Q. And what did that tell you about his -- any
9 acute kidney injury that he may have suffered as a --
10 as a result of the arrest?

11 A. Well, any acute kidney injury would have been
12 resolved by then.

13 Q. So it was resolved by the time --

14 A. Yes, ma'am.

15 Q. -- you saw him? Did you have any concerns --
16 when you saw Mr. Mikell on December 14th, had he -- had
17 his medication regimen been changed in any way from his
18 regimen prior to the colonoscopy in October of 2010?

19 A. Yes.

20 Q. And what -- what were the changes that were
21 made?

22 A. He would -- he had previously been on an ace
23 inhibitor called Fosinophril, which had been
24 discontinued. He had been on a drug called Tikosyn,
25 which was for his previous atrial arrhythmias that had

DR. VAN BAKEL -- DIRECT

1 been discontinued. He had been on an -- as needed drug
2 called Metolazone or Zaroxolyn, which was an adjunct
3 diuretic that had been discontinued. And he had been
4 on Coumadin, which had been discontinued.

5 Q. Was his -- when you saw him in December of
6 2010, was his medication regimen in any way being
7 dictated by his kidney function?

8 A. Well, the Fosinophril had been discontinued
9 presumably because of his kidney dysfunction. His
10 Tikosyn had probably been discontinued because of his
11 acute kidney injury, but he had had no further
12 arrhythmias. And his renal function was, in fact,
13 marginal for restarting, so.

14 Q. And just to clarify, do you know why he was
15 taken off the of Tikosyn while he was in the hospital
16 at MUSC?

17 A. Because of the acute kidney injury.

18 Q. Now, I understand he was -- he was put into
19 the hypothermia protocol?

20 A. Yes. And that also would have been a reason
21 to have -- to have stopped it. Because Tikosyn has
22 what are called pro arrhythmic affects, which Tikosyn
23 is a type of drug that can actually provoke ventricular
24 tachycardia. And hypothermia -- well, hypothermia,
25 along with Tikosyn, can provoke ventricular

1 tachycardia, so he was appropriately discontinued from
2 the the Tikosyn because of the hypothermia protocol?

3 Q. Now, when you -- we've heard from the
4 plaintiff's expert this week, who testified that
5 Mr. Mikell was -- was more susceptible to suffering a
6 pulmonary embolism, some type of clot or arrhythmia
7 after he was discharged from Kindred because he was
8 taken off of certain medications, including the Tikosyn
9 and another medication called Coumadin. When you saw
10 Mr. Mikell on December 14th of 2014, were you
11 comfortable with his medication regimen at that time?

12 A. Yes, I was. The reason that I -- was that he
13 had -- he was on Tikosyn for atrial arrhythmias, and he
14 had no evidence of recurring atrial arrhythmias. He
15 was off -- he had no indication for resuming his
16 Coumadin because his ejection fraction was last -- at
17 the last what was 43 percent, and he was on Coumadin
18 for his atrial arrhythmias, and he didn't have any of
19 those. So when we looked at him, you know, seeing him
20 for the first time in a long time after all of the
21 things that had happened to him, we did not think he
22 had an indication to either resume Coumadin at that
23 time, or to resume Tikosyn at that time.

24 Q. Go ahead.

25 A. And his -- his kidney function had been

1 stable, but it was still compromised. So we were
2 actually very worried about trying to start any of
3 these medications at the time.

4 Q. When you say "compromised", was that in
5 relation to his chronic --

6 A. Yes, that his chronic kidney disease put him
7 at some risk for any of these types of medications to
8 be restarted.

9 Q. And to clarify, what is Coumadin used for?

10 A. Coumadin is a blood thinner or an
11 anticoagulant.

12 Q. So was it your opinion that neither Tikosyn
13 nor Coumadin were indicated for Mr. Mikell when you saw
14 him in December of 2010?

15 A. Yes, that is my opinion. I didn't think that
16 either one of them were indicated.

17 Q. We also heard from the plaintiff's expert that
18 Mr. Mikell was placed on another medication for his
19 anemia called Aranesp?

20 A. Yes.

21 Q. Are you familiar with Aranesp?

22 A. Yes.

23 Q. And -- and is there a risk of clot and cardiac
24 arrest associated with Aranesp?

25 A. There -- there is an increased incident of

1 thrombosis or a clot, but not to my knowledge of -- of
2 cardiac arrest following with that.

3 Q. Did you have any concerns with regard to
4 Mr. Mikell being on Aranesp when you saw him in
5 December of 2010?

6 A. No.

7 Q. In your opinion, and based on your treatment
8 of Mr. Mikell, was he at any greater risk for pulmonary
9 embolism, clot, or arrhythmia in January of 2011, when
10 he died, than he was prior to his colonoscopy in
11 October of 2011?

12 A. No, I don't believe he was. I mean, he was --
13 he was mobile, so he was getting around. He would not
14 have been, to -- to my thought, he would not have been
15 at increased risk at that time for a pulmonary embolism
16 because he was mobile. His ejection fraction was good
17 and he was having no atrial arrhythmias at the time.

18 Q. And I think you mentioned that when you saw
19 him in December, his functional capacity had actually
20 started to improve or was improving?

21 A. Yes, by his history -- now, remember, we
22 haven't seen him since July. But by his history, he
23 was doing better over the several months following his
24 hospitalization.

25 Q. And I'm sorry actually -- your note indicates

1 that "Since the last visit, Mr. Mikell had had quite an
2 astounding adventure in the hospital. He was
3 undergoing diagnostic colonoscopy for constipation and
4 suffered a cardiac arrest that was complicated by
5 prolong intubation and acute renal failure". What did
6 you mean when you said "he had an astounding adventure
7 in the hospital?"

8 A. Well, I suppose that could be considered my
9 poetic license. Typically we don't put that sort of
10 thing in our notes, but he -- it was an incredible
11 journey that he went through following his cardiac
12 arrest. And, luckily, he made it through that and was
13 able to come see me in clinic. But, you know, I didn't
14 mean that in any kind of pejorative way or anything
15 like that. I think it was, again, my poetic license in
16 my notes.

17 Q. Okay. So in December of 2010, was it your
18 understanding that he was at home?

19 A. Yes.

20 Q. And that he was undergoing some home
21 rehabilitation?

22 A. Yes. That he -- that in our -- in early
23 December, he had told us that he was getting some home
24 re -- home health and home rehab.

25 Q. Dr. Van Bakel, have you -- are you familiar

1 with the home health records?

2 A. Yes.

3 Q. Have you seen this document?

4 A. I had not seen this document until now.

5 Q. Okay. Does this document indicate to you --

6 MR. RANSOM: Objection, Your Honor. This is not a
7 part of his medical record. He just testified he's
8 never seen it before. He's not been identified as an
9 expert to provide opinion testimony in the case --

10 THE COURT: Okay. I understand.

11 BY MS. FLEMING:

12 Q. Dr. Van Bakel, were you aware as of December
13 30, 2010, that Mr. Mikell had been discharged from home
14 health because all of his goals had been met?

15 MR. RANSOM: Objection, Your Honor.

16 THE COURT: I'll -- I'll sustain the objection to
17 leading the witness. Please don't lead the witness.

18 MS. FLEMING: Okay.

19 BY MS. FLEMING:

20 Q. Dr. Van Bakel, are you aware of what Mr.
21 Mikell's status was when he was discharged from home
22 health in December of 2010?

23 A. Was I aware before this piece of paper was
24 given to me? I was not aware of his condition from the
25 time I saw him at clinic until I heard that he had

1 died.

2 Q. Okay. That's all I have. Thank you.

3 A. Okay.

4 THE COURT: Cross-examination.

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

6 Q. Good afternoon, Dr. Van Bakel.

7 A. Good afternoon.

8 Q. I believe that the exhibit that's been marked
9 by Ms. Fleming, that's -- are those all of your
10 cardiology notes for Mr. Mikell?

11 A. Yes, sir, I believe they are.

12 Q. Okay. So I want to just go through some of
13 this quickly with you. You had seen him back in May of
14 2010? I think the date of the office visit was May
15 25th?

16 A. Yes, sir.

17 Q. And at that point in time, you had noted that
18 he had had good compliance with his diet?

19 A. Yes.

20 Q. That he was working full time at the
21 Canterbury House?

22 A. Yes.

23 Q. That he was not being able to exercise as much
24 as he liked because of his work schedule?

25 A. Yes.

1 Q. He was actually working six days a week?

2 A. Yes.

3 Q. Swimming on Sundays?

4 A. Yes.

5 Q. He actually reported to you a very active
6 lifestyle?

7 A. Yes.

8 Q. And I think your comment was that he was
9 continuing to do fairly well?

10 A. Yes.

11 Q. All right. And then when you saw him on July
12 27, 2010, that would have been the last time that you
13 saw him before the hospitalization?

14 A. That's correct.

15 Q. At that point in time, he had told you that he
16 had his 12 year old son staying with him for the
17 summer?

18 A. Yes.

19 Q. That he was walking up to two miles two days a
20 week?

21 A. Yes.

22 Q. Twice a week -- he wasn't reporting any
23 shortness of breath with any of his activities?

24 A. Correct.

25 Q. And you described him as being quite stable?

1 A. Yes.

2 Q. And that was as a result of the work that you
3 had done with him, I think, your phrase was in
4 "titrating his medications"?

5 A. Yes.

6 Q. Okay. And the medications that you had been
7 prescribing for him, and that he was taking in July of
8 2010, you would agree with me that those were all
9 medically necessary?

10 A. Yes.

11 Q. And then you saw him next on December 14,
12 2010, which was a couple of weeks after he had been
13 released from the hospital?

14 A. Yes.

15 Q. Okay. Now, he was -- presented a somewhat
16 dramatically different picture at that point in time?

17 A. Yes.

18 Q. Okay. So much so -- and I'm not criticizing
19 your poetic license, but you described it as quite an
20 astounding adventure in the hospital, meaning that you
21 were personally quite surprised to hear the extent of
22 the illness that he had survived?

23 A. Yes.

24 Q. You noted that he was clearly debilitated?

25 A. Yes.

1 Q. All right. And that his chronic renal failure
2 had worsened; correct?

3 A. If I put that, I would say that the creatinine
4 that actually came -- well, that note was dictated
5 before we got the lab work back. So it's what his
6 creatinine actually was that dictates what his renal
7 function was. So he did have acute kidney injury in
8 the hospital. But once we got the lab work back, after
9 I dictated my note, it would suggest that it was back
10 to his usual chronic disease state.

11 Q. And he was still still anemic and receiving
12 these Aranesp injections?

13 A. Yes.

14 Q. And you don't disagree that many of his
15 pre-hospitalization medications had been discontinued
16 or changed; I think you said partly due to this kidney
17 injury?

18 A. Yes, all appropriately.

19 Q. You testified that you didn't feel comfortable
20 restarting him on some of those medications because of
21 his status when you saw him there in December?

22 A. That's correct.

23 Q. And you would agree that none of the things
24 that he experienced during his hospitalization were in
25 any way positive developments for him?

1 A. I would not, no.

2 Q. Thank you, Dr. Van Bakel. I don't have any
3 other questions.

4 THE COURT: Redirect.

5 **REDIRECT EXAMINATION BY MS. FLEMING:**

6 Q. Dr. Van Bakel, I do have one question for you.
7 Did anything that happened during Mr. Mikell's arrest
8 or subsequent hospitalization increase his risk of
9 death from -- risk of death after -- after -- when you
10 saw him in December of 2010?

11 A. No, I actually don't think so. Every measure
12 of his cardiac and renal function, after his
13 hospitalization was the same or better than what it was
14 before his hospitalization.

15 MS. FLEMING: Thank you. That's all I have.

16 THE COURT: Recross?

17 MR. RANSOM: Nothing further, Your Honor.

18 THE COURT: Okay. Doctor, you may step down.

19 Thank you very much. Call your next witness please.

20 MS. FLEMING: Thank you. The defense calls Dr.
21 Michael Zile.

22 DR. MICHAEL ZILE, after
23 having been duly sworn, testified as follows:

24 THE CLERK: Please state your first and last name,
25 spelling your last name loudly, clearly into the

DR. ZILE -- DIRECT

1 microphone.

2 THE WITNESS: Michael Zile, Z -- like in zebra --
3 /i-l-e.

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

5 Q. Dr. Zile, thank you. Could you tell the jury
6 a little bit about your educational background and
7 experience and -- training, I guess, and experience?

8 A. Yes, ma'am. I went to medical school in
9 Chicago at Rush University. I did an internal medicine
10 residency at Rush Presbyterian, St. Louis Hospital in
11 Chicago. And then I went to Boston to do a clinical
12 cardiology fellowship, followed by a research
13 cardiology function. And then I was on staff at the VA
14 Hospital in Boston until 1988, when I moved here to
15 Charleston in August of '88.

16 Q. And how long have you been with the Medical
17 University of South Carolina?

18 A. Since I arrived in August of 1988.

19 Q. And are you -- do you have any particular area
20 of specialty?

21 A. My special area is heart failure.

22 Q. And so, just to clarify, are you board
23 certified?

24 A. Yes, ma'am. I'm board certified in Internal
25 Medicine and board certificate in Cardiology.

DR. ZILE -- DIRECT

1 Q. And are you a member of any professional
2 organizations?

3 A. Several. I don't think you want me to list
4 all of them, but the American -- all the associations
5 that our cardiology group would be familiar with, the
6 American College of Cardiology, the American Heart
7 Association, the Heart Failure Society of America and
8 several others.

9 I was also the chairman of the committee that
10 makes the exam that all cardiologists have to take in
11 order to be board certified, which is called the
12 American Board of Internal Medicine. So I was not only
13 on that committee for ten years, but the chairman of
14 that committee. So most of the cardiologists around
15 the country right now will have a diploma with my name
16 signed on it because of that function.

17 Q. Now, do you currently hold any clinical
18 positions at MUSC?

19 A. I'm the Charles Ezra Daniel Professor of
20 Medicine at the Medical University.

21 Q. Now, it's my understanding that you actually
22 provided care to Mr. Mikell?

23 A. I did.

24 Q. And when did you first -- when did you first
25 meet -- when did you meet Mr. Mikell?

1 A. So Mr. Mikell was transferred from Roper
2 Hospital in 2003 to the Medical University. And during
3 that period of time, I was the physician in charge of
4 cardiology inpatient service. He came to my inpatient
5 service first.

6 Q. And do you recall what the reason -- why
7 Mr. Mikell was brought to MUSC in August of 2003?

8 A. Yes, ma'am. He had had a very severe episode
9 of low blood sugar, which we call hypoglycemia, and had
10 a loss of consciousness, and I believe a cardiac
11 arrest, was admitted to Roper Hospital. They felt that
12 he had severe congestive heart failure, and they wanted
13 to have the Medical University provide our expertise in
14 the care of heart patients for Mr. Mikell.

15 MS. FLEMING: And I'd like to go ahead and mark
16 for identification Defendant's Exhibit 8, please.

17 (WHEREUPON, Defendant's Exhibit No. 8 was marked
18 for identification.)

19 BY MS. FLEMING:

20 Q. Doctor, can you identify what's been marked
21 identification as Defendant's Exhibit 8?

22 A. These are clinical records from the Medical
23 University, which include hospital discharge summaries
24 from 2003, several echocardiograms, several out patient
25 notes from the time that I took care of Mr. Mikell. I

DR. ZILE -- DIRECT

1 don't think you want me to go through every one of
2 these, but --

3 Q. No, just identify the group.

4 A. So these appear to be my hospital notes and
5 the diagnostic tests that he had, and my out patient
6 clinic notes.

7 Q. Okay. Now, in 2003 when he came to be your
8 patient, you mentioned that he had been -- he had
9 had -- had an arrest at that point?

10 A. I think he had ventricular tachycardia that
11 was actually induced by the fact that he had this very,
12 very, very low blood sugar. His blood sugar was in the
13 30s. Most of you have blood sugars sitting here in
14 this room of about 100. So this would be two-thirds
15 reduction. And I think that's why he lost
16 consciousness and had irritability in his heart.

17 When people have a very, very low blood sugar,
18 they change a lot of things in their blood. They
19 change the PH or acidity in their blood. They change
20 the chemicals or electrolytes, potassium, for example.
21 And it puts people at risk for these kind of events.

22 Q. What was his prognosis when you first met him
23 in 2003?

24 A. So, Mr. Mikell had chronic heart failure. And
25 his -- if I recall his ejection fraction was between 40

DR. ZILE -- DIRECT

1 and 50, in that range. His five year mortality, the
2 chance of him dying within five years was 50 percent or
3 greater. The chance of him being hospitalized for
4 recurrent heart failure within six -- any six month
5 period of time was 50 percent.

6 His eight year mortality -- I'm sorry -- the
7 chances of him dying within eight years exceeded 80
8 percent. So his prognosis, from the point of view of
9 what his survival expectation would be, and what his
10 expectation of recurrent hospitalizations would be, are
11 the numbers that I just gave you. It's easy to
12 remember 50 percent in five years, and 50 percent for
13 hospitalizations in six months.

14 And that doesn't include -- when you say
15 prognosis, we also talk about how the patient actually
16 feels. And as Dr. Van Bakel's already testified, he
17 had symptoms of chronic heart failure. And the
18 disability that people have with chronic heart failure
19 is profound. There is -- as you've heard probably
20 testimony about Mr. Mikell, he had difficulty with
21 activities of daily living and -- and activities
22 outside, he had difficulties in daily living.

23 Q. Now, did -- did his prognosis change at any
24 point in time prior to or after his cardiac arrest in
25 October of 2010?

DR. ZILE -- DIRECT

1 A. The fact that he had chronic heart failure
2 throughout the time period from 2003 to 2010, his
3 morbidity -- I'm sorry, his chances of survival and his
4 chances of hospitalization, we call that morbidity and
5 mortality, were exactly the same. So the short answer
6 to your question is they were the same the first day I
7 saw him and the last that Dr. Van Bakel saw him.

8 Q. Now, the jury has heard a lot about heart
9 failure, cardiomyopathy, and ejection fraction. I'd
10 like to have you explain some of these things to them.

11 A. Sure.

12 Q. So just bear with me for a few minutes.

13 MR. RANSOM: Your Honor, if I may ask Ms. Fleming
14 to at least let me look at the records before she
15 starts publishing them to the jury that are on the
16 overhead right now.

17 MS. FLEMING: Oh, sure.

18 (PAUSE.)

19 MS. FLEMING: Your Honor, permission for the
20 witness to step down?

21 THE COURT: I'm sorry?

22 MS. FLEMING: May I have permission for the
23 witness to step down?

24 THE COURT: Yes, ma'am.

25 (The witness stepped down from the witness

1 stand.)

2 MR. RANSOM: Your Honor, could we approach for
3 just a moment?

4 THE COURT: Yes, sir.

5 (WHEREUPON, a bench conference was had.)

6 BY MS. FLEMING:

7 Q. Now, Dr. Zile, can you explain to the jury
8 what Mr. Mikell's heart condition was when you first --
9 when he first came to be your patient?

10 A. So, we use the word "chronic heart failure" --

11 MS. FLEMING: Your Honor, I'm sorry.

12 (Court reporter interruption.)

13 THE COURT: Where do you want him to stand so you
14 can hear -- all right. These boards sort of block the
15 sound. She's got to hear everything you said, so
16 please speak loudly. Okay. If I can't hear you, I
17 will tell you. If I can't hear you, she can't hear
18 you. Okay.

19 A. So patients with chronic heart failure have
20 abnormalities in the structure of the heart and the
21 function of the heart. And heart failure can be
22 divided roughly into two kinds of heart failure.
23 Mr. Mikell, actually, had both at different times. So
24 when I first saw him, this picture demonstrates the
25 main pumping chamber of the heart. This is a so-called

DR. ZILE -- DIRECT

1 left ventricle of the heart. Dr. Van Bakel explained
2 to you the concept of ejection fraction.

3 So ejection fraction means when the heart is
4 fully relaxed and full of blood -- for example, there's
5 a 100 ml, milliliters of blood. When it develops force
6 and contracts, there's 50 mls left. So a hundred to
7 start with, 50 left, that means 50 went out. That
8 percentage is a 50 percent fraction of ejection for
9 ejection fraction.

10 So people with heart failure that have an
11 abnormality to refill the heart have a normal ejection
12 fraction, but their heart muscles are thicker than
13 normal. It contracts normally, but it doesn't relax.
14 And because it doesn't relax normally, the pressures in
15 the lungs go up. So people develop fluid in their
16 lungs and fluid in their feet, and that's part of the
17 clinical syndrome of chronic heart failure. Dr. Van
18 Bakel mentioned both of those things.

19 Mr. Mikell also developed an abnormality that's
20 called systolic heart failure in which his ejection
21 fraction during periods of time actually fell. So if
22 you look at the timeline -- can I put this back up?

23 Q. Yes, sir. Please. Uh-huh.

24 A. If you look at the timeline of when I first
25 saw him, you know, in 2001, it says non-ischemic

DR. ZILE -- DIRECT

1 cardiopathy ejection fraction 20 to 30 percent. When I
2 saw him, his ejection fracture was 40 to 50 percent.
3 But if you follow this through the whole course, there
4 were times which, because of other reasons, he
5 developed rhythm abnormalities in his atrium. His
6 ejection fraction fell, and his heart transitioned to
7 this more dilated state. In other words, you know,
8 bigger than normal, and it didn't eject normally. And
9 through the care that we provided, we were able to pull
10 him back towards this kind of heart failure, but he
11 also had chronic heart failure.

12 When -- when we use the term cardiomyopathy --
13 cardiomyopathy, if you break it down, cardio, heart;
14 myo, muscle; pathy, pathology. So he had a heart
15 muscle pathology. This is a heart muscle pathology.
16 This is a heart muscle pathology. So depending on
17 where we were in his treatment, and where he was in his
18 course, he sort of transitioned back and forth between
19 these two. But he always had heart failure.

20 And Ms. Fleming asked what was his outlook here
21 versus his outlook here, exactly the same. Whether he
22 had an ejection fraction of 25 percent, or whether he
23 had an ejection fraction of 50 percent, chances of
24 dying were exactly the same.

25 Q. And why is that, Dr. Zile?

DR. ZILE -- DIRECT

1 A. Well -- well, the short answer to that is --

2 MR. RANSOM: Your Honor, if I can interpose an
3 objection.

4 THE COURT: What's your legal objection?

5 MR. RANSOM: Well, again, now we're getting into
6 this business about opinions, about his chances of
7 dying. And I think that's beyond the scope --

8 THE COURT: Just let him testify to his treatment
9 of the patient, please, ma'am.

10 MS. FLEMING: I think that it's -- may I approach?

11 THE COURT: Let him testify about his treatment
12 that he administered to the patient; okay. And then
13 his -- and then his condition when he discharged him;
14 okay?

15 MR. COOKE: Your Honor, I think we need to take
16 this matter up if we can.

17 THE COURT: Well, let me hear the question. He
18 can testify to his treatment. He can testify to what
19 what happened when he was discharged, and how
20 successful the treatment was. Okay. Let's keep it to
21 his treatment.

22 BY MS. FLEMING:

23 Q. Dr. Zile, in treating Mr. Mikell, was it
24 important to you to be able to assess his long term
25 prognosis throughout the course of your treatment?

1 A. Yes.

2 Q. And why -- why was that important?

3 A. Because it's important to make the patient
4 aware, to make the family aware, what his outlook was
5 like, to provide as high a level of care as we possibly
6 could. And in part, that's why I referred him in 2009
7 to Dr. Van Bakel.

8 Q. You may sit down if that's more comfortable.

9 (The witness returned to the witness stand.)

10 THE COURT: For the record, the motion is denied.
11 Okay. At this point in time.

12 MR. RANSOM: Thank you, Your Honor. I would also
13 move to strike --

14 THE COURT: Pardon?

15 MR. RANSOM: I would also move to strike the
16 opinion testimony.

17 THE COURT: All right. Let me see the lawyers up
18 here on that one.

19 (WHEREUPON, a bench conference was had.)

20 THE COURT: All right. Madam Forelady, ladies and
21 gentlemen of the jury, I'm going to have to ask you to
22 leave the -- leave the courtroom so I can listen to the
23 attorneys on this motion, and they feel free to comment
24 on the facts. Don't discuss the case amongst
25 yourselves.

DR. ZILE -- DIRECT

1 (WHEREUPON, the jury leaves the courtroom at
2 3:35 p.m.)

3 THE COURT: All right. I understand the
4 plaintiff's objection is that this doctor -- I'm
5 sorry -- I don't remember his name --

6 THE WITNESS: Zile.

7 THE COURT: Zile is going to give an opinion; is
8 that correct?

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

10 THE COURT: All right. What's your legal
11 objection?

12 MR. RANSOM: Okay. First and most important, Dr.
13 Zile has never been identified by the Medical
14 University as an expert witness who is going to provide
15 opinion testimony in this case. He, of course, is one
16 of Mr. Mikell's treating physicians. And in that
17 context, his deposition has been taken so that we could
18 learn what the care that was provided to
19 Mr. Mikell, and to see what was in his records and ask
20 him about things that was taking place with
21 Mr. Mikell's treatment and care.

22 So we've not been given any notice that they
23 were intending to call Dr. Zile as a witness, to start
24 rendering opinions -- for example, about what the
25 likely chance of him dropping dead at any moment might

DR. ZILE -- DIRECT

1 be..

2 Secondly, Judge, is Mr. Cooke was arguing two
3 days ago, you know, there's a standard that has to be
4 met in the admission of evidence. And we haven't
5 heard, for example, that it's more likely than not that
6 Mr. Mikell was going to die within five months or
7 within five years. And so from that standpoint, these
8 opinions don't have sufficient scientific reliability
9 to merit being presented to the jury because we're
10 simply feeding this notion that they're going to
11 speculate about what his life expectancy was.

12 So he's not been identified. They haven't lay a
13 foundation.. His opinions don't meet the necessary
14 standard for admissibility in the evidence. And those
15 are the things --

16 THE COURT: Okay. Ms. Fleming, I'll be glad to
17 hear you. I believe it's your witness.

18 (PAUSE.)

19 THE COURT: Let me hear your arguments. I'll let
20 you confer with your counsel before you finish your
21 arguments. Okay.

22 MS. FLEMING: Okay.

23 THE COURT: Let me just tell you my problem; okay?

24 MS. FLEMING: Okay.

25 THE COURT: So you'll know, and you can address

DR. ZILE -- DIRECT

1 it. Yesterday Mr. Cooke was arguing about allowing --
2 or whenever it was -- the testimony about the cause of
3 death, because he hadn't been notified. At least he
4 did -- was notified some eight to ten days, a week
5 prior to the trial. And here today in the trial,
6 you're wanting to offer this guy as an expert without
7 any notice except right now.

8 Now, that's my difficulty. He hadn't been
9 identified as an expert. He's been identified as a
10 fact witness. He can testify about the facts all day
11 long. He can testify about the treatment. He can
12 testify about how sick he was. He can testify about
13 his -- anything concerning his treatment of this
14 individual. But to get into the fact about his life
15 expectancy, his possibility of dying and giving those
16 opinions, I'm inclined not to allow it because you
17 haven't identified him as such. That's my problem.

18 MS. FLEMING: Your Honor, well, two issues --

19 THE COURT: Do you understand my -- my concern --

20 MS. FLEMING: I do. And I'd like to just point
21 out two things. One, he's testified that the
22 prognosis, long term mortality rate, whatever you want
23 to call it, is relevant to his treatment of a patient.

24 THE COURT: I -- I don't have any problem with him
25 giving his prognosis for the patient, but that

DR. ZILE -- DIRECT

1 shouldn't come in as an opinion about whether he's
2 going to die, not die, or any possibilities of him
3 dying.

4 MS. FLEMING: Well, and secondly --

5 THE COURT: He can give his prognosis all day.
6 That's part of the fact witness.

7 MS. FLEMING: Well, Your Honor, secondly, this
8 witness was deposed on October 7th of 2014 by Mr.
9 Ransom. And Mr. Ransom asked him whether he had an
10 opinion --

11 THE COURT: Well, I understand that.

12 MS. FLEMING: -- as to the cause of death at that
13 time --

14 THE COURT: I understand that.

15 MS. FLEMING: -- and he testified to that --

16 THE COURT: I have no problem with that. But he
17 took the deposition as a fact witness, and you know it
18 make a difference.

19 MS. FLEMING: Well, in all fairness he asked the
20 witness in his deposition what materials he reviewed
21 prior to the deposition, and it included a number of --
22 it included basically the whole file, a number of
23 depositions. He had -- he's had notice of Dr. Zile's
24 opinions since the Fall of 2014.

25 So -- and -- and what better witness than his

DR. ZILE -- DIRECT

1 own cardiologist to testify about his heart condition
2 and how it affected his overall risk of death.

3 THE COURT: Well, I don't have any problem with
4 that argument. My problem is you never told the other
5 side, hey, he's going to be an expert witness. I'm
6 going to qualify him. He's going to give some
7 opinions, and give a synopsis of those opinions. I
8 think that's what the rule requires. That has not been
9 done.

10 And I know, on the other hand, it was late but
11 at least you knew before he walked in the courthouse in
12 the middle of trial. Now, that's my problem. Now, if
13 you want to talk to Mr. Cooke, I'll be glad for you to
14 talk to him and continue your arguments. Okay.

15 (PAUSE.)

16 MS. FLEMING: Your Honor, I think our position is
17 that the -- the best remedy to the plaintiff's late
18 notice with regard to Dr. Kofke's opinion, is to allow
19 Dr. Zile to testify regarding causation.

20 And, secondly, he was notified -- this isn't a
21 situation where he was never notified. He was asked
22 outright in his deposition, do you have any opinions
23 regarding cause of death.

24 And, third, this is -- his testimony is a
25 natural flow of his treatment of this patient. I don't

DR. ZILE -- DIRECT

1 know how you can separate the two. They are so -- they
2 are so related.

3 THE COURT: Well, maybe you and I are having a
4 difficulty with the word "prognosis". I have no
5 problem with him giving the prognosis on his discharge
6 and whatever happened to him as far as treatment is
7 concerned. That doesn't mean I'm going to let him give
8 an opinion as to his probabilities of dying or not
9 dying, or whatever he's going to say.

10 Now, if you want me to listen to the testimony
11 while the jury is out, I'll be happy to do that. I'll
12 give you that benefit, and listen to it if you want to
13 do that.

14 MS. FLEMING: Yes, we'll do that.

15 THE COURT: Pardon?

16 MS. FLEMING: We'll do that, please. We'd like
17 for you to do that.

18 THE COURT: I want to hear where you're going and
19 what kind of opinion you're to get from it. I have no
20 problem if you're giving prognosis, but that doesn't
21 mean he's going to give some type of opinion. Okay.
22 And it -- maybe it's a fine line, and it probably is a
23 fine line in this case.

24 BY MS. FLEMING:

25 Q. So, I think where we left off was -- Dr. Zile,

DR. ZILE -- DIRECT

1 did Mr. Mikell's long term prognosis change in any way
2 between the time that you first saw him in 2003, and
3 December of -- or I'm sorry, January of 2011, when he
4 died?

5 A. No.

6 Q. And can you please state the basis or explain
7 why his prognosis did not change?

8 A. So his clinical diagnosis was chronic heart
9 failure. That never changed. He always had chronic
10 heart failure. If you -- if you look at all of the
11 literature in -- in -- in the published literature,
12 some of -- many of which I am the author of, and you
13 ask the question what's the natural history and treated
14 history of chronic heart failure, and you draw a
15 survival curve -- so -- from the time that you see
16 somebody, and you -- and you ask the question how many
17 people survive at year one, two, three, four, five and
18 so on, the -- the -- the -- for any new patient with
19 chronic heart failure, at any point in time, the next
20 five years are latent with the fact that 50 percent of
21 the people die during that five years.

22 And if you ask further the question of, do
23 they -- do they get hospitalized with heart failure --
24 for recurrent heart failure, the answer is on a six
25 month basis, there is a 50 percent chance that they

DR. ZILE -- DIRECT

1 will be rehospitalized at -- at any -- at any given
2 time of observation. So those are -- those are numbers
3 which we understand as -- we, in the heart failure
4 world, who take care of patients, understand those are
5 the risks. And those are our own observations, and
6 then those are the published observations in the
7 world's literature.

8 (THE COURT: Let me -- let me see his prognosis
9 sheet upon discharge; have you got one?

10 MS. FLEMING: There is not -- that's not stated in
11 the medical records.

12 THE COURT: That's not in any of his medical
13 records?

14 MR. RANSOM: Judge, I got my last office note that
15 Dr. Zile saw Mr. Mikell on April 30, 2010. This is
16 Plaintiff's Exhibit 37. And his impression was "I
17 believe this patient is doing exceedingly well at this
18 point".

19 (PAUSE.)

20 THE COURT: Let me give that back to you. All
21 right. Anything else you want to ask the doctor before
22 I rule?

23 MS. FLEMING: Yes, please.

24 BY MS. FLEMING:

25 Q. Dr. Zile, why is it important for you, as

DR. ZILE -- DIRECT

1 Mr. Mikell's -- any patient's treating physician, to
2 understand and know a patient's short and long term
3 prognosis in the course of your treatment?

4 A. It dictates how you take care of them.

5 Q. And in this instance, did it dictate or affect
6 how you took -- how you took care of Mr. Mikell?

7 A. Yes.

8 Q. And how so?

9 A. By the -- by the drug -- the treatment regimen
10 that we provided, by the level of monitoring of those
11 treatment regimens. And in the end, when Mr. Mikell's
12 condition became more and more difficult to manage, to
13 refer him to a health care setting in which the
14 intensity and care could be raised.

15 So I, as a single practitioner, have a nurse
16 that's available to me intermittingly. Dr. Van Bakel,
17 in the Heart Failure Clinic, has nurses and advanced
18 practice nurses available to him five day a week. So
19 the ease with which patients can be followed, almost on
20 a daily basis, is possible in the Heart Failure
21 Transplant Clinic, where it's not possible in my
22 clinic.

23 So knowing what his prognosis was, knowing what
24 his recent past history was, knowing when he had been
25 hospitalized, and what his condition was after

DR. ZILE -- DIRECT

1 hospitalization, dictated the choices that I made for
2 therapy and management.

3 Q. So it -- it dictated your decision to refer
4 him to Dr. Van Bakel in early 2010?

5 A. Yes.

6 Q. And, Dr. Zile, is it possible -- is there
7 any -- is there any possibility, to a reasonable degree
8 of certainty, most probably to determine Mr. Mikell's
9 cause of death?

10 A. Cause of death?

11 Q. Yes.

12 A. No.

13 Q. And why is that?

14 A. Because at the time we know that no autopsy
15 was performed. It was not witnessed. And, therefore,
16 causality can't be assigned. If you ask the question a
17 different way, and we can assign a mode of death, which
18 is as close as we can get.

19 Now, a mode of death is a terminology that's
20 used when we study these kinds of patients in clinical
21 studies, and we try to examine the underlying path of
22 physiology, the disease -- the natural history of the
23 disease. And the word "mode" refers to an
24 observational term. So the observational term, in
25 terms of mode of death for this patient, is called

DR. ZILE -- DIRECT

1 sudden death which means that it's an unexpected event
2 of -- of dying within 24 hours of being seen by -- by
3 anybody else.

4 Q. And is that consistent with how you testified
5 in your deposition?

6 A. Yes.

7 Q. And based upon your treatment of patients with
8 heart failure, including Mr. Mikell -- particularly in
9 patients with perceive with ejection fraction, are you
10 able to -- or is there any -- any research or
11 literature that you rely on -- rely on in order to
12 determine whether a patient -- or whether Mr. Mikell
13 died from a cardiovascular cause?

14 A. Yes.

15 Q. And what -- what do you --

16 A. So there -- there are number of studies that
17 have examined in a method that we call epidemiology,
18 which is the history of natural -- the natural history
19 of the disease. And those data demonstrate that 50
20 percent of the time, people die from non-cardiovascular
21 causes; 50 percent of the time they die from
22 cardiovascular related causes.

23 Q. So is there any way to determine, in this
24 instance, whether -- actually let me back up. We've
25 heard from Dr. Van Bakel that Mr. Mikell was not

DR. ZILE -- DIRECT

1 restarted on his Tikosyn or his Coumadin following his
2 discharge from Kindred Hospital. Did you -- as a
3 treating physician, as his treating physician, did you
4 disagree with any of those changes?

5 A. No.

6 Q. And were those medications indicated at that
7 time?

8 A. Tikosyn and Coumadin, at the time that Dr. Van
9 Bakel saw him following the Kindred hospitalization,
10 were not indicated at that time.

11 Q. Would you, yourself, have put him back on
12 Tikosyn or Coumadin?

13 A. No, ma'am.

14 Q. Did the fact that he was not on Tikosyn or
15 Coumadin make him more susceptible to suffering any
16 type of arrhythmia, pulmonary embolism, or blood clot?

17 A. No.

18 Q. And why do you -- why do you hold that
19 opinion?

20 A. His Tikosyn was used to suppress his rhythms
21 that belong to the atrial arrhythmia category. It had
22 been several -- it had been a substantial period of
23 time since he had the last atrial arrhythmia, so there
24 was no indication to restart Tikosyn at that point.
25 Because he didn't have any arrhythmias -- I mean, he

DR. ZILE -- DIRECT

1 was on Coumadin because he had had intermittently
2 arrhythmias between the 2003 and 2009 range. But once
3 the arrhythmias were absent, then there was no
4 indication for Coumadin.

5 MS. FLEMING: I think that's all, Your Honor.
6 Thank you.

7 THE COURT: Okay. All right. I -- you're trying
8 to get into opinions that I think go beyond prognosis,
9 go beyond that, especially about the percentage of
10 people for five years, and how many die, how many
11 don't. And I'm just not going to allow that opinion.

12 If you -- if you had given notice that you were
13 going to qualify him as expert, I think he would be
14 perfectly qualified, but that hasn't happened. I'm not
15 going to allow it at this point in time in the trial.

16 Now, as far as the treating physician, he's
17 going to be limited to what he did as the treating
18 physician, and any prognosis he gave to him upon
19 discharge. Okay?

20 MS. FLEMING: That's fine, prognosis upon
21 discharge?

22 THE COURT: Pardon?

23 MS. FLEMING: Prognosis upon discharge?

24 THE COURT: Yeah.

25 MS. FLEMING: Yeah.

DR. ZILE -- DIRECT

1 THE COURT: Is it in writing?

2 MS. FLEMING: Well, let me --

3 THE COURT: I mean, has he produced it to writing
4 or has he come up with it now?

5 MS. FLEMING: No, I don't think you write in a
6 patient's medical record --

7 THE COURT: Well, a lot of records have prognosis.
8 I don't know if this one does because I haven't seen
9 the records.

10 MS. FLEMING: It's contextural. I mean, I think
11 that what you were shown was a little bit of a
12 misrepresentation, you're talking about a patient --

13 THE COURT: What I was shown is that -- is that
14 this doctor's medical records?

15 MS. FLEMING: Yeah.

16 THE COURT: Of Mr. Mikell?

17 MS. FLEMING: It is.

18 THE COURT: It is? Well, let me -- that's all --
19 that's all we have is that two pages?

20 MS. FLEMING: No. No. No. No. That entire
21 stack of records that Dr. Zile identified --

22 THE COURT: All right. Well, what does it say on
23 discharge? That's what I'm asking you?

24 MS. FLEMING: He never discharged him.

25 THE COURT: Pardon?

DR. ZILE -- DIRECT

1 MS. FLEMING: He was never discharged from his
2 care.

3 THE COURT: He never discharged him?

4 MS. FLEMING: No. He -- I think the testimony has
5 been that he was continuing to treat him.

6 THE COURT: Okay. I'm going to allow him to
7 testify what he did for the patient, how he treated the
8 patient. Okay. If he didn't discharge, there's no
9 prognosis. He -- he can testify what he did for the
10 patient, and how he treated the patient, and the
11 problems he had with the patient.

12 As far as these opinions, don't get me wrong,
13 Doctor, I think you're qualified to give these
14 opinions. The problem is they haven't identified you
15 before today. Okay. Yes, sir?

16 MR. RANSOM: We would renew our motion to strike
17 the opinions that were given.

18 THE COURT: I'm not -- no, denied. Okay?

19 MS. FLEMING: Yes, thank you.

20 THE COURT: Any question about it?

21 MS. FLEMING: No.

22 THE COURT: Is there anything else you want to
23 proffer?

24 MS. FLEMING: I don't --

25 THE COURT: I don't want to cut your proffer off.

DR. ZILE -- DIRECT

1 MS. FLEMING: Not at this time.

2 THE COURT: Well, this is the only opportunity I'm
3 going to give you to proffer.

4 MS. FLEMING: I think we've covered everything.

5 THE COURT: I'm not going to send the jury out for
6 any more proffers. That's why I want to do it all now.

7 MS. FLEMING: No.

8 THE COURT: Mr. Cooke, is there anything you want
9 to proffer? I'll give you an opportunity to do that.
10 Because I just don't want to have to bring the jury
11 back in and back out to proffer whatever you want to
12 proffer.

13 MR. COOKE: No, Your Honor. I just don't want to
14 run afoul of your ruling.

15 THE COURT: If you do, I'll let you know. Okay.
16 I'll say something -- I'll say something -- I'll call
17 her up here quietly; okay? I'm not going to yell at
18 her or get mad at her; okay?

19 MR. COOKE: I just want to say, I told her that I
20 thought it was within your ruling she could ask those
21 last questions about, did you believe that he still
22 needed to be on Tikosyn or --

23 THE COURT: I don't have any problem with that. I
24 think that's part of his treatment process. I don't
25 have any problem with that.

DR. ZILE -- DIRECT

1 I do have a problem with him talking about the
2 percentages, how many people die after five years, et
3 cetera, et cetera, et cetera; okay? Ms. Fleming, do
4 you understand?

5 MS. FLEMING: I do. Thank you.

6 THE COURT: Okay. Yes, sir.

7 MR. RANSOM: If -- and, Judge, to be clear about
8 this, so we've already heard from Dr. Van Bakel about
9 the management of the medications, including the
10 Tikosyn. And Dr. Van Bakel saw Mr. Mikell several
11 times after Dr. Van -- Dr. Zile last saw him. And so I
12 think that any further testimony about all of that
13 would be --

14 THE COURT: Have you ever heard the statement,
15 you've got part of the hog, now you're asking for the
16 whole hog?

17 MR. RANSOM: Yes, sir.

18 THE COURT: No, sir, denied.

19 MR. RANSOM: Thank you.

20 THE COURT: Now, let me see you a second.

21 (PAUSE.)

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

23 COURT REPORTER: Can I have a--

24 THE COURT: Do you want to take a short break --
25 all right. We'll take about a ten minute break.

DR. ZILE -- DIRECT

1 MR. RANSOM: And -- and forgive me, Mr. Apostolou
2 has just whispered in my ear --

3 THE COURT: I'm sorry, what?

4 MR. RANSOM: Mr. Apostolou has just pointed out to
5 me a very cogent point that I want to make to the
6 court.

7 THE COURT: Okay.

8 MR. RANSOM: And that is, you know, Dr. Zile did
9 not ever see Mr. Mikell again after April 30th of 2010,
10 so he didn't even know that any of those medications
11 had been changed. So he doesn't have any knowledge
12 about any of that.

13 THE COURT: I thought he --

14 MR. RANSOM: So any opinion -- any testimony he
15 might give about that must necessarily be opinion in
16 nature. The last time he ever saw Mr. Mikell was on
17 April 10th of -- or, yeah, April 30th of 2010, at which
18 point in time, he said I believe this patient is doing
19 exceedingly well at this point. He didn't even know
20 that any of the medications had been changed.

21 THE COURT: How about asking him what medications
22 he was on then on April the -- April 20th of 2010 to
23 his knowledge.

24 MS. FLEMING: May I ask another question in
25 addition to that?

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1 THE COURT: Yeah. You can ask what you want about
2 the medications. I'm going to find out what he knows
3 and what he doesn't know, not what he's read or
4 somebody has told him. What he knows about his
5 patient.

6 BY MS. FLEMING:

7 Q. Dr. Zile, was Mr. Mikell, even after you
8 referred him to Dr. Van Bakel, did he remain your
9 patient?

10 A. Yes.

11 Q. Okay. And so this very last note appears to
12 be April -- from April, 2010, was Mr. Mikell still your
13 patient in December of 2010?

14 A. Yes.

15 Q. Okay. And what -- what medications was he on
16 when you saw him in April of 2010?

17 A. I mean, I can't give you that from memory.
18 But if you point out the note that corresponds to that,
19 I can read them.

20 Q. Sure. I'll find it for you.

21 MR. RANSOM: I've got it right here.

22 (Document handed to witness.)

23 A. So this is my note, addressed to Jeff Akhtar,
24 who is his primary care physician. All right. And I
25 note, Flonase, Zaroxolyn, aspirin, Bidil, --

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1 COURT REPORTER: I'm sorry.

2 THE COURT: Slow down so she can take it down,
3 please, sir.

4 A. I'm sorry. Flonase, Zaroxolyn --

5 THE COURT: Do you need them spelled?

6 COURT REPORTER: No, I can -- as long as I can get
7 them.

8 THE COURT: Okay.

9 THE WITNESS: Aspirin.

10 THE COURT: Bayer?

11 THE WITNESS: I think --

12 THE COURT: -- or St. Paul -- St. Phillips, excuse
13 me.

14 THE WITNESS: I think we can go with the generic
15 aspirin.

16 THE COURT: Okay. All right.

17 THE WITNESS: But Bayer Aspirin is a good choice.

18 THE COURT: Bayer Aspirin is a good choice?

19 THE WITNESS: Yes, sir.

20 THE COURT: Okay.

21 THE WITNESS: Bidil, Atrovent, Lasix, Insulin,
22 Tikosyn, Warfarin, Omeprazole, Metoprolol, Crestor,
23 potassium, Fosinophril. There are a couple that I
24 didn't mention, but they're really not important to the
25 cardiac situation. There's compression stockings and

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1 there's CPAP in there, but those aren't really
2 medications.

3 Q. Now --

4 THE COURT: I think he's concerned about the
5 Coumadin and the Toporal(sic).

6 MS. FLEMING: And the Tikosyn.

7 THE COURT: Tikosyn. Tikosyn. And the....?

8 MS. FLEMING: And the Coumadin.

9 THE COURT: Coumadin?

10 MS. FLEMING: Yes.

11 THE COURT: I think he said he was on those two,
12 right?

13 MS. FLEMING: At that time, yes.

14 THE COURT: I don't have any problem if -- you
15 asking him -- assuming, would it be appropriate with a
16 person that had a cardiac arrest to take those -- that
17 person off those medications.

18 MS. FLEMING: Okay.

19 THE COURT: Okay. I'll let you do that.

20 MR. RANSOM: My concern, Judge, was with --

21 THE COURT: I know you've got a concern, but I'm
22 going to -- I'm going to allow her to do it. Okay.

23 MR. RANSOM: Judge, if I may --

24 THE COURT: Right or wrong, I'm going to let her
25 do it.

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1 MR. RANSOM: May -- may I be heard?

2 THE COURT: Yeah, I guess so.)

3 MR. RANSOM: So my concern --

4 THE COURT: I'm getting tired of listening now,
5 but go ahead.

6 MR. RANSOM: My concern, Judge, was with the
7 testimony during the proffer, where he said that after
8 Mr. Mikell was released from the hospital, restarting
9 those medications was not indicated. And my point is
10 Dr. Zile never saw him after he came out of the
11 hospital; how could he know what was and wasn't in
12 there?

13 THE COURT: Like I said, I'm going to let her ask
14 him, assuming his patient had a cardiac arrest, would
15 it be appropriate for treatment to take him off those
16 two medications, is what I'm going to let her do.

17 MR. RANSOM: Thank you, Your Honor.

18 THE COURT: Okay. But thank you for your
19 argument. I appreciate it. Your motion is denied.
20 Ms. Fleming, are we on the same page?

21 MS. FLEMING: We are. And if I run afoul, just
22 please call me up.

23 THE COURT: Is there anything else we need to take
24 up while the jury is out?

25 MS. FLEMING: No.

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1 THE COURT: All right. We're going to take about
2 a ten minute break. Thank y'all so very much. Doctor,
3 you may step down. Don't talk to anybody about the
4 case during the trial; okay -- or during break.

5 THE WITNESS: Yes, sir.

6 (WHEREUPON, a brief recess was taken.)

7 THE COURT: Anything before we bring the jury?

8 MR. RANSOM: Nothing from the plaintiff.

9 THE COURT: Anything from the defendant?

10 MS. FLEMING: Nothing.

11 THE COURT: Okay. Bring us the jury, please.

12 (WHEREUPON, the jury enters the courtroom at
13 approximately 4:27 p.m.)

14 THE BAILIFF: All jurors are present, sir.

15 THE COURT: Thank you very much. If you'll
16 continue, please. Direct.

17 MS. FLEMING: Thank you.

18 BY MS. FLEMING:

19 Q. Now, Dr. Zile, when we left off, we were
20 talking about Mr. Mikell's cardiac history. And I
21 think you mentioned that he had several inpatient or --
22 while he was under your care, did he have several
23 inpatient hospitalizations due to his heart failure?

24 A. And his arrhythmias, yes, both.

25 Q. Okay. Now, you see the timeline that's put up

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1 in front of you. It looks like he had an admission in
2 October of 2005, what was that related to?

3 A. Okay. Yes. So, October -- so it's 10/4/05, I
4 think. It's a little hard for you guys to try to read
5 this. It's a little hard for me to read this.

6 Q. Sure.

7 A. But 02/04/05 (sic), he was admitted for the
8 treatment of his atrial arrhythmia. And the reason
9 that he was admitted was because he had become more
10 symptomatic.

11 You can see in September of '05, his ejection
12 fraction all the way to the end of the record there,
13 says "ejection fraction 20 to 30 percent". So there
14 was an indication at that point that his heart
15 failure -- his -- his -- the -- the status of his
16 pumping chamber, the left ventricle, had gotten
17 somewhat worse. His symptoms were persistent.

18 And so the treatment of choice, in terms of
19 management then, was to try to get rid of this atrium
20 arrhythmia, which included doing an electro cardio
21 version.

22 Q. And so after that, were you able to -- were
23 you able to treat his ejection fraction and achieve
24 some improvement in that?

25 A. It took a while. If you -- if you push up the

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1 record there a little farther for me to see, you can
2 see that there were a number of other echocardiograms
3 which eventually -- if you go all the way down to
4 10/20/06, it got up to 34 percent. And on February of
5 2008, it actually reached almost 50 percent -- or about
6 50 percent. So the care -- his care, in terms of
7 improving the structure and function of his heart,
8 included changing his medications, treating these
9 atrial arrhythmias with several different techniques.
10 But we were able to eventually get his ejection
11 fraction somewhat better, or towards a better condition
12 in terms of the structure and function of his heart.

13 Q. Now, in February of 2008, did you refer him to
14 cardiac rehab at MUSC?

15 A. Yes, I did.

16 Q. And what is cardiac rehab?

17 A. So, Mr. Mikell continued to have significant
18 symptoms of dyspnea, shortness -- sorry -- shortness of
19 breath with activity, and a limited tolerance to
20 exercise to a degree that he wished, and we wished for
21 him to have. So cardiac rehab is an organized
22 monitored structured program in which exercise is
23 gradually introduced to the patient, and exercise is
24 monitored in terms of blood pressure and EKG and
25 symptoms.

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1 So it includes several different aspects,
2 walking on a treadmill. Those people who can't walk on
3 a treadmill because they have orthopedic injuries,
4 would do arm exercises. There's lifting weights, that
5 are light weights, and they are taught how to do it
6 correctly.

7 So cardiac rehab is an organized, step wise
8 program to increase people's exercise tolerance,
9 strength. And also cardiac rehab does teaching about
10 diets and food control, salt intake, and -- you know,
11 all those things are part of cardiac rehab.

12 Q: And did you personally talk with Mr. Mikell
13 about factors that he, himself, could do to try to help
14 improve his heart function?

15 A. Yes, we did. We -- Mr. Mikell and I spent a
16 lot of time talking about what -- the other factors
17 which contributed to his heart failure and to his
18 symptoms were. We talked about his sleep apnea and the
19 need to continue to use the CPAP mask at night time or
20 whenever he slept.

21 We talked about the control of his diabetes,
22 which is a difficult issue. We talked about his diet,
23 both in terms of controlling the diabetes and in
24 controlling the amount of salt that was in his diet.
25 Sodium chloride, salt is the thing that poses a problem

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1 with patients with heart failure. We talked about how
2 much fluid he was drinking. And we talked about his
3 overall weight..

4 Mr. Mikell suffered from -- from being
5 significantly overweight for a -- for a considerable
6 period of time. We even talked about doing surgery for
7 that at one point. So it was something that we talked
8 about every time that I -- we, as a team, talked about
9 every time we saw him, to try to emphasize the
10 importance of that.

11 Q. And overall, was he compliant with your
12 recommendations?

13 A. He did pretty well. There were times where he
14 slipped. I suspect that anybody that's been on a diet
15 knows what I'm talking about. There were times when he
16 was able to follow our advice more strictly. There
17 were times where he had more difficulty.

18 Q. Now, in -- in August of 2009, did he have
19 another inpatient admission to MUSC?

20 A. Yeah, it was pretty severe. As I remember, he
21 had a great deal of swelling. And not to be indelicate
22 about this, but he had swelling in his legs. He had
23 swelling in abdomen.. He actually had swelling in his
24 scrotum. And it was difficult for him to walk or sit.
25 And that -- that posed a real series of just quieting

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1 symptoms for him.

2 Q. Now, did you continue to treat him after he
3 was discharged in August of 2009?

4 A. Yeah. We tried very hard to ramp up the level
5 of follow-up. We were seeing him -- when I say "we", I
6 mean the nurse practitioners, who work in cardiology.
7 It's not really their job to do that, I sort of asked,
8 as a favor to me and to Mr. Mikell, you know -- we had
9 two or three different nurse practitioners. I asked
10 them, could they please, over and above their job
11 description, could they see Mr. Mikell almost every
12 other day. They were willing to do that.

13 They -- that allowed us to look at him from
14 day-to-day, and see how much water pill medicine, how
15 much diuresis we could get. How he was doing. We
16 asked him to weigh himself every day. We weighed him.
17 So we were seeing him extremely frequently. At some --
18 some weeks, three times in a week, which is pretty hard
19 to maintain.

20 Q. Now, during the time that you cared for
21 Mr. Mikell, did you have any discussions with him about
22 his prognosis?

23 A. Several times. As a matter of practice, every
24 patient that I have who has a new diagnosis of heart
25 failure, regardless of what their ejection fraction, I

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1 sit down with him and when the family is available --
2 with the family. We start that in the hospital. We
3 continue that as an outpatient. And I know that we had
4 several conversations with Mr. Mikell, including the
5 time that we talked to him about being in an
6 experimental program to look at new device therapy, new
7 medical therapy. We sat down and we said specifically,
8 this is why we're concerned about you. These are the
9 things that we are worried about. We gave him actual
10 numbers. So I sat down and looked at Mr. Mikell,
11 eyeball-to-eyeball, and said this is a very serious
12 condition. The chances of you dying are 50 percent in
13 five years. This is what I tell every single patient
14 that I see --

15 MR. RANSOM: Objection, Your Honor.

16 THE COURT: What is your legal objection?

17 MR. RANSOM: The same issue that we argued about
18 previously.

19 THE COURT: I'm sorry?

20 MR. RANSOM: I said the same issue that you ruled
21 on previously.

22 THE COURT: All right. Overruled. Let's don't go
23 any further. Okay.

24 A. So -- so in answer to your questions, this was
25 a conversation that I had with Mr. Mikell on several

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1 occasions. I don't think I said it to him every single
2 time. It gets a little worrisome for patients to hear
3 how sick they are, but there were periods when it was
4 important to emphasize to him, you know, what -- what
5 the dangers, and how hard he needed to work. How hard
6 we were working. And I think we got the message pretty
7 clear to Mr. Mikell. I think he understood.

8 BY MS. FLEMING:

9 Q. Now, at some point, you referred him to your
10 colleague, Dr. Van Bakel, in the Heart Failure Clinic.
11 And why did you -- why did you do that?

12 A. It was unsustainable to see him as frequently
13 as we needed -- we thought we needed to see him. So
14 Dr. Van Bakel has a clinic situation, which he has
15 nurses available to him every single day, nurse --
16 advance practice nurses, nurse practitioners or
17 physician's assistant, so that -- so that I'm not
18 asking a favor of somebody, or somebody to go beyond
19 the -- the description of their job. So -- so he had
20 the -- the Heart Failure Clinic has the resources to
21 provide a higher level of care.

22 The second reason I referred him to Dr. Van
23 Bakel is because I've known -- we call him Bennie.
24 I've known Bennie for -- for a lot of years. I knew
25 him when he was a fellow, and I was an attending. And

1 he's absolutely one of the best clinicians I've ever
2 met in my entire life. And I looked at Bennie. And I
3 said, Bennie, look, I think I'm doing the best I can,
4 but I'd really like for you to look over my shoulder
5 and, you know, tell me is there something I missed.
6 What else can I do. How else can we help Mr. Mikell.

7 I don't want you to think that's overly humble.
8 It's -- it's just the way in which we practice at the
9 Medical University. We -- we try to take -- to take
10 advantage of expertise of our colleagues, of our
11 partners. And what I was looking for was Bennie to
12 look over my shoulder, and say, Mike, you did
13 everything you could, or here's some other things that
14 we could do; and to provide a higher level of care so
15 that people there could see him more frequently.

16 Q. Now, after you referred Mr. Mikell to Dr. Van
17 Bakel in the Heart Failure Clinic, was he still your
18 patient? Were you still involved in his care?

19 A. Yes.

20 Q. Okay. And was he still your patient in
21 December of 2010?

22 A. And remind me the context of that? That's
23 just before the colonoscopy?

24 Q. December of 2010 --

25 A. Oh, December of 2010, when he was -- after the

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1 colonoscopy and so on. Yes, Bennie and I hadn't -- I
2 hadn't given up all total care and the -- the care was
3 in the context of he's in the Heart Failure Clinic.
4 Bennie and I would discuss his care from time to time,
5 but I never discharged him from my care.

6 And the idea was if -- if -- if the need for
7 him -- arose for him not to be seen in the Heart
8 Failure Clinic, then he would come back to me. So I
9 was his main cardiology doctor, and I was -- I was
10 still involved in his care, at somewhat of a distance
11 because Bennie was doing the hands-on work.

12 Q. Now, I believe you have a record in front of
13 you. Do you recall the last data that you saw
14 Mr. Mikell?

15 A. In terms of this note?

16 Q. Yes.

17 A. You know, I have to tell you that I don't -- I
18 don't remember whether I saw Mr. Mikell after this. I
19 was made aware that he -- he had some problems. It's
20 usually my custom to go and see patients in the
21 hospital, even -- even if I'm not directly involved
22 with their care. It's possible that I went to see
23 Mr. Mikell while he was in the hospital. Honestly, I
24 don't remember. So is this the last time I saw him?
25 I'm not sure. But certainly this is the last note that

1 I wrote and the last time I saw him as outpatient,
2 which is April 30, 2010.

3 Q. And was Mr. Mikell on Tikosyn and Coumadin
4 according to that note?

5 A. Yes, ma'am.

6 Q. Now, we've heard testimony that Mr. Mikell was
7 taken off of the Tikosyn and the Coumadin at some point
8 in time during his hospitalization; do you, in any way,
9 disagree with him being taken off of the Tikosyn?

10 A. No.

11 Q. Do you disagree with him taking off -- being
12 taken off of the Coumadin?

13 A. No.

14 Q. With either of those medications indicated for
15 him in December of 2010 --

16 MR. RANSOM: Objection, Your Honor.

17 THE COURT: I'll sustain the objection.

18 BY MS. FLEMING:

19 Q. I don't -- Dr. Zile, why -- why was -- why
20 were Coumadin and Tikosyn not indicated at that time?

21 A. There were no indications for the application
22 of those two drugs --

23 MR. RANSOM: Objection. I'm sorry, Your Honor, I
24 couldn't hear the question. I'm not quite sure what
25 timeframe she's referring to, but I think she's trying

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1 to get around the earlier --.

2 THE COURT: I'll sustain the objection. Let's
3 don't go any further. Okay.

4 BY MS. FLEMING:

5 Q. Just to clarify, you -- you didn't disagree
6 with Mr. Mikell being taken off of his Tikosyn or his
7 Coumadin during the time that he was -- after his
8 arrest?

9 A. No, I did not disagree. Let me put it
10 positively, I agree.

11 Q. Dr. Zile, was Mr. Mikell taken off of his
12 Tikosyn and Coumadin due to his acute renal
13 insufficiency, or for some other reason?

14 A. While I'm not the one that made the decision
15 in the hospital, there were several indications to
16 discontinue those drugs; specifically, he was put in
17 hypothermia. And the hypothermia, when the body's
18 temperature goes down, the susceptibility to certain
19 drugs goes up.

20 And there's something in the EKG that's called a
21 QT interval. I hope none of you have ever had to be
22 placed on Tikosyn, but when we admit patients to the
23 hospital, when we start Tikosyn and other
24 antiarrhythmic drugs, any other drugs that treat
25 arrhythmias, and we look at this portion of the EKG

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1 that's called a QT interval, it is -- many, if not most
2 of the drugs, can prolong that.

3 Well, when you lower the body's temperature, the
4 QT interval gets longer all by itself. So just because
5 of the hypothermia alone, the QT interval gets longer,
6 which now creates a real issue for the use of Tikosyn.
7 So prophylactically, he was taken off Tikosyn, because
8 we know that the QT interval is going to get long when
9 their body temperature drops, which was necessary for
10 his treatment.

11 So I think that was the main reason that we
12 ordinarily, and as a matter of routine, take people off
13 of any drug that prolongs the QT interval. And that
14 includes other drugs, if I'm allowed to go outside of
15 this one drug, but antipsychotic drugs, for example,
16 certain -- certain drug for psychiatric conditions can
17 cause QT interval as prolonged.

18 Certain drugs that are used for ulcers can
19 prolong the QT intervals. So all of those drugs would
20 have been stopped. Because we know that his QT
21 interval will get longer while his body temperature was
22 low.

23 Q. And when you referred to the QT interval, does
24 that refer to a specific portion of the electrical
25 system in the heart that makes it beat?

1 A. Well, the -- the QT interval sort of
2 encompasses the electrical activation of the heart. So
3 everybody has a pacemaker. It's like a starter in a
4 car. So something that gives you that initial spark,
5 which then moves the motor so-to-speak. So in the
6 heart, there is a pacemaker called sinoatrial atrial
7 node.

8 And that -- when the sinoatrial node gets
9 activated, when electricity is there, and then when
10 electricity flows down the rest of the wires -- quote,
11 unquote, wires in the heart, there are reflections on
12 the EKG. And those are divided into parts of the waves
13 that are given letter designations.

14 So the Q wave is the first evidence that there's
15 electrical activation in the heart. And then there's a
16 QRS, and then there's a T wave. And then -- so the
17 distance between the start of the electrical activity
18 and the end of the electrical activity is called a QT
19 interval. And so that marks a specific area of the
20 electrical properties of the heart, which these rhythm
21 drug cans affect.

22 Q. And what is -- what is a risk associated with
23 the lengthening of the QT interval?

24 A. So, if the QT interval becomes prolonged, you
25 can develop a lethal -- lethal ventricular arrhythmia,

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1 and -- and have a particularly ventricular fibrillation
2 or a kind of ventricular tachycardia -- I'm sorry --
3 I'm using words that you're probably not familiar with.
4 But when the -- when I showed you a picture of the
5 ventricles -- okay -- which are the -- which are the
6 pumping chambers of the heart.

7 Q. Do you need to step down?

8 A. Your Honor?

9 THE COURT: Yes, sir.

10 (The witness stepped down from the witness
11 stand.)

12 BY MS. FLEMING:

13 A. So when we talk about the electrical activity
14 of the heart -- pardon -- so when we talk about the
15 electrical activity of the heart, the pacemaker lives
16 in the receiving chamber, which is called the atrium.
17 And ordinarily there's a little spot in the atrium that
18 acts as your -- your initiating pacemaker. And it
19 sends signals down, what are euphemistically called
20 wires. So they're like electrical pathways in the
21 ventricle.

22 Sometimes under certain circumstances, the heart
23 gets irritable. And there are rogue pacemakers that
24 want to take over. So in Mr. Mikell's condition, in
25 fact, there were several of those in the atrium, that's

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1 why you had these atrial arrhythmias that need
2 cardioversion and other therapy. But sometimes they
3 come from the ventricle.

4 So these -- these -- these -- these pacemakers
5 sort of take over when they shouldn't. So they
6 shouldn't be activated in the heart, but sometimes they
7 do. Because they get irritable.

8 So when you asked the question, what does --
9 what does Tikosyn do, Dr. Van Bakel used the word
10 pro-arrhythmia, which means makes the arrhythmia and
11 abnormalities worse.

12 You can get a rhythm that starts down here in
13 the ventricle. And there's two kinds of rhythms, one
14 in which the heart beats, but it beats very fast. And
15 that's called ventricular tachycardia. This is the
16 ventricle, tachy means fast; cardio means heart. So
17 it's the ventricle that has a fast heart beat.

18 Sometimes you can get ventricular fibrillation.
19 The word fibrillations means --

20 COURT REPORTER: I'm sorry. Your Honor --

21 THE COURT: Slow down just a little bit, and speak
22 up. Okay. Slow down just a little bit because she's
23 trying to take everything down.

24 THE WITNESS: Yes, sir. I'm sorry.

25 THE COURT: You are going a mile a minute.

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1 THE WITNESS: My apologies.

2 THE COURT: Thank you very much.

3 A. So when -- let me just backtrack then --

4 THE COURT: No. Don't backtrack. Just keep
5 going. Just slow down and go forward.

6 A. Yes, sir. So ventricular fibrillation, when
7 that happens, the heart is not able to generate any
8 pressure or eject any blood. And that's -- that --
9 that can happen with this particular drug Tikosyn. So
10 what -- so when the QT interval gets longer than
11 normal, you could have ventricular tachycardia or
12 ventricular fibrillation.

13 Q. Thank you.

14 A. I'm sorry, Your Honor, I'm a northerner. We
15 have a tendency to talk faster --

16 THE COURT: You've been down here long enough to
17 be a southerner by now.

18 A. Yes, sir. I would like to think of myself
19 that way.

20 THE COURT: Okay. That's good.

21 BY MS. FLEMING:

22 Q. Dr. Zile, would it be fair to say that leaving
23 him on the Tikosyn, while he was in a hypothermic
24 protocol, could have put -- would have put him at risk
25 for some type of ventricular arrhythmia?

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1 A. Yes, ma'am.

2 Q. Okay. Now, we talked also about Coumadin. Why
3 was the Coumadin not indicated in December of 2010?

4 MR. RANSOM: Objection, Your Honor.

5 THE COURT: Overruled.

6 A. In December of 2010 after he was discharged
7 from Kindred?

8 BY MS. FLEMING:

9 Q. That's correct.

10 A. Okay. Well, I think you have to ask the
11 question the other way, which is was there an
12 indication to take Coumadin. We never -- we -- we work
13 very hard not to prescribe a drug that doesn't have a
14 specific indication and target at the time that we
15 prescribe it. And we often re-evaluate. I can tell
16 you with Mr. Mikell, every single time I saw him, I
17 reevaluated every medication that he was on, and tried
18 to make the decision, does he need to still be on it.

19 Mr. Mikell used to ask me, Dr. Zile, do I have
20 to take all these medicines? And we frequently went
21 through each one of them and said, what are the
22 indications.

23 So in this particular case, there was not an
24 indication. So the indications that had been present
25 before, which was the atrial arrhythmias, had been gone

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1 for a substantially long enough time that we didn't
2 need to consider Coumadin therapy at that point.

3 Q. And -- and why do you give patients, who have
4 atrial arrhythmia, Coumadin?

5 A. So people who have atrial fibrillation, the --
6 may I just step down for one minute more, Your Honor?

7 THE COURT: Yes, sir.

8 (The witness stepped down from the witness
9 stand.)

10 A. Just to give you a clear indication, in the
11 atrium here, when we say that people have atrial
12 arrhythmias, or atrial fibrillation, we mean that the
13 atrium itself looks like a bag of worms. It doesn't
14 contract properly. And there are parts of the atrium
15 here, which are not pictured, which are called the
16 appendices. There -- there are small projections that
17 blood can get in and form a blood clot.

18 So when people have atrial fibrillation, they
19 can form blood clots in the atrium. And those blood
20 clots can break off and cause an embolism. So the
21 Coumadin reduces the chances of that happening. Now,
22 it doesn't reduce it to zero, but it reduces it to as
23 low as we can get it with medical therapy.

24 BY MS. FLEMING:

25 Q. Dr. Zile, was there any reason to put him --

1 to put Mr. Mikell back on the Tikosyn after the
2 hypothermic protocol was completed?

3 A. No.

4 Q. And why is that?

5 A. Because he wasn't having any atrial
6 arrhythmias -- the indication in him was atrial
7 arrhythmias; he wasn't having any.

8 Q. And would that also apply to the Coumadin?

9 A. Yes.

10 MS. FLEMING: Nothing further. Thank you.

11 THE COURT: Cross-examination.

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

13 Q. Dr. Zile, do you have Plaintiff's Exhibit 37
14 there with you?

15 A. Yes, sir, I do.

16 Q. May I have that please?

17 A. Yes, sir.

18 Q. Thank you. Dr. Zile, you didn't make the
19 decision to take him off of either the Tikosyn or the
20 Coumadin, correct?

21 A. No, sir.

22 Q. And are you familiar with the details of the
23 hospitalization that he went through in October and
24 November?

25 A. I have read some of the -- some of the

1 hospital records, but I wasn't the person making the
2 decisions in the hospital.

3 Q. And you are familiar with the description that
4 the hospitalization, that your colleague, Dr. Van Bakel
5 gave?

6 A. Yes, sir.

7 Q. It was a pretty serious event; right?

8 A. Yes, sir.

9 Q. Okay. Your records reflect that the last time
10 that you saw Mr. Mikell was on April 30, 2010, and
11 we've got that note marked as Plaintiff's Exhibit 37;
12 right? That's the last time you saw him?

13 A. As an outpatient, yes, sir.

14 Q. Okay. And the time that you saw him on April
15 30, 2010, I've got this Exhibit 37, Plaintiff's Exhibit
16 37 up on the screen, your impression was you believed
17 this patient is doing exceedingly well?

18 A. That's exactly the words that I put on the
19 paper, yes, sir.

20 Q. Thank you. I don't have any other questions.

21 MS. FLEMING: I done have --

22 MR. RANSOM: Your Honor, we'd offer -- I'd sorry
23 -- we'd offer Plaintiff's Exhibit 37 into evidence.

24 THE COURT: Thirty-seven -- any objection?

25 MS. FLEMING: No objection.

1 THE COURT: Thirty-seven admitted without
2 objection.

3 (WHEREUPON, Plaintiff's Exhibit No. 37 was
4 admitted into evidence.)

5 MS. FLEMING: I'd also ask that and we move to
6 admit Defendant's Exhibit 7 into evidence at this time
7 as well.

8 MR. RANSOM: Plaintiff objects to that exhibit,
9 Your Honor.

10 THE COURT: All right. You're talking about the
11 Plaintiff's No. 7; is that right?

12 MS. FLEMING: No. It's Defendant's No. 7.

13 THE COURT: I mean, excuse me. It's Defendant's
14 No. 7. What about No. 8?

15 MS. FLEMING: I'm sorry. It's No. 8.

16 THE COURT: That's what I was thinking, No. 8.

17 MS. FLEMING: That's right.

18 THE COURT: Do you have an objection to No. 8?

19 MR. RANSOM: Yes, Your Honor, I have an objection
20 to No. 8.

21 THE COURT: What's your legal objection?

22 MR. RANSOM: If I could have the exhibit. So
23 Plaintiff's Exhibit No. 8 appears to be a complete --
24 well, not a complete copy, but a copy of all of the
25 office notes that Mr. Mikell had prior to --

1 THE COURT: I think it's all cardiology records
2 that Dr. Zile had in his office, I believe.

3 MR. RANSOM: I think that's right, Judge.

4 THE COURT: That's what it is. Do you have any
5 objection to it?

6 MR. RANSOM: Yes, sir, I do object. Because
7 number one, many of these records, there was no
8 discussion whatsoever about them. All right. This is
9 highly technical information contained in these
10 records. There's been no explanation provided to the
11 jury for them to be able to understand --

12 THE COURT: Well, that's fine. But what's your
13 legal objection? I mean, he's authenticated the
14 records. They're relevant. Now, if there's some
15 opinion in there, and you want to -- opinions you want
16 to redact, that's a different story.

17 MR. RANSOM: Well, there's opinions that aren't
18 admissible, and there's also no foundation.

19 THE COURT: Well, if you want to redact the
20 opinions, that's fine. But as far as the records
21 themselves, I'm going to allow them in subject to your
22 proposal to redact whatever opinions you don't think
23 are appropriate. I'm going to allow them in with the
24 objection. Okay. I'll give you an opportunity to see
25 what you think needs to be redacted from an opinion

1 standpoint.

2 MR. RANSOM: All right.

3 THE COURT: Okay. All right. Now, yours --
4 your's was number what?

5 (WHEREUPON, Defendant's Exhibit No. 8 was
6 admitted into evidence.)

7 MR. RANSOM: Thirty-seven.

8 THE COURT: Thirty-seven. Any objection -- I
9 believe you didn't have any objection to Plaintiff's
10 37; is that right?

11 MS. FLEMING: No. If that's the note we were just
12 talking about, then no.

13 THE COURT: All right, 37 admitted without
14 objection. Do you have any cross or you through with
15 cross?

16 MR. RANSOM: Yes, Your Honor.

17 THE COURT: Do you have any redirect?

18 MS. FLEMING: No, Your Honor. Thank you.

19 THE COURT: All right. Doctor, you may step down.
20 Thank you so very much. Let me see the attorneys up
21 here just a second.

22 (WHEREUPON, a bench conference was had.)

23 THE COURT: I'll let you put on the record
24 whatever you want. All right. Madam Forelady, ladies
25 and gentlemen of the jury, I think the next witness is

1 going to be rather lengthy, and it's 10 minutes to
2 five, so we'll continue in the morning. And I'll, for
3 your information, we won't work Saturday or Sunday.
4 And I think probably we'll finish the case hopefully
5 Monday, for your edification, your planning.

6 Please don't discuss the case amongst
7 yourselves. And I'll see you in the morning at 9:30.
8 Have a good evening.

9 (WHEREUPON, the jury leaves the courtroom at
10 4:50 p.m.)

11 THE COURT: Ms. Fleming, I don't have 6 or 7 or 8
12 offered. Does the court reporter have them offered --

13 COURT REPORTER: Well, we just talked about eight.

14 THE COURT: How about six and seven?

15 COURT REPORTER: I have six and seven in. I can
16 go through the records and check --

17 THE COURT: You have them in?

18 COURT REPORTER: I do.

19 THE COURT: Okay. All right. She says they're
20 in. I just missed it. Okay.

21 COURT REPORTER: I can double check.

22 MR. RANSOM: I did, too, Your Honor. What is
23 Plaintiff's No. 6 --

24 COURT REPORTER: You had them in too, right, or do
25 you need to check through the record -- I have them in.

1 THE COURT: Defendant's No. 6 is the one minute
2 chart. The Defendant's No. 7 is the medical record of
3 Dr. -

4 MR. RANSOM: Okay. Thank you.

5 THE COURT: -- of Dr. Van Bakel. And eight is the
6 records from Dr. Zale(sic).

7 COURT REPORTER: I have everything in except for
8 three.

9 MR. RANSOM: So I do -- if I may be heard on the
10 record?

11 THE COURT: All right. We are on the record.

12 MR. RANSOM: Yes, sir. Judge, so beginning with
13 Defendant's Exhibit 7, and this is -- it looks like
14 it's about 25 pages. And it's a number of progress
15 notes for Mr. Mikell with the cardiology office. And I
16 don't really have an objection to the progress notes
17 themselves.

18 THE COURT: Are you talking about seven or eight
19 now?

20 MR. RANSOM: Seven.

21 THE COURT: The court reporter tells me they have
22 already been admitted.

23 MR. RANSOM: Well, I -- Judge, I didn't hear the
24 offer -- and I apologize, I didn't hear her offer them.
25 I was having trouble hearing what she was saying, but I

1 didn't hear her offer them into evidence. And I would
2 have objected.

3 THE COURT: Okay. Okay. I'll hear you on 7.

4 MR. RANSOM: I'm sorry, Judge. So I don't object
5 to the cardiology notes itself. What I do have an
6 objection to are these lab test results, and these EKG
7 strips. And my objection is really quite focused. And
8 that is there has not been any testimony from an expert
9 witness that would lay a foundation to allow the jury
10 to understand either what those EKG rhythm strips or
11 any of these ten pages of laboratory test results mean.
12 And so --

13 THE COURT: What legal objection is that?

14 MR. RANSOM: Well, the objection is --

15 THE COURT: Whether they can understand it or not
16 is, I mean --

17 MR. RANSOM: It tends to confuse the jury. They
18 get back in the jury room, they start looking at
19 medical records that nobody has explained to them what
20 they mean, and they are left to draw their own lay
21 conclusions, and confuse themselves about what's really
22 taking place. So that's the objection. It tends to
23 confuse the jury.

24 THE COURT: Ms. Fleming -- I assume you got the
25 same objection for No. 8?

1 MR. RANSOM: That's right. Among the other things
2 that I've already put on the record is, this is, you
3 know, literally, as I understand it, six or seven years
4 of cardiology office notes, virtually none of them have
5 received any explanation from a qualified witness in
6 order for a jury to be able to understand the
7 information that they contain.

8 THE COURT: Okay. Ms. Fleming.

9 MS. FLEMING: Right. So with regard to Exhibit 7,
10 if I can address that first, any lab values or EKG
11 that's in there, are referenced in Dr. Van Bakel's
12 note. And the labs, in particular, pertain to the
13 creatinine, which pertains to the kidney function,
14 which is directly at issue. And the EKG shows that he
15 was not in an arrhythmia.

16 So I don't -- I disagree with that. I think
17 that's relevant. I think he -- I think Dr. Van Bakel
18 explained -- minutely explained what every aspect of an
19 EKG is, but --

20 THE COURT: I assume he's talking about Rule 403,
21 where it's confusing the issues and misleading, I
22 assume, are undue waste, delay, or needless -- I assume
23 he's making a 403 objection. Okay. I assume.

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

25 THE COURT: Okay.

1 MR. RANSOM: And part of my concern is, as we
2 know, I think we've got one, maybe two nurses on this
3 jury, who are going to be inclined to go back and take
4 that type of unprocessed data, if you'll allow me to
5 call it that, and start interpreting it not only for
6 themselves, but for other jurors. And then this case
7 isn't being decided upon the testimony, but it's rather
8 being decided on the jury room science that takes
9 place, unguided by expert testimony from the witness
10 stand.

11 And so, for example, if it's true hypothetically
12 speaking, assuming for purposes of argument, that Dr.
13 Zile has included in one of his office notes some
14 commentary about what the heart rhythm strip shows, I
15 don't have a problem -- all right -- with that opinion.
16 I mean, I've got a -- I object to opinions in medical
17 records going into evidence. But if there's been a
18 physician who has provided testimony, or if there's a
19 record that's in evidence that interprets that heart
20 rhythm strip, that's one thing.

21 But I don't want these medical providers on that
22 jury back there, holding up that rhythm strip, and
23 diagnosing Mr. Mikell all on their own. And I don't
24 want them going through his lab values, and trying to
25 make their own diagnosis, when no doctor has provided

1 any guidance as to what those lab values actually mean.

2 THE COURT: Ms. Fleming.

3 MS. FLEMING: Dr. Van Bakel --

4 THE COURT: Speak up.

5 MS. FLEMING: With regards to Exhibit 7 --

6 THE COURT: Speak up louder. I can't hear you
7 talking; louder. Speak up. To you, it's going to
8 sound like you're yelling at me, but yell at me. Talk
9 louder.

10 MS. FLEMING: I'll yell at you.

11 THE COURT: Yell at me.

12 MS. FLEMING: I'm kidding.

13 THE COURT: Okay.

14 MS. FLEMING: With Exhibit -- Exhibit 7, Dr. Van
15 Bakel discussed that this patient was not in an
16 arrhythmia when he saw him in 2014, and that EKG shows
17 as an objective test, that shows he's a normal science
18 rhythm. The lab values, he testified that he reviewed
19 the creatinine to assess Mr. Mikell's kidney function.
20 The reason he did that, and he testified about
21 how he obtained lab values, so that another objective
22 test that he's already discussed, and informed the jury
23 about. That's all that is.

24 THE COURT: All right. Your objection is
25 overruled on 7. Let me hear you on 8. The same

1 argument?

2 MR. RANSOM: Well, again, so the idea is this,
3 number one, a whole bunch of opinions in all that big
4 stack --

5 THE COURT: I said if it's an invalid opinion,
6 we'll redact it. Okay.

7 MR. RANSOM: Yes, sir. All right.

8 THE COURT: I mean, I'll do that. I don't think
9 the opinion is -- is admissible. And if it's hearsay,
10 I don't think it's admissible. Okay.

11 MR. RANSOM: But so -- but so, Judge, if I may
12 continue with the argument, so if the opinions
13 themselves aren't admissible -- all right -- then
14 everything in that record then, that needs
15 interpretation is going to be left to the lay
16 interpretation of this jury. And --

17 THE COURT: Well, there's a lot left to the
18 interpretation of the jury. Okay.

19 MR. RANSOM: You know, there was no testimony --

20 THE COURT: In any case -- not only this case, but
21 in any case.

22 MR. RANSOM: Well, I don't know in -- if every
23 case Mr. Ransom is making an objection, Your Honor, but
24 --

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

1 MR. RANSOM: I say, I don't know if in every case
2 Mr. Ransom is making an objection, but the -- what
3 we're basically trying to do is take all of these
4 records, about which there was absolutely no testimony,
5 and as a substitute for testimony -- all right --
6 sticking all these records into evidence, so that the
7 jury then has to go back there. And if they are
8 inclined to read them, try to figure out for themselves
9 what does all this mean.

10 You'll notice that virtually every medical
11 record that the plaintiff has offered into evidence,
12 we've had a qualified expert witness on the stand, who
13 has looked at that record, and told them this is what's
14 going on in this record. This is what we think is
15 important.

16 And with so many of those documents that she's
17 just sort of dumping on the jury, there's been no
18 foundation provided. They don't have any guidance for
19 understanding what those records mean. The test
20 results that she refers to, I don't have a problem with
21 the creatinine test result, but they've got ten pages
22 of test results that go beyond the creatinine.

23 And so, again, this is going to result in our
24 medical people on the jury going back there and saying,
25 well, creatinine is not the only measure of renal

1 function. Look, let's see. They've got some other
2 tests that might measure that, too. And that's what
3 I'm trying to avoid. Because then they're not deciding
4 the case on the basis of the evidence.

5 THE COURT: You probably shouldn't have put two
6 nurses on the jury -- if there are two -- I don't know.
7 You shouldn't have put two nurses on the jury.

8 MR. RANSOM: Well, I couldn't keep them all off,
9 Judge.

10 THE COURT: Are there -- I mean, I don't know.
11 Are there two nurses on the jury -- I know there's a
12 pharmacist, I think, on the jury.

13 MR. RANSOM: But see this is -- my point is, it's
14 inviting these people here on the jury, who have some
15 insight into science and medicine, to go back there and
16 start drawing conclusions, unguided by any testimony
17 from a qualified witness on the stand.

18 THE COURT: Let's do this. Okay. Apparently, you
19 feel right strongly about your motion. Do you have a
20 copy of the exhibit?

21 MR. RANSOM: I do not.

22 MS. FLEMING: I can get one for him.

23 THE COURT: Ms. Fleming, give him a copy of the
24 exhibit. And overnight, you mark what you don't think
25 should be admissible, so we're talking about specifics.

1 Okay.

2 MR. RANSOM: Excellent. Thank you, Your Honor.

3 THE COURT: Give it to me in the morning, and I'll
4 make a decision before it's time to send them back to
5 the jury, one way or the other. Okay?

6 MR. RANSOM: Very good.

7 THE COURT: Can you do that, Ms. Fleming?

8 MS. FLEMING: Yes, very easily.

9 THE COURT: Is there anything you want to say on
10 Exhibit No. 8?

11 MS. FLEMING: I would -- I would essentially --
12 essentially say the same thing that I said --

13 THE COURT: You are doing good. Talk loud.

14 MS. FLEMING: It's a little embarrassing to talk
15 to --

16 THE COURT: Don't be embarrassed. Please don't.
17 Talk loud.

18 MS. FLEMING: Yeah, so --

19 THE COURT: I'm trying -- I'm hard of hearing.
20 And I want -- I want you to talk loud. You are a
21 wonderful lawyer. You are smart. But you got assert
22 yourself; talk loud. I don't mean to embarrass you.
23 I'm not trying to.

24 MS. FLEMING: You're not, Judge. It's -- you're
25 not embarrassing me at all. I have the same position

1 with regard to eight that I had seven. And Dr. Zile
2 authenticated all those records. He said that those
3 are his cardiology notes and everything that he has
4 access to. He went through a timeline and explained
5 various details of Mr. Mikell's cardiac history,
6 inpatient admissions, cardio versions, all kinds of
7 things that occurred over the course of seven years,
8 eight years, that he provided care for this man.

9 I mean, I think that that's -- that's fair. I
10 think it's been explained. We have talked about
11 echocardiograms. I mean, short of going through every
12 single echocardiogram and highlighting the ejection
13 fraction, the jury has heard it. They've been told
14 what that means.

15 And that's not the only thing. I mean, their --
16 I mean, all the objective tests that were done, the
17 left heart cath, the cardio versions, the EKGs are
18 relevant to that, to show -- I mean, I don't even know
19 if there are that many in that second set. But it just
20 shows that his rhythm is in and out, and that he's, you
21 know, back to a normal rhythm or not. I mean, it's
22 just an objective finding.

23 THE COURT: What about -- what about his argument
24 with the nurses looking at stuff that the doctor hasn't
25 explained, and -- and either interpret it properly, or

1 not interpret it properly. I think he's really being
2 speculative on that, but what's your thoughts on that?

3 MS. FLEMING: Well, I mean, the same argument --
4 the argument could be made to various parts of the
5 record that he's already inserted, where he's had a
6 witness explain a single sentence of a record. I mean,
7 they could go and look at the rest of the record, and
8 use their imagination to infer what a particular
9 witness meant. So not every medical document that he's
10 inserted into the record has been fully read or
11 explained to the jury. It's the same -- it's the same
12 issue.

13 THE COURT: Okay. Thank you so very much. I'm
14 going to let him sort of mark the copy you're going to
15 give him, and I'll take a look at it in the morning.
16 And I'll -- he could provide you a copy of it. And you
17 may agree with some of it, and you may not. But I'll
18 rule after I have an opportunity to look at what he
19 specifically talking about. Okay, Ms. Fleming?

20 MS. FLEMING: Yes, thank you.

21 THE COURT: Thank you so very much for your
22 argument. Anything else?

23 MR. RANSOM: Well, so I'll -- I'll just highlight
24 the parts that I think should be redacted?

25 THE COURT: Yeah.

1 MR. RANSOM: Good.

2 THE COURT: Either redact it or not going in.
3 Okay?

4 MR. RANSOM: Yes, sir.

5 THE COURT: If you'll give that to me in the
6 morning, we'll take a look at it and I'll make a
7 decision.

8 MR. RAMSOM: Yes, sir.

9 THE COURT: All right. Anything else before we
10 break for the evening?

11 MR. COOKE: How do you want to deal with the
12 deposition excerpts?

13 THE COURT: On what, now?

14 MR. COOKE: How do you want to deal with the
15 deposition excerpts, that there was some objections to?

16 THE COURT: Well, have you got -- Ms. Fleming,
17 have you given me back what I gave you?

18 MS. FLEMING: I have it for you.

19 THE COURT: If you -- I haven't had it yet. I was
20 going to read it -- I was going to read it and make a
21 decision -- okay. I just haven't seen it yet, because
22 what I had didn't match up.

23 MR. COOKE: Right. I was just reminding you in
24 case you want to do it tomorrow sometime.

25 THE COURT: Okay. Thank you. Thank you so very

1 much. You did a good job.

2 MS. FLEMING: Thank you. I appreciate that.

3 THE COURT: All right. Anything else?

4 MR. COOKE: No, sir.

5 MR. RANSOM: Nothing from the plaintiff.

6 THE COURT: Pardon?

7 MR. RANSOM: Nothing from the plaintiff.

8 THE COURT: All right. We'll see you in the
9 morning at 9:30. Thank you very much.

10 (WHEREUPON, the hearing was concluded.)

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* * * Friday, April 22, 2016 * * *

THE COURT: Anything from the plaintiff before we bring the jury?

MR. RANSOM: Judge, I don't want to belabor the issue, but I did want to renew my motion to strike on the opinion testimony from doctor --

THE COURT: To strike what now?

MR. RAMSOM: The opinion testimony of Dr. Zile that you had ruled was inadmissible, but is nevertheless in the record before the jury.

THE COURT: I've already ruled on that; right?

MR. RANSOM: I think that you have, but I just wanted to protect myself on the record, Judge.

THE COURT: Okay. All right.

MR. COOKE: Nothing.

THE COURT: If I haven't ruled, I've ruled now. You're overruled. Okay. Are you ready to proceed?

MR. COOKE: We are ready. Let me -- she's getting our witness ready.

THE COURT: Okay. Let me know when you're ready so we can bring the jury in. Okay?

MR. COOKE: Okay.

THE COURT: Is the defense ready to bring the jury?

1 MR. COOKE: Yes, Your Honor.

2 THE COURT: Okay. Bring us the jury, please.

3 MR. RANSOM: Your Honor, I -- I can present to you
4 the redacted -- or the portions that I've highlighted
5 for your consideration. This was exhibit 7 or 8 --

6 THE COURT: Have you shown it to defense counsel?

7 MR. RANSOM: Yes, I have.

8 THE COURT: Do y'all have any objections to the
9 redactions?

10 MR. COOKE: Actually I haven't seen it. Is this
11 it here?

12 MR. RANSOM: Yeah. We got all this right here.

13 MR. COOKE: We haven't had a chance to look at
14 it.

15 THE COURT: Well, let them -- give them a chance
16 to look at it. They may agree with it.

17 MR. RANSOM: Okay.

18 THE COURT: But if they don't, we'll hear it.

19 (PAUSE.)

20 (WHEREUPON, the jury enters the courtroom at
21 approximately 9:35 a.m.)

22 THE BAILIFF: All jurors are present.

23 THE COURT: Thank you very much. If you'll call
24 your next witness, please..

25 MS. FLEMING: The defense calls John Fisher.

JOHN FISHER -- DIRECT

1 A. So, we have an electronic medical system
2 called Epic. And as great as it is, it can't do
3 everything that the doctors would like. So things that
4 it can't do, come to my team, and then we develop these
5 applications for the doctors, for administration, for
6 research, et cetera.

7 Q. Are you familiar with the PICIS electronic
8 medical record?

9 A. Yes, I am.

10 Q. And when was that discontinued from use at
11 MUSC by the Department of Anesthesia?

12 A. PICIS went dormant on July -- July 1, 2014,
13 when the University switched over to Epic.

14 Q. And why -- what is your understanding of why
15 the University switched to the Epic chart?

16 A. Prior to Epic, the University had a myriad of
17 different systems, about seven or eight, each were
18 purchased to do certain things. In the case of PICIS,
19 PICIS was used by surgery, perioperative services, and
20 anesthesia. We had another system for medical records;
21 another system for medication; another system for labs.
22 And they wanted to consolidate it down into one system
23 and Epic was able to do that for us.

24 Q. What -- what is PICIS?

25 A. So PICIS is an application that was used by

1 perioperative services, surgery and anesthesia, and
2 that's what they used to document everything that
3 happened during the surgery.

4 It's comprised of two major pieces; there's a
5 user application, which is what the nurses, the
6 doctors, and the residents used. And it also has a
7 back-end database, which is where all data is stored.
8 Everything that is entered into PICIS, both from the
9 users and from any machine linked into it, all
10 information is stored on that database.

11 Q. Now, in your position, have you worked with
12 the PICIS database?

13 A. Yes, I have.

14 Q. And were you able to go into the database for
15 Mr. Mikell's case?

16 A. Yes, I was.

17 Q. Does anyone else at MUSC have access or user
18 rights to the database other than you?

19 A. No one, no.

20 Q. In working with the database, have you been
21 able to determine whether any data, including any vital
22 sign data, or oxygen saturation data has been deleted,
23 changed, or modified in any way?

24 A. No. It cannot be done from the database site.

25 Q. So just to clarify, when you said that you

1 actually went into the database, and tried to confirm
2 whether any data had been deleted, modified or changed,
3 what values did you look -- what -- what parameters or
4 values did you specifically look at?

5 A. So when I looked at Mr. Mikell's record, I
6 specifically looked at all values that are located
7 right here (indicated).

8 Q. And so that would include the oxygen
9 saturation, the SP02, the temperature?

10 A. Yes, ma'am.

11 Q. The EKG rhythm?

12 A. Yes, ma'am.

13 Q. The heart rate?

14 A. Yes, ma'am.

15 Q. The spontaneous respiratory rate?

16 A. Yes, ma'am.

17 Q. The ventilator respiratory rate?

18 A. Yes, ma'am.

19 Q. The FI02 percentage?

20 A. Yes, ma'am.

21 Q. The end tidal CO2 percentage?

22 A. Yes, ma'am.

23 Q. The expired tidal volume and the PIP, the
24 Positive Inspiratory Pressure value; correct?

25 A. Yes, ma'am.

JOHN FISHER -- DIRECT

1 Q. And what was your conclusion?

2 A. My conclusion was that no data had been
3 modified, altered or deleted in any way.

4 Q. So does that tell you whether Donna Embrey
5 altered any of those numbers that were entered into
6 that database -- or entered into this record?

7 A. She did not alter any of these numbers.

8 Q. Did anyone alter any of the numbers that are
9 shown in the -- in the one minute version of the
10 anesthesia record?

11 A. No, ma'am.

12 Q. And where -- the -- the items that you've
13 highlighted, are those values that directly
14 communicated from the monitors in the room into the
15 PICIS system?

16 A. Yes.

17 Q. So no human being actually enters those values
18 that we see from 7:48 on?

19 A. Typically no, correct.

20 Q. So in looking at the database, if no -- if
21 none of these values that we've just discussed have
22 been deleted, modified or altered, what does that tell
23 you with regard to what we see in the one minute
24 version of the anesthesia record?

25 A. So PICIS receives information from the two

JOHN FISHER -- DIRECT

1 machines in the operating room, the anesthesia machine
2 and the Phillips monitor at one minute intervals. So
3 based on what I've discovered, in looking at this one
4 minute report, the values that you see here on this
5 report are accurate.

6 Q. Now, what did you do to confirm -- how did you
7 confirm that none of this data had been altered,
8 destroyed, deleted or modified in any way?

9 A. So the only way that data can be modified in
10 any manner in PICIS is through the user application.
11 PICIS has what's called an audit trail. It tracks
12 everything that is done in the system. I know that
13 it's been mentioned a few times in prior testimonies,
14 and there is literally audit trails for everything in
15 PICIS.

16 And so what I did is I looked at all the real
17 time variables for Mr. Mikell's case, and then crossed
18 it with this audit trail, and found absolutely no
19 modifications whatsoever between the two.

20 Q. And when you say real time variables, is there
21 -- is that a title that appears on the top of
22 anesthesia record?

23 A. It's -- it's right here (indicated).

24 Q. And. So when we're talking about the real
25 time variables, you're talking about the numerical

1 values that we see in from 7:48 through the rest of the
2 record; is that correct?

3 A. Correct. That is the only information that
4 comes from those machines.

5 Q. And, Mr. Fisher, have you seen this document
6 before?

7 A. Yes, I have.

8 Q. And could you tell the jury what it
9 represents?

10 A. So if you were to look at a database, a
11 database -- if you're familiar with Microsoft Excel, a
12 database is an enormous Excel sheet. This represents
13 the real time data for Mr. Mikell in that format. I
14 believe there are about 136 columns in this report.

15 Q. And so why -- why did you create this -- or
16 how did you create this report, I guess, when -- maybe
17 I should have asked that differently. Does this report
18 represent all of the values that we see in the one
19 minute version of the record?

20 A. Yes. So the way that this report is laid out,
21 the column here listed as started, that's the time in
22 which information was recorded. And then these
23 different columns here -- and even though you can't
24 really understand what they mean because says C'-0-0-1,
25 C-0-0-0 -- they are corresponding to the different

1 vital data that's coming into the machines. The reason
2 that they're named as such, as new machines are
3 introduced -- it's kind of an expanding system, so if
4 MUSC were to purchase a new kind of anesthesia machine,
5 then that would start populating in the new column, and
6 not corrupt data in older columns.

7 Q. And so all of the data that you have entered
8 or you have -- you have collaborated in the document
9 that you're looking at, is all data that's directly
10 derived from the PICIS database for Mr. Mikell's case?

11 A. Yes, ma'am.

12 Q. And does it correspond with what we see in the
13 one minute version of the anesthesia record?

14 A. Yes, ma'am.

15 Q. I should have asked you this before, but how
16 does PICIS -- how does PICIS obtain, or at what
17 interval does it -- does it -- did it record data from
18 the monitors?

19 A. It received data at one minute intervals.

20 Q. Now, how many hours, during the discovery
21 process in this case, how many hours have you spent
22 trying to determine whether Mr. Mikell's anesthesia
23 record was unchanged?

24 A. I spent approximately about 500 hours in the
25 last six months.

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1 Q. Why did you do that?

2 A. I believe when the legal printout
3 documentation from PICIS was presented to Mr. Ransom,
4 he had proposed that the values were modified. And so
5 knowing that the database was unmodifiable, we wanted
6 to see if that was, in fact, true or not.

7 Q. And what was your final conclusion?

8 A. That the data was not modified in any manner.

9 Q. And so when you say the data was not modified,
10 would it be fair to say that all of the vital sign data
11 that we see throughout the one minute version of
12 Mr. Mikell's anesthesia record, is accurate and
13 reliable?

14 A. All of the numeric data on top of this report
15 is reliable.

16 Q. So that would include the continuation of the
17 chart through whenever he was discharged from the PICIS
18 system; correct?

19 A. Yes, ma'am.

20 Q. Now, we've seen different versions of the
21 PICIS record throughout the week. We've seen a 15
22 minute version and the one minute version. And I'd
23 like to just have you just clarify something with
24 regard to the 15 minute version:

25 A. Sure.

1 Q. Do you recognize this copy of the record?
2 Does this copy represent the 15 minute version of the
3 anesthesia record?

4 A. Yes. Yes, ma'am.

5 Q. Do you know -- or what is your understanding
6 of how the values for the different parameters that we
7 see on the left side of the screen, how -- how did
8 PICIS plot the numerical values that we see for 7:45
9 for each 15 interval?

10 A. Well, we're talking about just the numbers at
11 the top right now?

12 Q. Yes.

13 A. I know that internally in the program, it's an
14 averaging out rhythm. But admittedly, I don't know
15 what averaging out rhythm they're using. And it's not
16 something that's really in the control of MUSC. That's
17 a PICIS program decision.

18 Q. And so does the 15 -- which version is the
19 most accurate version of the record?

20 A. Definitely the one minute version.

21 Q. Now, were you able to confirm at what time
22 PICIS started capturing data for Mr. Mikell's case?

23 A. The first time we started seeing information
24 for Mr. Mikell's case was at 7:48.

25 Q. Okay. So, we see on the one minute version of

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1 the record, that we don't have any vital signs yet
2 other than the heart rhythm prior to 7:48 a.m. And why
3 -- what is your understanding of why PICIS did not
4 start capturing information or data for Mr. Mikell's
5 case before 7:48 a.m.?

6 A. Typically, this happens when the patient is
7 unable to be transferred from the pre-op area to the
8 surgical area, at least through the -- as far as the
9 program is concerned. And this could happen for -- for
10 any number of reasons: User error possibly, one of
11 them; program error; communication error between the
12 two systems.

13 Q. Was it uncommon to have issues like this, what
14 happened in this case with the PICIS system?

15 A. It was fairly rare, but not -- it could
16 happen.

17 Q. And did PICIS -- did PICIS offer an
18 application that allowed IT to help the user or the
19 doctor, CRNA remedy the problem or issue?

20 A. Yes, ma'am.

21 Q. And how was that done in this case?

22 A. I believe that if I'm to understand correctly,
23 I believe that the support person would log into PICIS
24 themselves. They have a bit more rights than the
25 physician does, and they would finish the transfer of.

1 the patient into what's called a transfer bucket. And
2 then from there, they are able to transfer the patient
3 then to the OR setting in PICIS.

4 Q. And at that point, could the -- could the CRNA
5 or physician then see the record on their computer
6 screen and start charting?

7 A. Yes, ma'am.

8 Q. And how would -- how would the user -- we've
9 heard a lot about text messages and pages to IT, does
10 MUSC have a paging system in place for doctors and
11 nurses to put a page into IT?

12 A. Yes. So the paging system at use at the
13 Medical University is a system called Simon, S-i-m-o-n.
14 And as a part of this system, they also have a web
15 interface in which you can go search for a doctor or
16 really anyone who has a pager -- it wasn't limited to
17 just doctors. So in this case, the support team have
18 their own pagers. You could select that pager, then
19 type a brief message, hit enter and it would go off and
20 go to that pager.

21 Q. So it would notify IT that someone needed help
22 with the record?

23 A. Exactly.

24 Q. And was that a fairly common practice? You
25 had a team in place to help with that?

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1 A. MUSC has various IT support teams for all
2 programs that they use. And all of them, my team
3 included, we all have a pager that if something were to
4 go wrong, or if a user is having an issue, or not
5 really sure how to use the program or -- not able to
6 provide care or whatever, they can -- then text these
7 teams, and we would respond as fast as possible to
8 alleviate the problem for them.

9 Q. Okay. Now, we've seen on the -- on the
10 anesthesia record, we see this -- we see this real time
11 data graph on the bottom of the record; are you
12 familiar with that graph?

13 A. Yes, ma'am.

14 Q. Okay. And I think we've seen various versions
15 of this graph throughout the week. We've seen what's
16 depicted here as a graph that appears on the one minute
17 version of the record; can you see these, Mr. Fisher?

18 A. Yes.

19 Q. Okay. And we've also seen a graph that
20 appears on the 15 minute version of the record. Now,
21 if you've confirmed that no vital sign information was
22 populating in the PICIS system prior to 7:48 a.m, is
23 the graph that appears on the one minute version of the
24 record accurate or reliable?

25 A. No, ma'am. The graph that appears on both of

1 these reports derives from the numeric data from the
2 top. It's not separate data. It's not independent.
3 They -- they are intended to reflect the same data. So
4 knowing that the database shows that no information,
5 outside of the EKG rhythm, was being plotted prior to
6 7:48, the graph being shown on the one minute report
7 must be wrong.

8 Q. And so the graph on the 15 minute version of
9 the record, can you explain how the data -- how the
10 graph plots the data on this 15 minute version of the
11 record?

12 A. According to the documentation we have from
13 the PICIS vendor, it is for each column, which
14 represents 15 minutes, it takes three points
15 representing the closest to the five minute values. So
16 between 7:45 and 8:00, 7:45, 7:50 and 7:55. And then
17 it would plot those points. And then in the case of
18 the SP02 line, would then draw a line between those
19 points.

20 Q. And at the top of the 15 minute record, do you
21 have any understanding of how PICIS plotted the
22 information in the 15 minute version of the record?

23 A. As I said before, I know it is an averaging
24 algorithm, but I don't know what algorithm it is. It's
25 not your typical add up the value, divide by the

1 number. But that's -- it's beyond MUSC's control.

2 Q. So would it be fair to say that the number
3 that appears for -- for instance, in the 15 minute
4 version of the chart, at 7:45 for the pulse ox being
5 47.5, would it necessarily be the average of the pulse
6 ox symmetry value over that 15 minute period?

7 A. Correct.

8 Q. Now, we've talked a lot this week about an
9 audit trail; are you familiar with the audit trail
10 that's been --

11 A. Yes, ma'am.

12 Q. -- placed in front of you. Can you explain to
13 the jury how -- what each column on the audit trail
14 represents? And we start with the column on the left
15 hand side of the page.

16 A. So the first column here, the date, that's the
17 time on the record that the event happened.

18 Q. You can mark it. Okay.

19 A. So, this is the date. It's -- these are the
20 times in which the event in this column occurred
21 according to the medical record. This is the type of
22 event -- the kind of -- the classifying of different
23 types. I'm not really fully certain of the
24 classification.

25 This is -- if the user made a comment when they

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1 were putting in the event, it would go here. This is
2 the action taken upon the event. You can see we have
3 created a deleted, modified. This date/time column
4 here is the date/time in which the action occurred. So
5 typically, upon creation, so on -- so on this top line
6 here, you could see that this is a transfer to action.
7 And its creation date up here is 7:35:09. And the date
8 here on the medical record is 7:35. So typically when
9 it's created, it should match what the medical record
10 is. Finally, this last column is the user that did the
11 action.

12 Q. Once the -- once the PICIS chart was open,
13 could two different users chart in the system from
14 different locations?

15 A. No, ma'am.

16 Q. And have you confirmed, could this audit trail
17 be altered, deleted, destroyed, modified in any way?

18 A. No, ma'am.

19 Q. And so any changes to the narrative portion --
20 and I'll show you the narrative portion up here on the
21 anesthesia record -- so would any changes to this, what
22 we've been calling the narrative portion under the
23 anesthesia event section of the record, appear in the
24 audit trail?

25 A. Yes, ma'am.

1. Q. Now, do you see the several entries on the top
2 portion of the record by Dr. Eric Nelson?

3 A. Yes, ma'am.

4 Q. What time were those -- according to this
5 audit trail, what time did Dr. Nelson make those
6 entries into the record, where it says
7 "anesthesiologist assessed patient, anesthesiologist
8 present for"?

9 A. It appears to be 7:49 and four seconds; 7:49
10 and five seconds.

11 Q. So does that indicate the time in which Dr.
12 Nelson was actually physically entering those values --
13 or that information into the medical record?

14 A. Yes, ma'am.

15 Q. Nothing further. Thank you, Mr. Fisher.

16 THE COURT: Cross-examination.

17 MR. RANSOM: Thank you, Your Honor.

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

19 Q. Good morning, Mr. Fisher.

20 A. Good morning.

21 Q. You've -- you've testified that you have been
22 able -- excuse me -- to verify that the information in
23 the spread sheet has not been modified, deleted or
24 altered in any way?

25 A. The numeric data, yes, sir.

1 Q. Okay. What have you done, if anything, to
2 confirm that it's actually accurate?

3 A. I'm not sure how I would be able to do that.
4 It's coming from the machine itself.

5 Q. Okay. So in other words, you can tell us that
6 these numbers haven't been modified, altered or
7 tampered with in some way, but you can't tell us that
8 they actually accurately represent, for example, what
9 Mr. Mikell's blood oxygen saturation was at 7:48?

10 A. I don't know anything about those machines.
11 If they're not accurate, then there would be a problem
12 with those machines.

13 Q. Okay. So in terms of the validity, if you
14 will, of all of these numbers, you can't confirm or
15 deny that? There's nothing that you can do in looking
16 at the system to determine that?

17 A. With these numbers, no. But it's also
18 important to know that these reports do not reflect
19 what was shown on the monitors in the operating room.
20 These are for reference.

21 Q. Well, but those are numbers that are being
22 electronically recorded by the machines that are in the
23 room; right?

24 A. I suppose what I'm saying is that if you're
25 implying that these numbers on this report are wrong,

1 then the numbers would have been wrong on the machines
2 in the operating room.

3 Q. Well, I suppose that's true. All I'm asking
4 is you can't -- in the work that you've done preparing
5 for your testimony today, there's nothing that you can
6 do in looking at these machines to be able to verify
7 the accuracy of those numbers?

8 A. The only thing I can verify is that those are
9 the numbers that came from the machine.

10 Q. All right. Now, you -- you talked about the
11 audit trail. And I wanted to ask you, have you seen
12 the audit trail for the changes that were made to the
13 narrative when it was printed out in April of 2013?

14 A. No, sir.

15 Q. Have you looked for that audit trail?

16 A. No, sir.

17 Q. And it hasn't been provided in this case, has
18 it?

19 A. I don't know.

20 Q. So, for example, when we see that somebody
21 went in at some point in time, between October of 2010
22 and April of 2013, and it switched around the order of
23 some of these entries, there would be an audit trail
24 that would tell us who did that?

25 A. Define what you mean by "switch the order

1 around"?

2 Q. Well, I just want you to assume that the order
3 is different in the April record, than it was in the
4 October.

5 A. But do they have the same date, the same time?

6 Q. Well, they are in a different order.

7 A. That -- that doesn't -- that should be
8 immaterial if they have the same date and time.

9 Q. Well, I'm not asking you if it's material.
10 I'm just asking you if you've been able to determine
11 who it is that did that and when?

12 A. It wouldn't be in the audit log because they
13 weren't modified. The fact that they are printed in a
14 different order doesn't matter. What would be in the
15 audit log is if they changed the time.

16 Q. Well, does the audit log in the computer
17 somehow or another change the order of the entries when
18 the record is printed?

19 A. That's possible if it's a different report.
20 And I believe we've seen earlier this week, and other
21 testimonies, that those two are different reports. One
22 is an anesthesia record; the other is an anesthesia
23 PACU report.

24 Q. So that's your explanation for why those are
25 in a different order?

1 A. That's one of them. I don't -- I don't have
2 any control over how PICIS prints its reports. But
3 what I do know is that the data shown on the reports
4 come from the same source, the database. And for me if
5 the dates and the times are the same, the order in
6 which they're printed on the report doesn't -- it
7 doesn't imply any change.

8 Q. You don't know. The short answer is, you
9 don't have an explanation. You can sit here and guess
10 and speculate, but you don't really know; do you?

11 A. I don't really know what, sir?

12 Q. Why these two records are different?

13 A. To me, they are not different because the
14 dates and the times are the same.

15 Q. Okay. So you don't -- you don't see the
16 difference?

17 A. I'm not really sure what difference you see.
18 If they say that they -- if this report says this event
19 happened at this date and time, and this report says
20 this event happened at the same date and time, the same
21 two events happened at the same date and time. There's
22 no difference. Without a second variable, you can't
23 imply that -- I can no sooner imply one event happened
24 before another off that report, than you can, if they
25 have the same date and time.

1 Q. Okay. Well, I just want to make sure that
2 we're clear, that you don't see that these entries are
3 in a different order?

4 A. I do see that they're in a different order,
5 but if they have the same date and time, then the
6 entries haven't been modified.

7 Q. Well, okay. You don't have any explanation
8 for that; do you?

9 A. As I said, they are different reports. It's
10 not uncommon for two different reports to print things
11 in a different manner. What I'm saying is that the --
12 the information, the key information, which is the
13 date, the time, and the event were not modified. And,
14 therefore, were not in that audit trail.

15 Q. Okay. Let me show you what has been marked as
16 Plaintiff's Exhibit 42 and 43. And these are printouts
17 from the anesthesia record. This one is Exhibit 42,
18 and you'll see it's printed October 2nd at 1815. And
19 do you notice how it's got a line right here for EKG
20 rhythm?

21 A. Yes, sir.

22 Q. Okay. And then Exhibit 43 is printed out
23 October 1st at 1348, and you'll see there's no EKG
24 rhythm column?

25 A. If I could see the top of the other report?

1 Q. Let me just hand them to you.

2 A. Sure.

3 Q. And you can look at them both.

4 (Handed to witness.)

5 Q. So one of them has got a column along here, in
6 the real time variables for EKG rhythm, and the other
7 doesn't; right?

8 A. Yes, sir.

9 Q. So somebody's gone back in, the second time
10 around, and added that column in? Does that show up on
11 the audit trail that you're referring to?

12 A. Yes, sir.

13 Q. Can you show us where that happened and who
14 did it?

15 A. What the audit -- well, what this is going to
16 show is that it had always been there, regardless if it
17 was printed in that report or not.

18 Q. So you can't explain to us how it is that that
19 column shows up in the second record, but not in the
20 first?

21 A. The best explanation I can give is that the
22 way that -- what that report shows was changed, not
23 that the data was changed, but the fact that the report
24 shows it could have been changed.

25 Q. Now, in terms of the empty boxes that we see

1 here?

2 A. Yes, sir.

3 Q. And that's for all of his vital signs
4 information, you can't tell us what goes in there, can
5 you?

6 A. No, sir. There was no data that was flowing
7 at the time.

8 Q. Okay. So you don't know what was going on
9 with Mr. Mikell at that time?

10 A. Correct.

11 Q. All right. And in terms of the -- the
12 narrative part of the chart, these entries that have
13 been typed in here -- I mean, you agree that's all
14 being done by a human being? That's not information or
15 --

16 A. No, sir. No, sir. Only the -- the parts that
17 are marked "memo" are actually typed by the person,
18 everything else is -- is in the system. You hit a
19 program, and the system writes it into the event log.

20 Q. Well, we know, for example, from the audit
21 trail that you can go in and change the times; right?

22 A. Yes, sir.

23 Q. Okay. The last thing I wanted to ask you was
24 about this part of the chart right here, where it
25 reflects the Propofol starting at 7:41; have you been

1 able to confirm the accuracy of that data?

2 A. I haven't been asked to look at that data.

3 Q. You haven't been asked to look at that?

4 A. No, sir.

5 Q. Okay. Could you confirm that?

6 A. Given another 50 or 100 hours.

7 Q. I mean, is there an audit trail that would
8 show whether or not that value has been tampered with?

9 A. Yes, sir.

10 Q. All right. Have you looked at that audit
11 trail?

12 A. Again, I have not been asked.

13 Q. Thank you. I don't have any other questions.

14 THE COURT: Any redirect?

15 MS. FLEMING: No -- No, Your Honor. Thank you.

16 THE COURT: Mr. Fisher, thank you so very much.

17 You may step down.

18 THE WITNESS: Thank you, sir.

19 THE COURT: Call your next witness.

20 THE BAILIFF: Your Honor, the jury requests a
21 restroom break.

22 THE COURT: Okay. All right. Madam Forelady,
23 leave your notepads in the chair, and we'll take a
24 short break. Let the bailiff know when you're ready to
25 come back, please, Madam Forelady.

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1 (WHEREUPON, the jury leaves the courtroom at
2 10:14 a.m.)

3 THE COURT: All right. We'll take about a 10, 15
4 minute break.

5 (WHEREUPON, a brief recess was taken.)

6 THE COURT: Bring us the jury.

7 (WHEREUPON, the jury enters the courtroom at
8 approximately 10:30 a.m.)

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

10 THE COURT: Thank you very much. Call your next
11 witness, please.

12 MR. COOKE: Thank you, Your Honor. The defense
13 would call Dr. Eric Nelson.

14 DR. ERIC NELSON, after
15 having been duly sworn, testified as follows:

16 THE CLERK: Please state your first and last name,
17 and spell your last name loudly and clearly into the
18 microphone.

19 THE WITNESS: Eric Nelson, N-e-l-s-o-n.

20 **DIRECT EXAMINATION BY MR. COOKE:**

21 Q. Good morning, Dr. Nelson.

22 A. Good morning.

23 Q. Can you tell the jury who you are?

24 A. I'm -- my name is Eric Nelson. I'm an
25 anesthesiologist at the Medical University of South

1 Carolina. I was the attending anesthesiologist during
2 Mr. Mikell's colonoscopy almost six years ago.

3 Q. October 1, 2010. How old are you?

4 A. Thirty-seven.

5 Q. Where do you live?

6 A. Currently in Mount Pleasant.

7 Q. What family do you have here?

8 A. I have a wife, Melissa, and two sons that are
9 seven and nine, Evan and Alex. And my parents also
10 moved here about three years ago, and they live in
11 Mount Pleasant now as well.

12 Q. Where did you grow up?

13 A. I grew up in the southwest suburbs of Chicago,
14 a town called or Orland Park, and basically lived there
15 my whole life.

16 Q. Until now?

17 A. Until now, yeah. Until, I guess, college and
18 then now, so.

19 Q. Walk us through your educational history. We
20 can skip high school, I guess, up there somewhere.
21 Where did you go to college?

22 A. I did my undergraduate at the University of
23 Iowa, where I actually majored in business. Then after
24 college, I came back to Chicago. I went to Medical
25 School at the Chicago College of Osteopathic Medicine

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1 at Western University. After medical school, I did a
2 one year internship, also through medical school. And
3 then anesthesia training is four years, so internship
4 and then three years.

5 Then I did my three years of residency at Rush
6 University Medical Center, which is one of the big
7 teaching hospitals in Chicago. After that, I came down
8 here and did a fellowship in cardiac anesthesia at
9 Medical University South Carolina. So I spent just an
10 extra year training in anesthesia for heart and lung
11 surgery.

12 Q. Now, let me back up. You went to the -- you
13 said the Chicago School of Osteopathic Medicine?

14 A. Yes.

15 Q. Now, just for those of us who haven't heard of
16 this, you can be either the allopathic or osteopathic;
17 is that right?

18 A. My credentials are DO rather than MD. DO
19 medical schools have been around for 150 years or so.
20 And then my residency was a MD residency. So all the
21 training is the same, everything we learn in medical
22 school is the same. The big difference is they say,
23 kind of the philosophy of taking care of the whole
24 patient, mind, body and spirit, but all the classes are
25 the same. We actually take additional classes in

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1 muscular skeletal, so spinal and manipulation. So
2 basically, we learn how to crack backs, so.

3 Q. But this is not some kind of fringe --

4 A. No, no, no. It's --

5 Q. -- or something like that?

6 A. No, it's been -- the Chicago School, I
7 believe, is the second or third osteopathic medical
8 school in the country. It's -- osteopathic medicine
9 started in Kansas. That was the first medical school.
10 And the original first osteopaths were actually MDs,
11 and then they kind of started medical school, and
12 wanted to do more integrative medicine. And so I'm not
13 sure, off the top of my head, how many DO schools there
14 are now. However, this next year, all of the
15 residencies will be combined.

16 And so basically if you're a DO, you can do any
17 residency, take all the same boards. I have all the
18 same board certifications as any other anesthesiologist
19 does. They just aren't as popular down here because
20 there's not as many medical schools in the Southeast as
21 there are, say, in the Midwest.

22 Q. And you do have medical licenses?

23 A. Yes. Currently I'm licensed to practice in
24 the State of South Carolina.

25 Q. So -- and I didn't mean to get off on that

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1 side track -- but what got you interested in
2 anesthesiology?

3 A. It was -- I believe my third year of medical
4 school, I initially thought I wanted to do primary
5 care. And then you start -- the first two years of
6 medical school are all just classroom work. And then
7 your third year, you start in rotations, so you just
8 shadow doctors and -- I started getting interested in
9 anesthesiology during my surgical rotation. I spent a
10 lot of time up at the head of the bed with the
11 anesthesiologist. The surgeon -- the surgeon I was
12 with tended to do a lot of go-stand-up-there. And the
13 anesthesiologist just started teaching me and kind of
14 showing me what they did. And I thought it was really
15 neat and I just kind of took it from there.

16 Q. So then what -- after medical school, what did
17 you have to do to become an anesthesiologist?

18 A. It was four years of residency. The first
19 year is actually required to do just a general -- they
20 call it a rotating internship. So you spend 12 months
21 kind of rotating through all the different medical
22 specialties. And actually the American Board of
23 Anesthesiology, which is our certifying board, allows
24 you to only do one month of anesthesia. Because they
25 want you to be kind of well versed and well rounded.

1 And then after that, you do three years of just
2 anesthesia, so.

3 Q. So you did four years of college, four years
4 of medical school, then four years of residency?

5 A. Yes.

6 Q. And internship. And at that point you are...?

7 A. Then you're eligible to take your boards. So
8 your boards are written boards. And once you pass your
9 written boards, you go on to take oral boards. So your
10 written boards are just a test that you sit down for
11 and take, all about anesthesia and patients.

12 And then once you pass, that you do oral boards,
13 where you basically sit in front of two senior
14 anesthesiologists that are vetted and trained, and they
15 present cases to you and ask questions. And the idea
16 being that you pass them if you answer the questions
17 appropriately, as what they consider a reasonable
18 anesthesiologist would do. And after that point in
19 time, you are considered board certified in anesthesia.

20 Q. And then at some point after that, you decide
21 to go into cardiac anesthesiology?

22 A. Yes. So immediately following residency, I
23 came down here to do a cardiac anesthesia fellowship --

24 Q. Why that -- what -- what made you want to do
25 that?

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1 A. Just during my training, I really enjoyed
2 doing anesthesia for heart surgery. I enjoyed taking
3 care of the patients. I liked the physiology of the
4 way the heart and the lungs, all the blood vessels play
5 together. I enjoyed the surgery. The patients tend to
6 be really sick. I found it as an interesting
7 challenge. And some of the anesthesiologists, I guess,
8 who had the biggest influence on me were cardiac
9 anesthesiologists, and so I kind of gravitated towards
10 that because they tended to be the ones that got
11 called. When you got into trouble, when somebody
12 needed help, they tended to say let's call a cardiac
13 anesthesiologist. They're used to doing some of the
14 biggest cases and the sickest people.

15 Q. What do you have to know as a cardiac
16 anesthesiologist -- not every -- don't tell me
17 everything.

18 A. Right.

19 Q. But generally what do you -- what areas do you
20 have to know about for that, that you -- that a regular
21 anesthesiologist wouldn't necessarily know?

22 A. It's not so much knowing more than a regular
23 anesthesiologist would know, it's more just -- you get
24 more used to dealing with sick people. People who have
25 -- people whose hearts don't work as well, who have

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1 problems with their valves; who have problems with
2 their lungs. It's more of a -- I would say a comfort
3 level because you're dealing with those patients on a
4 daily basis.

5 The other thing that we do do in cardiac
6 anesthesia fellowship, is we spend a lot of time doing
7 echocardiography, which is the ultrasound of your
8 heart. And so after the year of fellowship, we sit and
9 take -- we call them the echo boards, which is
10 basically a test, and we become certified in reading
11 echocardiography and performing it.

12 So during a lot of cases, we -- most open heart
13 cases, we actually do an ultrasound and examine the
14 patient's heart during the entire procedure.

15 Q. And so did you finish your fellowship in --

16 A. Yes.

17 Q. -- cardiac --

18 A. I did. I finished my fellowship. And then
19 sat for and passed my echo boards afterwards.

20 Q. When did you do that?

21 A. I finished the fellowship in June of 2009.
22 And it's all changed so much now, as everything goes to
23 computer testing. I think I waited a couple of months
24 because that's when the echo test was available. Now,
25 I think the test is available much sooner after

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1 fellowship, so the fellows are taking it in July or
2 August, but I believe I took it that Fall and passed
3 it.

4 Q. So -- so in October of 2010, you had all --
5 every -- all the certifications --

6 A. Yes --

7 Q. -- that I just described, you had?

8 A. Yes. I had finished fellowship. I had passed
9 all my boards. I was a board certified
10 anesthesiologist.

11 Q. And then what other certifications do you have
12 now?

13 A. One other certification that I've obtained
14 since then is a certification by -- it's the Heart
15 Rhythm Society, which is mostly cardiologists that deal
16 with your heart -- your heart is mostly run by
17 electrical signals. And I have a certification for
18 them with dealing with patients with pacemakers and
19 defibrillators.

20 And so if that makes sense, basically, I passed
21 a certifying exam that says I'm qualified to deal with
22 these patients and manipulate pacemakers, if necessary.
23 I did that just because we keep seeing more and more
24 patients with pacemakers and defibrillators for
25 surgery. And it's often necessary to change some of

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1 the settings or turn some of the special features these
2 have on and off.

3 Q. Now, when were talking the other day, you gave
4 me some statistics about how few anesthesiologists
5 there are that have that board certification?

6 A. I believe I'm one of ten in the US, maybe in
7 the world, that has this certification. For
8 anesthesiologists, it's usually done by cardiologists.

9 Q. What was your title in October of 2010?

10 A. Assistant Professor of Anesthesiology.

11 Q. And what areas of the hospital did you work
12 in? What types of procedure did you work in?

13 A. Pretty much all areas of the hospital because
14 I did mostly hearts. I was at Ashley River Tower where
15 we do -- I should say -- I didn't do -- I don't do pain,
16 management, ICU Care in the ICU or pediatrics. And by
17 pediatrics, I just kind of mean kind of kids under
18 eight years old. But being at the Ashley River Tower,
19 which is the adult hospital, all matters of heart,
20 lung, surgery, surgery on the blood vessels, abdominal
21 procedures. We spend a lot of time with the
22 cardiologists and their procedures.

23 And, also, there's a large portion of our work
24 that involves the endoscopy suite where this happened,
25 so doing colonoscopies and endoscopies.

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1 Q. So it seems like kind of opposite ends of the
2 spectrum, you go from doing open heart surgery to doing
3 a colonoscopy?

4 A. Correct.

5 Q. Why -- why would that be the case for somebody
6 with your training?

7 A. It's just kind of the way that we practice.
8 We do everything. And so those of us that do open
9 heart surgeries, kind of just do -- sometimes we can do
10 more procedures than other people. But I mean
11 everybody can do colonoscopies for the most part, but
12 not everybody can do open hearts.

13 The other reason we actually get called to the
14 endoscopy center somewhat frequently just because
15 somebody has a really bad heart. Probably the most
16 frequent calls that we get requested for are patients
17 who have mechanical hearts, just because they act a
18 little bit differently, and we're used to dealing with
19 those patients during the procedure, and kind of know
20 the physiology of the mechanical heart and how it
21 works. And so we help take care of those patients.

22 Q. Do you know who made the decision for you to
23 be involved with Mr. Mikell?

24 A. It would have been whoever made the schedule
25 the day before.

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1 Q. Would they have known to match somebody with a
2 heart problem up with a -- with a cardiac
3 anesthesiologist?

4 A. Not necessarily. Sometimes people come in and
5 we get a warning that somebody is coming in that's
6 really sick, and they think they'd benefit from a
7 cardiac anesthesiologist. Other times, the schedule
8 just gets made and you get put down there. And it's
9 kind of whoever shows up. We actually -- patients like
10 Mr. Mikell, and his co-morbidities, we see very often
11 down there.

12 Q. And then -- would you say that everybody --
13 every anesthesiologist who would be assigned, would be
14 competent to handle those types of patients?

15 A. Yes.

16 Q. What about the Digestive Disease Center at the
17 Medical University, is that a well respected facility?

18 A. I believe so as far as I -- I believe they
19 have a very good national reputation. I know we get
20 referrals from all over the state. We see -- probably
21 a lot of patients we see have come from elsewhere to
22 get their procedures done there, essentially throughout
23 the state, so.

24 Q. One last thing on your -- on your
25 qualifications, what professional societies do you

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1 belong to?

2 A. The American Society of Anesthesia, the
3 Society of Cardiac Anesthesia. This past year, I
4 became the fellowship director, so I'm in charge of our
5 cardiac anesthesia fellows, so I'm part of the Society
6 of Academic Anesthesiology Associations -- there's a
7 lot of A's in that title. Sorry. And the Heart Rhythm
8 Society as well, since I have that certification.

9 Q. Is there any way of estimating how many
10 colonoscopies you participated in as of October 1,
11 2010?

12 A. At that point, probably -- I would say over a
13 hundred. We get assigned to the Digestive Disease
14 Center, probably on almost a weekly basis. And every
15 time we're down there, we do a dozen or more cases at a
16 time, so.

17 Q. Tell the jury, if you would, about your
18 involvement with Mr. Mikell. And if you need to look
19 at records, just let me know what they are, and we'll
20 find them for you. But if you could, just -- just
21 start from the beginning.

22 A. Sure. I remember he was the first case of the
23 day, which tends -- I think it's nice, because I can
24 have a little more time to review the record. I
25 usually look up my first cases the night before and see

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1 if there is anything I need to know that's extra.

2 I remember I met him in the holding area and
3 reviewed his records, and seen that he had a -- quite a
4 few medical problems, including sleep apnea. COPD,
5 that he had had some arrhythmias problems, problems with
6 the conduction system of his heart that seemed to be
7 under control --

8 COURT REPORTER: Your Honor, could I get him to
9 slow down just a little bit.

10 A. Oh, I'm sorry.

11 BY MR. COOKE:

12 Q. It's all you Chicago folks.

13 A. I know, right. Sorry. And he had problems
14 with his conduction system, and also his ejection
15 fraction, which is the amount of blood your heart pumps
16 out was low. Most people, your ejection fraction would
17 be 60 to 70 percent. I believe his was in the 40s.
18 And at one time, it was even lower, in that he had been
19 admitted to the hospital and referred to MUSC a while
20 back for a heart transplant work up.

21 I met him in the holding area, had a discussion
22 with him to -- what we do for colonoscopies. Many of
23 you have had one, it is a real deep sedation. And it's
24 considered a general anesthetic in the fact that you
25 are asleep and can't respond. We can't just kind of

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1 shake you by the shoulder and wake you up, which would
2 be more of a conscious sedation.

3 But we just run an infusion of a drug called
4 Propofol, which goes through your IV during the entire
5 procedure. The nice thing about this drug is it's very
6 quick on, and very quick off. So when we turn it off,
7 it's only about 10 or 15 minutes. When we turn it on,
8 it works relatively quickly.

9 Because of Mr. Mikell's diseases in his lungs
10 and his heart, we decided to just start an infusion at
11 a rather low dose. I'm sorry -- I should back up.

12 When I met him in the holding area, we talked
13 about kind of the different ways we could do this
14 procedure, one of which was the sedation that I had
15 just started to explain. And the other would be to go
16 all the way to sleep and put a breathing tube in.

17 And so we put a breathing tube in so you can
18 control their airway, or put them on a ventilator for
19 the case. I remember discussing with him that maybe,
20 in some ways, that's a better choice because he has
21 sleep apnea. So when you have sleep apnea, the tissues
22 in your airway kind of collapse, and we call it
23 obstruction, so you can't get a breath in. And so this
24 alleviates that.

25 However, patients who have bad hearts and lungs,

1 one of the issues with putting a breathing tube in is
2 it can be hard to get them off of the ventilator. So
3 their body kind of gets used to the ventilator doing
4 the work for them. And even when you wake them up,
5 they're not strong enough to breath enough on their own
6 and get off the ventilator.

7 And so I discussed this with him. The benefit
8 of -- the colonoscopy is the -- the surgery -- the
9 procedure itself lends itself to people with sleep
10 apnea in a beneficial way. If you've ever known
11 somebody with sleep apnea, if they don't want to wear
12 their CPAP -- they tend to be more comfortable if they
13 just sit up. A lot of people will sleep on the Lazy
14 Boy. And so for a colonoscopy, a patient tends to be
15 sitting up a little bit, and a little bit tilted on
16 their side, and so it helps open up the airway.

17 I told him, from what I remember, that I think
18 we can do this safely without the breathing tube.
19 Because my fear is if we put the breathing tube in,
20 you'd end up in the Intensive Care Unit. We could have
21 a hard time getting you off the ventilator.

22 However, because you're sitting up, we can, I
23 think, do this safely. The caveat being we have a
24 pretty low threshold to put the breathing tube in, if
25 necessary. And so I discussed this plan with Donna,

1 and she was in agreement.

2 As I know the anesthesia record has been passed
3 around a lot, and basically the plan was we would give
4 him a little bit of Versed or Midazolam, which is kind
5 of like an IV form of Xanax. We give it to a lot
6 patients before we go back. It just kind of takes the
7 edge off. It'll be like having a couple of cocktails.
8 Gave him that. And then went back there and started
9 the Propofol infusion.

10 And we only started it at 75, which is actually
11 a very low dose. However, he was very sleepy just from
12 the Versed. And we started it at a low dose. We dose
13 it in micrograms per kilogram per minute. And so it
14 factors in his body weight, and 75 is a rather low
15 dose, but it was enough to put him to sleep.

16 Q. We've been over this before you got here, but
17 what were the risk factors that you had to take into
18 account?

19 A. They were pretty numerous. One of the biggest
20 ones, as an anesthesiologist, would be just the sleep
21 apnea. And so at times, it could mean that it's
22 difficult to mask the patient, which is when we have a
23 mask on somebody and we're squeezing a bag and
24 breathing for them, sometimes that creates extra
25 difficulty.

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1 The other difficulty would be just getting the
2 breathing tube in, if necessary. Examining his airway
3 in the pre-op period, it didn't look like he would be a
4 difficult airway actually. And so -- which isn't
5 uncommon. Some people, you ask them to open their
6 mouth, and you can't see anything but tongue in them.
7 Whereas other people, you ask them to open their mouth,
8 and you can see their uvula. Typically, if we can see
9 your uvula in the back of the throat, it tells us it
10 shouldn't be an issue to put in a breathing tube.

11 The things to us that were even more worrisome
12 were just his heart condition. So both the arrhythmia,
13 even though it was under control, and also his heart
14 failure, so his lower ejection fraction were worrisome
15 just because a lot of our drugs can depress your heart
16 function, so -- which is another reason we started it
17 at a lower dose.

18 Q. Just going back on the -- on the work up that
19 he had, what prior records did you have access to -- to
20 review on Mr. Mikell?

21 A. The next thing was he had everything done at
22 MUSC, and so I was able to look at his notes from his
23 cardiologist, and also his previous echocardiograms and
24 review those. Basically, if you're having surgery, and
25 especially an elective procedure, we take into account

1 if somebody is ill and has a lot of disease stated.
2 And as anesthesiologists, you want to make sure that
3 you're the best that you can be. So is there anything
4 that your cardiologists, your pulmonologist, one of
5 your doctors can do to make you better, to make this
6 procedure as safe as possible, and so we reviewed the
7 notes and made sure all the notes from the cardiologist
8 said, you know, he was doing well.

9 The other thing we ascertained is just -- do you
10 get around okay. A lot of times, if you're able to
11 kind of do your activities of daily living, be it
12 around your house, going to work, walking a couple of
13 blocks, we consider that you have a good enough
14 functional status that you should do okay during the
15 procedure as well.

16 Q. In addition to your work-up with him, had he
17 had a pre-anesthesia work-up with another physician?

18 A. Yes. We have a pre-operative clinic that some
19 patients go to. I believe he saw Dr. Inabinet in the
20 pre-op clinic. The big purpose of that is just to make
21 sure that no further testing or work-up is necessary.

22 Q. And is that routinely done for people going
23 into these procedures?

24 A. Not routinely. It's routinely done for people
25 who have a lot of co-morbidity such as he had.

1 Q. All right. I'm not -- I won't promise I won't
2 interrupt you again.

3 A. No problem.

4 Q. But I did interrupt you, as you were starting
5 to walk us through the process. Now, let me -- let me
6 pause for a moment -- and this is probably as good a
7 time as any to -- to put this narrative record up as a
8 reference point. All right.

9 Now, let me give you a little lesson here.

10 A. Sure.

11 Q. If you -- if you find that you -- at any time
12 need to point to something, I think you can just put
13 your finger on there.

14 A. Okay.

15 Q. And then when you want to erase it, you push
16 that thing, and something comes up, and you just hit
17 clear.

18 A. Okay.

19 Q. Okay. Because when you just point at that
20 screen, nobody can tell what you're pointing at unless
21 you touch it.

22 A. All right.

23 Q. So let's just use this as a guide -- as a
24 guide if we can?

25 A. Okay.

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1 Q. First of all, did you make some of these
2 entries and did other --

3 A. Yes.

4 Q. -- providers make some?

5 A. So I just want to mention that it's been a few
6 years since we used PICIS, because now we've switched
7 to Epic. But if I remember correctly, when you log-in,
8 you document under your name or initials, so mine would
9 be EWN. So anything that's made under that is
10 something that I directly put in.

11 However, Donna was logged in for the whole case,
12 so there could be times where I can make a memo, if I
13 didn't log myself in, it would show up under DBE. But
14 anything that says EWN is something I put in directly.
15 And I believe the way this system worked, I could only
16 chart in the computer in the room, so.

17 Q. All right. And -- and we'll talk about that
18 in a few minutes, too. But so using this as a guide,
19 if you will, can you -- can you walk us through --
20 don't have to read every line up there, but where are
21 we so far? You talked about bringing him into the
22 room?

23 A. So we -- we met in the holding area, and
24 talked about everything. And typically before we leave
25 the holding area, is when we would give you the Versed.

1 I'm not sure if anybody in the jury has ever had
2 surgery, but most people -- you are a little nervous
3 beforehand, so you want something that makes you a
4 little bit sleepy. So it's a very common practice to
5 give somebody a little bit of that med before we go
6 back.

7 And then 7:25 would just be kind of the opening
8 and the starting of the chart, which is usually done in
9 the holding area.

10 And then the mark at 7:35, the transfer to
11 button would be the button we hit right before we would
12 go back. And so, basically, 7:25, you put hit the
13 button, and you roll back to the procedure suite.

14 And 7:42 would be opening -- signaling opening
15 the chart. When you get in the room -- usually you get
16 in the room, and open the chart right away.

17 Q. Now, let me -- let me give you a couple of
18 times that aren't on there, but if I tell you that the
19 record says that the dose of Versed was given at 7:35
20 and one at 7:36, would that add up with what you recall
21 here?

22 A. Yes, I believe so. Basically, to me, it would
23 signify that we gave the Versed as we were rolling out,
24 which is usually what we do.

25 Q. All right. And I did interrupt you again.

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1 A. No, no problem.

2 Q. So keep going.

3 A. So just based on the narrative, the -- all
4 those entries at 7:42 would be just a button that Donna
5 hit that basically signified we were starting the
6 anesthetic. Induction in this case is a little bit
7 different than kind of your stereotypical induction if
8 you were putting a breathing tube in.

9 So when you say "induction", when you put a
10 breathing tube in, we're giving a syringe of Propofol,
11 a syringe of another drug, and putting a breathing tube
12 in, and that's induction.

13 When we just start an infusion induction, it's
14 kind of a lot longer. So the induction time, it's kind
15 of spread out as the infusion starts, and it starts to
16 build up in your body. It's a more -- much gradual
17 going to sleep. Sometimes patients are talking and
18 then they fade off, versus we give you a lot of
19 medicine in a syringe, and you're just out like a
20 light. And so that would be the 7:42.

21 And then 7:48 shows when I was in the room, it
22 just documented that I was there for the induction part
23 --

24 Q. Some of those things seem kind of formal like
25 "I, parentheses", or another attending

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1 anesthesiologist --

2 A. Right.

3 Q. Did you type that whole thing out and --

4 A. No, no, no, no. These are all, basically, I
5 think unless it says "memo", it just comes in by
6 itself.

7 Q. All right.

8 A. And so these are pre-populated by PICIS, so I
9 just click a button.

10 Q. All right. But you have to click the button?

11 A. Yes.

12 Q. For it to come under EWN?

13 A. Correct.

14 Q. So there's a group of them right there in the
15 7:48. If I tell you -- if I tell you that the audit
16 trail shows that you made those entries at 7:49 --

17 A. Uh-huh.

18 Q. -- would that -- does that sound right
19 according to your memory?

20 A. Yes. That would be when I was in the room. I
21 remember we got in the room. I went in the room. It
22 seemed like his oxygen saturations were down a little
23 bit. Because of his sleep apnea, we initially
24 attributed it that maybe he was obstructing, so he
25 wasn't able to get air pass his soft tissues. They

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1 were kind of collapsing his airway --

2 COURT REPORTER: If he could just slow down.

3 A. Sorry. I'm sorry. I'm a loud talker, too,
4 according to my wife. All right. Sorry. So this one
5 up here, where Donna wrote that I was in there and put
6 a nasal airway and the O2 sats came up, it was at that
7 time -- I was in the room. It looked like he had
8 desaturated a little bit, so we put -- it goes in your
9 nose and kind of goes down past your tongue, and it
10 just helps prop open your airway. And so we put that
11 in. And then he was able to breathe better. There
12 wasn't anything obstructing his airway.

13 BY MR. COOKE:

14 Q. All right. Let me stop you on that one for a
15 second. So when the procedure began, and I'm going to
16 tell you that the record shows that the Propofol was
17 begun at 7:41; does that sound about right?

18 A. Yes.

19 Q. And let me digress for a moment. There's
20 another note that says that the scope was in at 7:42,
21 is that -- is that possible, that you could have
22 started a Propofol then and then the scope?

23 A. Yes -- yes, I mean it all just -- it's very
24 specific to the patient. From what I remember,
25 Mr. Mikell was pretty sleepy just with the Versed. And

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1 so it's not at all unplausible that he got just a
2 little bit of the Propofol infusion started, and he was
3 sleepy enough to have a colonoscopy done.

4 Q. All right. Now, when you're -- when you're
5 actually in there, do you recognize any margin of error
6 for a human entered information?

7 A. Yes. Because you are going to the chart and
8 charting versus what's actually happening. And so I
9 mean -- back in the -- it makes me feel old, but back
10 in the old days when we just used paper charts, you
11 would just go back and kind of chart everything when
12 you had a chance. And it's almost the same as this.
13 Nothing kind of shows up on the narrative unless you go
14 to the computer, and actually push a button. And so
15 oftentimes, we are too busy dealing with the patient
16 and making sure they are safe, or doing things --
17 putting monitors on, starting medicine. And then you
18 go back and say, okay, I think this happened at this
19 time.

20 Q. All right. So at -- he started out with a
21 nasal cannula for delivery of oxygen?

22 A. Yes.

23 Q. And what's -- what's coming in through -- to
24 him through that tube?

25 A. Just oxygen. There's a little port that we

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1 hook up and usually run it on two or three liters per
2 minute, and it just gives you a little extra oxygen
3 going into your nose.

4 Q. And what -- what data is being monitored for
5 him?

6 A. So the -- we call them the ASA standard
7 monitor. And so we have a five lead EKG. We take your
8 blood pressure every two to three minutes. We monitor
9 your -- the SPO2, which is the oxygen content in your
10 blood. Then the other -- so the EKG monitors your
11 heart rate and rhythm. Also, we try to monitor your
12 end tidal carbon dioxide. There's a little side port
13 on our nasal cannula that can measure the carbon
14 dioxide, which is basically what you breathe out.

15 The one issue with this, if it's okay if I
16 digress a little bit -- and especially with these
17 colonoscopies -- is a lot of people when you go to
18 sleep, you become a mouth breather. And so, basically,
19 if it's not coming out of your nose, we're not going to
20 capture the data.

21 So if you're mouth breathing, we're not going to
22 pick up your carbon dioxide, and so that's why it's
23 important just to be watching the patient. And so I
24 would be able to see if you're breathing or not, versus
25 only going on data that's on the screen.

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1 Q. What was the reason for switching from a nasal
2 cannula to the nasal tube?

3 A. The nasal airway was just to help prop open
4 his airway. And so people with sleep apnea have a lot
5 of extra soft issue that's kind of in -- especially
6 back in your throat and your tongue. And as you go to
7 sleep, and that soft tissue relaxes, it occludes your
8 airway, so that air can't get through.

9 And this tube has a hole in the middle of it.
10 And so when you put it in, it kind of goes in your nose
11 and goes all the way to the base of your tongue. And
12 it helps prop open your airway and also allows air to
13 get through that way.

14 Q. Are you -- are you pumping the air in through
15 that tube?

16 A. No. You're not pumping the air in, you're
17 actually still breathing on your own, so.

18 Q. But you just have something like a stint
19 holding your --

20 A. Right, yeah. That's a great way to put it.
21 It acts like a stint to extend open your airway.

22 Q. Okay. All right. So then -- so are you
23 absolutely positive that you were in the room at 7:48
24 or 7:49?

25 A. Yes. I mean, I know I was in the room when we

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1 put the nasal airway in. I remember that. And also
2 there would be no other way to chart under my name,
3 because I don't share my user name or password with
4 anybody, so.

5 Q. I'm going to show you some values. You can't
6 see that yet, but I'm going to put something up for you
7 here. And just remind everybody, the SP02 is the -- is
8 that the top right line right under the -- under the
9 times?

10 A. Yes.

11 Q. Okay. So let's focus in a little bit here. I
12 assume that you know by now that the PICIS was not
13 collecting data until 7:48?

14 A. Correct.

15 Q. Now, does that mean that the equipment wasn't
16 working?

17 A. No. It just means the data wasn't going from
18 our monitor to PICIS.

19 Q. Did you see any reason at that time to cancel
20 the procedure or to stop?

21 A. No, because I don't -- to me, the computer has
22 nothing to do with patient care. Like I said, when we
23 did paper charts, we charted on paper. And so the fact
24 that data wasn't going over wouldn't be a reason for me
25 to start -- to stop a case or cancel a case. We also

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1 have -- I guess a good example would be across the
2 street at Roper, they still use paper charts. We have
3 paper charts in every operating room because, as I'm
4 sure you all know, if you have a computer at times, it
5 just decides to stop working.

6 We also have a lot of times where they update,
7 or we call them down time, so they're updating the
8 procedure in which case we just a paper chart. So, to
9 me, it wasn't a reason to stop or delay the case
10 because we were still monitoring all the vital signs.

11 Q. Do you know Donna Embrey?

12 A. Yes.

13 Q. Had you worked with her before?

14 A. Numerous times, yes.

15 Q. Is she an experienced and competent CRNA?

16 A. Yes, she is.

17 Q. Has she -- has she had experience with cardiac
18 patients as well?

19 A. Yes.

20 Q. Would it be concerning to you that she had
21 texted at 7:39 IT, to inform them that the chart wasn't
22 populating; and that she texted again at 7:46 to ask
23 them to call her, to help get it working?

24 A. I don't think it's concerning. I mean, it's
25 something that we do almost on a daily basis. The --

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1 the paging system that we use is a web page, and it's
2 actually on the same computer as the computer chart.
3 So it takes all of five or ten seconds to send a page
4 to somebody via that. And that's often what we do is
5 we page -- we'll page our anesthesia techs. We page
6 other people, and so.

7 Q. Would there be anything about that that would
8 prevent her from being able to pay attention to what's
9 going on with Mr. Mikell?

10 A. There shouldn't be because your -- your line
11 of sight -- actually, the way the computer is -- it's
12 hooked up to our anesthesia machine, so the computer is
13 here. Your ventilator and anesthesia machine is here,
14 and your vital signs are here. And so it's all within
15 your line of sight. And then the patient is here. So,
16 basically, everything is within your line of sight at
17 all times.

18 Q. What audio cues are being given?

19 A. The biggest is your pulse oximeter, and it's
20 tonal. And so the higher the tone, the higher the
21 oxygen percentage in your blood. It's one of those
22 things, as an anesthesiologist, it's reassuring if we
23 go into a room -- if we get called to a code, the first
24 thing I think the majority of us do is turn the tone
25 on, on that. Because oftentimes on the floor, it's not

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1 on because other people find it annoying. But in the
2 operating room, it's always on.

3 Q. Okay. I'm just going to pull this down so we
4 can kind of look at both at the same time if necessary.
5 And I want to try to correlate what was going on
6 according to the notes, with what was going on, on the
7 record here. So going to 7:48, you got your note here
8 that says that "anesthesia, present for induction",
9 Nelson -- "memo, Nelson MD in, nasal airway in, O2 sat
10 up to 94 percent, patient remains lateral". And indeed
11 at 7:48, the first reading -- you see that as 96.7?

12 A. Yes.

13 Q. Now, is that a good number?

14 A. Yes, it's very good.

15 Q. All right. And then it says at 7:51, you were
16 out?

17 A. Uh-huh.

18 Q. Is that correct to your knowledge?

19 A. I believe so. And so I know -- we put the
20 nasal airway in. I kind of stuck around to make sure
21 it was working, that his saturations came up. You can
22 see at 7:49 and 7:50, it dipped a little bit, which
23 really isn't that uncommon. Sometimes there's a little
24 bit of a delay between you starting to breathe a little
25 bit better and your sats coming up. And so that could

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1 be what happened here.

2 And then 7:51, the saturation of 90.1. I saw
3 that his saturation had come up and so I stepped out of
4 the room to go to another room. At the time, I was
5 covering two rooms down there. And so I think I went
6 out and checked on the other colonoscopy site at that
7 time.

8 Q. Were you comfortable -- well, I don't want to
9 put words in your mouth. Describe for the jury, if you
10 would, what your judgment was at the time that you --
11 that you decided it was all right to step out of the
12 room at 7:51?

13 A. As I said, I thought he was doing okay. We
14 put the nasal cannula -- nasal airway in. His
15 saturations had come up. Dr. Payne had started the
16 procedure and everything seemed to be stable and kind
17 of going as expected, so.

18 Q. And that -- that 90.1, is that -- is that an
19 acceptable --

20 A. Yes.

21 Q. -- saturation level?

22 A. Yes.

23 Q. Do you see any other numbers up there that
24 would be troubling to you?

25 A. I mean later on when he dipped to 80, and then

1 he dipped to 73, those are a little troubling. Then
2 you want to intervene again.

3 Q. Well, let's describe how your -- how your team
4 worked on that day. Donna Embrey is a CRNA?

5 A. Yes.

6 Q. And, of course, Dr. Payne is in the room doing
7 the procedure?

8 A. Yes.

9 Q. Is there anybody else in the room?

10 A. There's at least -- I believe there's an
11 endoscopy nurse, and either another nurse or a tech in
12 the room as well.

13 Q. What's the -- what's the interaction between
14 you and Donna Embrey in that situation?

15 A. In this situation, we -- from the beginning,
16 we kind of discussed the case, say this is what's going
17 on. These are what his medical issues are. This is
18 how I think we should do it. We agreed. She says
19 okay.

20 I'm in a supervisory role, and so I go there for
21 kind of the key parts. So at the beginning of the
22 case, the end of the case, I come in throughout the
23 case to make sure everything is okay. If there's any
24 issues, Donna would page me and let me know.

25 Q. Do you happen to recall whether the dosage of

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1 Propofol was reduced during that period of time when
2 you were putting the nasal airway in?

3 A. I don't recall. I'm sorry.

4 Q. Okay. We'll have the records on that. All
5 right. So how far -- how far away were you in terms of
6 the amount of time it would take you to get back?

7 A. I mean, maybe from me to you, it's a rather
8 small area. The rooms that we work in, there's four
9 rooms, and it's kind two across -- literally across the
10 hall from each other. And so the room I went to, I
11 kind of popped across the hall. Then I circled back
12 pretty quickly just because I knew we already had to
13 intervene once, and put the nasal airway in. And so
14 sicker patients, I tend to do more frequent rounds and
15 check in more frequently, just to make sure everything
16 is okay.

17 Q. And how can you be reached if somebody does
18 need you?

19 A. It's most commonly by pager. And so you can
20 send a page, either through the operator or through the
21 computer.

22 Q. Could somebody just yell out the door if they
23 needed you?

24 A. Yeah. I was close enough that if somebody
25 yelled through the door, I would hear them, which has

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1 happened actually -- since you mention it, it happens
2 kind of frequently down there, because everything is so
3 close together. So if somebody needs help, usually the
4 quickest thing to do is they stick their head out the
5 door, and just say we need help in here, so.

6 Q. I'm going to piece two pages of this record
7 together. That's about the best I can do. So, now
8 we've got 7:48, 7:49, 7:50, 7:51, 7:52, 53, 54, 55, 56,
9 57; do you know, Dr. Nelson, when you came back into
10 the room?

11 A. I know it was -- when I came back in, it was
12 when he -- his saturations were low. So I would -- I
13 don't remember the exact time, and if my time would
14 actually match up with here, but it was probably
15 between 7:55 and 7:58. Because I still remember, to
16 this day, I walked back in the room and the monitor he
17 was in -- what we call a junctional rhythm, which
18 basically is kind of a squiggly line on the EKG instead
19 of the nice QRS complex that you're used to seeing.
20 And I felt his pulse, and I didn't feel a pulse.

21 And so, at that point in time, I said we needed
22 to start chest compressions. And these patients are
23 propped up on a wedge on their side, and so we pull the
24 wedge out. Dr. Payne took the scope out. And we
25 started doing chest compressions because we realized

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1 that his heart, if it was beating or moving, was not
2 pumping blood adequately enough to the rest of his
3 body.

4 Q. Do you recall whether Ms. Embrey was already
5 bagging Mr. Mikell when you came in?

6 A. To my recollection she was not.

7 Q. And did you -- did you assist in turning him
8 and starting that process?

9 A. Yes. I believe, I was the one who lowered the
10 side rail and pulled the wedge out to start chest
11 compressions. And immediately at that time, Donna
12 began bagging him. And then subsequently, intubating
13 him.

14 Q. Okay. Now, of all those -- of all that data
15 up there, there are a lot of numbers; correct?

16 A. Yes.

17 Q. Do you know -- do you know how those numbers
18 get in that chart?

19 A. The numbers are directly brought from the
20 chart -- to the chart from our vital sign monitor.

21 Q. Okay. And what about the one thing up there
22 that's not a number, is that heart rhythm,
23 S-R-J-U-N-C-T-B-E-A- -- do you -- do your machines
24 recognize that and put that in there, or does that have
25 to be done by a person?

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1 A. I believe that's done by a person.

2 Q. Is that the only thing, to your knowledge up
3 there, that we're looking at that's entered by a
4 person?

5 A. To my knowledge, yes.

6 Q. Well, can you tell from looking at those
7 numbers -- well, I'm being a little unfair to you
8 here -- I'm going to give you the --

9 A. Oh, thanks.

10 Q. Can you tell from those numbers when
11 Mr. Mikell started to be bagged?

12 A. It was most likely at 7:56. Because the --
13 the bottom here, where it says PIP, is your peak
14 inspiratory pressure. And basically you're not going
15 to have a peak -- you're not going to have an
16 inspiratory pressure if you're breathing on your own.
17 Because your airway gets negative pressure as you
18 breath in; whereas when you use a bag, you're creating
19 positive pressure, if that makes sense.

20 And so that's why the numbers are zero, one, and
21 then this number at 7:55 is three. But then when it
22 jumps up to 7:28, 27 is -- I'm sorry -- 7:56, the
23 number 27 would present to me the beginning of starting
24 to bag mask somebody.

25 Q. And then what about the FI02, does that give

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1 you any indication?

2 A. Yes. Because the initial FI02s are in the 20s
3 here, which is more -- that has to do with nasal
4 cannula, and so the area of breathing in right now is
5 about 21 percent, FI02, which is the oxygen content.
6 Whereas -- and so if you would have just somebody on
7 nasal cannula with a little bit of extra oxygen going,
8 it would be in the high 20s like that. And then you
9 wouldn't be able to get that FI02 up to 99, to a 100
10 percent, unless you had a seal and were giving them
11 oxygen with a mask.

12 Q. So that would -- that would be consistent with
13 bagging him with --

14 A. Yes.

15 Q. -- outside of with the air supply?

16 A. Yes.

17 Q. So what confidence, if any, does this give you
18 that, in fact, you were back in the room by 7:55 or
19 7:56?

20 A. It gives me pretty good confidence. Because,
21 like I said, I remember walking in there and flipping
22 him on his back, and basically we started chest
23 compressions and bagging at exactly the same time.

24 Q. Now, there's a note here, I'm going to -- I'm
25 going to save you some suspense, and tell you that on

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1 the PACU record is -- see that one that says 7:56,
2 "DBE, memo, came into room". There's one that looks
3 just like that except it's got your initials and it
4 says 8:00?

5 A. Right.

6 Q. Now, when did you put that entry into the
7 record?

8 A. It would have been after everything had
9 happened, after we got him stabilized, after the code,
10 and he went to the recovery room -- or the PACU. I
11 went back and just tried to document, as best I could,
12 the events that happened. And so it would have been
13 8:30, 8:45. And then I back timed it so that it would
14 be -- fall in the chart when I thought it kind of had
15 happened, which to my recollection at that day was
16 about 8:00.

17 Q. Now, when -- did you -- did you make a note,
18 or look at a clock, or start a stopwatch, or do
19 anything like that when you came into the room to help
20 Mr. Mikell?

21 A. No. My only focus was on him to be honest
22 with you.

23 Q. Do you -- do you have any opinion whether the
24 8:00 number or the 7:56 number is a more accurate
25 reflection of when you actually came into the room?

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1 A. Based on the numbers and everything that we
2 looked at with the vital signs, I would say 7:56 is
3 more accurate. Because I know I -- there wasn't bag
4 masking going on until I came in the room. And as we
5 saw in the chart a minute ago, that started about 7:55,
6 7:56.

7 Q. So tell us everything that you and the -- the
8 rest of your team did to resuscitate Mr. Mikell?

9 A. The first thing is we started chest
10 compressions, which is basically just to get the blood
11 circulating again, to profuse the rest of your body.
12 Donna, at that point, put a breathing tube in. And
13 that just makes sure your airway is secure and makes
14 sure you're getting adequate oxygen to your lungs, and
15 also getting rid of carbon dioxide as necessary.

16 I believe we gave a milligram of Epinephrine,
17 which is common practice and it's part of the ACLS
18 guidelines. So ACLS just being what to do when
19 somebody has a heart attack or a cardiac event -- sorry
20 -- I shouldn't say heart attack, but a cardiac event.

21 And at one point, he -- his rhythm went into
22 ventricular fibrillation which is literally your heart
23 is just kind of squeezing like this. It's just getting
24 electrical signals from all over the place and it's not
25 pumping, rather it's vibrating. And so one of the

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1 answers to that is to defibrillate somebody or to shock
2 them. And so at one point, we did shock him.

3 I think we only had to shock him once, and we
4 got his rhythm back to sinus rhythm, and his heart was
5 beating again, and then adequately giving blood.

6 During all this as well, we started some extra
7 IV lines. We started a line in the artery, in his
8 wrist, so that we could see his blood pressure every
9 time his heart beats, but it also allows us to draw
10 labs to make sure everything looks okay.

11 I believe somebody else had put in a central
12 venous line, too, in case we needed to give drugs like
13 Epinephrin.

14 Q. Was -- was the Mayday team called?

15 A. Yes, they were. I called them kind of
16 immediately when I saw that he wasn't doing well, just
17 to get some extra hands on, experienced hands.

18 Q. How long did it take for the team to get
19 there?

20 A. A minute or two, I guess as long as it took
21 them to run down two flights of stairs.

22 Q. And were you already performing the procedures
23 that you described when they arrived?

24 A. Yes. By the time they arrived -- we were
25 already doing chest compressions and had started the

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1 whole ball rolling, so.

2 Q. And then did you have anything to do with his
3 care after -- after resuscitation was completed?

4 A. We made sure -- after he was resuscitated and
5 it looked like he was stable, we sent him to the
6 Intensive Care Unit. I believe the Intensive Care Unit
7 was full, and so he went upstairs to the PACU to be
8 monitored there until a bed was available in the
9 Intensive Care Unit. But I didn't have -- he then got
10 turned over to an ICU team, so.

11 Q. Whose idea was it to cool his body?

12 A. I believe it was Dr. Guldan's.

13 Q. Why is that done?

14 A. It's done -- if you have an event like this,
15 it helps just to protect all your organs and
16 essentially your brain. When you are really cold,
17 everything in your body kind of slows down. Ever so
18 often you hear stories -- this is how I equate it to --
19 a kid up in Minnesota or something falls through the
20 ice and they are underwater for what seems like a
21 really long period of time, and they come back somehow
22 after they're resuscitated. It's because your body get
23 so cold that it slows down so it doesn't require as
24 much oxygen.

25 So the idea is you cool somebody down after an

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1 event like this, kind of slow everything down, then
2 slowly warm them back up to protect their organs.

3 Q. You've had time to look back and think about
4 this case, have you not?

5 A. Yes. Yes.

6 Q. Well, the tell the jury in your own words why
7 did this happen to Mr. Mikell? If you guys were being
8 so careful with him, how did this happen?

9 A. I'm not sure. It's -- to me, it could have
10 been a couple of different things. It could have been
11 --

12 MR. RANSOM: Your Honor, I would have to object if
13 he's not sure. We don't need him to speculate.

14 MR. COOKE: He said it could --

15 THE COURT: I'll sustain the objection. Rephrase
16 your question.

17 BY MR. COOKE:

18 Q. In your opinion, most probably what -- what
19 events could have caused him to desaturate and go into
20 cardiac arrest?

21 MR. RANSOM: The same objection, Your Honor.

22 THE COURT: Overruled.

23 A. Again, I'm not sure if it was -- if his heart
24 caused the desaturation because it wasn't pumping blood
25 properly, or if he desaturated and then it caused his

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1 heart to go into what we call malignant rhythm, that
2 wasn't pumping properly.

3 I think he -- his heart disease was worse than
4 we initially suspected, and he was kind of teetering on
5 the edge so-to-speak. He was just sick.

6 Q. Do you -- do you have an opinion as to whether
7 the outcome would have been different had you been in
8 the room, yourself, the whole time?

9 MR. RANSOM: Objection, Your Honor.

10 THE COURT: I'll sustain the objection.

11 BY MR. COOKE:

12 Q. Do you believe that your having stepped out of
13 the room at 7:51 caused Mr. Mikell to go into cardiac
14 arrest?

15 MR. RANSOM: The same objection.

16 THE COURT: I'll sustain the objection.

17 BY MR. COOKE:

18 Q. All right. Do you have an opinion, to a
19 reasonable degree of medical certainty, based on your
20 knowledge, training, and experience, and what you have
21 observed, whether your leaving the room at 7:51 caused
22 or contributed to Mr. Mikell's suffering a cardiac
23 arrest?

24 THE COURT: Let me -- let me see the lawyers up
25 here just a second.

1 (WHEREUPON, a bench conference was had.)

2 BY MR. COOKE:

3 Q. Doctor, I told you that I was going to show
4 you the record of the Propofol administration?

5 A. Yes.

6 Q. And you see it right there?

7 A. Yes.

8 Q. Right where that big dot is?

9 A. Yes.

10 Q. And so what does that record show with regard
11 to the administration of Propofol?

12 A. It shows that the Propofol was started at
13 7:41. And at 7:51, the dose was decreased from 75 to
14 50.

15 Q. All right. In your opinion, was that
16 appropriate to reduce the dose based on what was
17 happening at that time?

18 A. Yes, it was. Because that would be right
19 around the time that we put the nasal airway in, and it
20 seemed like he was having a little trouble breathing.

21 Q. All right. And can you tell from that chart
22 when Ms. Embrey actually stopped the Propofol?

23 A. I'm not sure if that's what that little
24 asterisk at 7:53 means, but I'm not sure.

25 Q. Okay. Based on all the evidence that you've

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1 seen and all the information here, do you believe that
2 it was a deviation from the generally accepted standard
3 of care for you to have left the room at 7:51?

4 MR. RANSOM: Objection, Your Honor.

5 THE COURT: Overruled. Go ahead.

6 A. No, I don't believe it was.

7 BY MR. COOKE:

8 Q. And why not?

9 A. At the time I stepped out of the room, his
10 vital signs were stable. He was in the hands of an
11 experienced nurse anesthetist, and I was very close by.

12 Q. With all the information that you have gleaned
13 from this case, I want you to tell the jury, and tell
14 Mr. Mikell's family, is there anything that you think
15 that you or Ms. Embrey could have done better to help
16 Mr. Mikell?

17 MR. RANSOM: Objection, Your Honor.

18 THE COURT: Overruled. Go ahead.

19 A. Something I feel like I've asked myself
20 numerous times since this happened, and I'm not sure
21 what we could have done differently or better. I think
22 we recognized when we got into trouble very quickly --
23 I'm still not sure what actually transpired to cause
24 his heart to go into a non-perfusing rhythm. And even
25 to this day, it's on a weekly basis, we see patients

1 who have almost the exact same set of core mobilities,
2 and given the exact anesthetic and go through the exact
3 same thing, and they do fine.

4 MR. COOKE: Thank you. That's all I have.

5 THE COURT: Thank you very much.

6 Cross-examination.

7 MR. RANSOM: Thank you, Your Honor.

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

9 Q. Good morning, Dr. Nelson.

10 A. Good morning.

11 Q. Let me move these charts, so you and I can
12 have direct sight. Now, you would agree with me that
13 the type of training that you have in cardiac
14 procedures -- well, the -- that usually involves being
15 in an operating room setting, where you've got one
16 patient and you are spending hours upon hours in the
17 same place attending to one patient?

18 A. During fellowship you mean?

19 Q. Well, when you're being -- when you're the
20 anesthesia provider, for example, open heart surgery or
21 a lung transplant?

22 A. When I'm the attending or if I was the fellow
23 in that case?

24 Q. Either one.

25 A. So, when you're the fellow, you're in the room

1 the entire time. The attending anesthesiologist in
2 this case also does a supervisory role. And so
3 oftentimes we have a fellow or a resident doing an open
4 heart case, we also have another case in another room
5 as well.

6 Q. All right. You wouldn't, though, participate
7 in 12, 15, 20 open heart surgeries in a day, would you?

8 A. No. That's -- so the standard is if you have
9 a resident, you can have two rooms, so two ORs or two
10 procedural suites. CRNAs, you can have -- I believe up
11 to four sites. At MUSC, we do -- if you have CRNAs, up
12 to three sites.

13 Q. And there's a pretty big difference, either
14 there -- between the volume that you see in the DDC
15 Center doing colonoscopies, and the patient volume that
16 you see in a day when you're doing open heart surgery;
17 right?

18 A. For open heart surgery, yes.

19 Q. And the volume in the DDC Center is really
20 pretty high; right?

21 A. Yes.

22 Q. Okay. I think you had said that you see
23 upwards of 12 to 15 patients in a day?

24 A. Yes.

25 Q. And Mr. Mikell was the first patient that day?

1 A. Yes.

2 Q. And so if you don't keep the schedule with the
3 first patient, then you're behind the eight ball all
4 day; right?

5 A. Yes.

6 Q. And you -- because of the information that you
7 were able to review that Dr. Inabinet put together, and
8 because of your training in cardiology, you understood
9 very well that the obstructive sleep apnea and the
10 heart failure placed Mr. Mikell at an increased risk?

11 A. Yes. But I would like to correct you. It
12 wasn't Dr. Inabinet's information, it was the
13 information in his actual medical chart.

14 Q. Okay. And so, and it's true, you actually --
15 because of some of these electronic record systems that
16 they have at MUSC, you've got access to his entire
17 medical record?

18 A. Yes.

19 Q. Going all the way back to 2003, or whenever it
20 was that he first started coming to MUSC?

21 A. Yes.

22 Q. But now you didn't spend that morning going
23 over all of that record; did you?

24 A. No. I took kind of the most recent ones.

25 Q. Right. Right. So, for example, you would

1 have seen Dr. Zile's April 30, 2010, office note where
2 he said that Mr. Mikell was doing quite well?

3 A. Yes.

4 Q. But nevertheless, you knew that he was a heart
5 failure patient?

6 A. Yes.

7 Q. And you knew that he had obstructive sleep
8 apnea?

9 A. Yes.

10 Q. You knew that his doctors had recommended when
11 he went to sleep at night at home, that he would have a
12 device on his nose to generate I think -- a CPAP stands
13 for Continuous Positive Airway Pressure?

14 A. Yes.

15 Q. And one of the reasons that they wanted that
16 was because that airway pressure would help to keep his
17 airway from obstructing while he was at sleep?

18 A. Yes.

19 Q. And you also understand -- and, listen, I
20 appreciate you said you had a discussion with Mr.
21 Mikell about whether or not to actually intubate him
22 with a tube that goes down his throat.

23 A. Yes.

24 Q. And if his air -- you call that securing his
25 airway?

1 A. Okay.

2 Q. Right?

3 A. Yes.

4 Q. That's what you anesthesiologists call it?

5 A. Yes. Yes.

6 Q. And, of course, if his airway is secured with
7 an endotracheal tube, the problems that are created by
8 the obstructive sleep apnea, in terms of his airway
9 shutting off, those -- those are completely solved;
10 right?

11 A. Right.

12 Q. I mean, he's not going to obstruct if he's got
13 an ET --

14 A. No.

15 Q. -- tube?

16 A. No.

17 Q. All right. But now he took your advice in
18 deciding not to do that?

19 A. I don't know that it was my advice. I just
20 presented him with both options -- yeah, I guess you'd
21 say it was my advice. And I thought -- because I
22 thought the risks of any -- up in an ICU on a
23 ventilator, if we did the ET tube was higher than
24 obstructing.

25 Q. And that's kind of what I mean, Mr. Mikell was

1 a nice guy and he's probably pretty intelligent, but I
2 mean he's -- he's not going to argue with you about
3 your recommendation, is he?

4 A. Probably not.

5 Q. All right. So you made the decision that you
6 weren't to secure his airway, but now you still
7 understood very well that because of his obstructive
8 sleep apnea, he was at risk of obstructing his airway
9 once he was put to sleep with the anesthetic agent?

10 A. Correct.

11 Q. Okay. And there are things that can be done
12 to protect a patient's airway that are -- that fall
13 short of actually using an endotracheal tube to
14 intubate him; right?

15 A. Yes.

16 Q. Okay. One of the things that you can do to
17 protect a patient's airway is insert this nasal airway?

18 A. Yes.

19 Q. And it's a little bit uncomfortable to do,
20 isn't it?

21 A. Right.

22 Q. Patients don't really like having a tube stuck
23 up their nose and back down in the back of their
24 throat?

25 A. No.

1 Q. So it's fair to say that that's kind of a pain
2 to do that?

3 A. Okay.

4 Q. Right?

5 A. Yeah. I mean that's why we do it when they're
6 asleep.

7 Q. Okay. And the -- that was certainly an option
8 that you would have had to --

9 A. Well, we did do that.

10 Q. Well, but you didn't do it until after he had
11 already obstructed?

12 A. Right. That's typically what we do. We don't
13 insert a device like that unless somebody declares that
14 they need it, basically.

15 Q. Well, and this is sort of the point that I'm
16 trying to make with you here was, since you knew that
17 he used a CPAP machine at home, and that that was
18 necessary to keep him from obstructing when he is
19 asleep at home, you didn't really plan to do anything
20 other than having him sitting up a little bit?

21 A. Sitting up, and also on his side, yes.

22 Q. Okay. So there wouldn't have been anything
23 preventing you from this sort of a preventative, get
24 out in front of the problem measure, to put the nasal
25 airway in before he starts to obstruct and desaturate?

1 A. That's just not done, I mean --

2 Q. It could have been done, couldn't it?

3 A. I've never heard of it being done beforehand
4 to be honest with you. I don't think it's in the
5 literature at all either.

6 Q. Would it not have helped prevent him from
7 obstructing? Because that's what you actually did when
8 he started to obstruct?

9 A. Yeah, it may have helped. But like I said, we
10 had him sitting up and also in the lateral position,
11 which typically helps as well.

12 Q. And one of the really -- one of the main risks
13 that Mr. Mikell posed was because of his combination of
14 obstructive sleep apnea and congestive heart failure,
15 you knew that if he began to desaturate and wasn't -- I
16 think the medical term is ventilating, meaning
17 breathing effectively?

18 A. Uh-huh.

19 Q. Pretty quickly, his blood was going to build
20 up carbon dioxide, and that's what you call a
21 hypercapnic state?

22 A. Yes.

23 Q. All right. And you knew that his heart was
24 particularly sensitive to either low oxygen saturations
25 or elevated carbon dioxide levels, and the combination

1 of those two things is really bad?

2 A. Yes.

3 Q. And you knew that?

4 A. Yes.

5 Q. Okay. And you also understood that with a
6 patient like Mr. Mikell, who is -- if I can use the
7 word "fragile" from an anesthesia standpoint, that it
8 made sense to be more careful rather than less, and to
9 be paying more attention rather than less?

10 A. Yes.

11 Q. Okay. And you said that your general practice
12 is that you're in a supervisory role; correct?

13 A. Yes.

14 Q. And that means that you're responsible for
15 what takes place?

16 A. Uh-huh.

17 Q. And that means that you're the one who is
18 directing everyone else's conduct; right?

19 A. Meaning -- by "everyone", you mean the CRNAs?

20 Q. Well, it -- that's right. The anesthesia care
21 providers, they are under your authority? Donna is?

22 A. Yeah, I mean, I don't know that I'm directing
23 all of her conduct. But her duty is to carry out the
24 anesthetic plan that we come up with that -- that I
25 formulated, so.

1 Q. But it's also your responsibility to make sure
2 that the way that Mr. Mikell's care is provided is
3 safe?

4 A. Yes.

5 Q. All right. Because we can agree that if
6 certain procedures aren't followed, especially with a
7 patient like Mr. Mikell, even this routine colonoscopy,
8 is not safe?

9 A. Correct.

10 Q. Okay. So you're the one who's charged with
11 maintaining the patient's safety?

12 A. Yes.

13 Q. And you're the one who's charged with
14 supervising the nurse anesthetist?

15 A. Yes.

16 Q. And you're the one who's ultimately
17 responsible for all the decisions that are made?

18 A. Yes.

19 Q. You said that you were sort of in at the
20 beginning and out at the end, that's what -- that's
21 what your role is in these cases?

22 A. In there for induction during the -- with all
23 the big parts and checking in. And then at the end as
24 well, yes.

25 Q. But generally speaking, it's at the beginning

1 when the patient is put to sleep?

2 A. Yes.

3 Q. And then you come in at the end when it's time
4 to wake him back up?

5 A. Yes.

6 Q. All right. And so you wouldn't normally plan
7 on being present in the room during the middle of the
8 procedure?

9 A. No. I'm usually present -- check in every
10 hour or so.

11 Q. All right. And that morning, you had at least
12 one other patient that you were responsible for?

13 A. Yes.

14 Q. Now, was that patient also undergoing a
15 colonoscopy, or was it something more complicated?

16 A. I don't remember. It was most likely -- I
17 mean, it was in the Endoscopy Center, so odds are it
18 was a colonoscopy.

19 Q. Okay. But -- but there are sometimes things
20 that take place in the Endoscopy Center that are more
21 routine and sometimes it less routine; right?

22 A. Right.

23 Q. By you just don't remember what the other
24 procedure was?

25 A. No.

1 Q. All right. And you certainly agree, you don't
2 dispute that you, in fact, were in and out during
3 Mr. Mikell's procedure?

4 A. Yes.

5 Q. And as we sit here today, I wouldn't expect
6 that you would have nearly as good a memory about when
7 you were in and out as what you had back on October
8 1st?

9 A. No.

10 Q. And you probably didn't have, at any time, any
11 better recollection of when you were in and out than
12 right at the end of the event; right?

13 A. I guess not.

14 Q. I mean, so the way that it went that morning
15 was after Mr. Mikell was resuscitated, and he was then
16 taken to the PACU, you went -- you went to the terminal
17 there in the DDC room, got on the keyboard and entered
18 in the time at which you had come into the room?

19 A. Again, that was -- I don't know how exact that
20 8:00 was, because I didn't look at a clock when I came
21 into the room.

22 Q. Well, okay so -- and I understood that today
23 you were going to run away from that number -- all
24 right. But we -- you would agree with me that when
25 you're standing there at keyboard, at about 8:30, 8:34

1 that morning -- all right -- your purpose in making
2 these entries is for them to be accurate?

3 A. Yes.

4 Q. You're intending for them to be accurate?

5 A. The events, yes.

6 Q. Yes. Well, your entries and the information
7 that you're entering into the system, your goal in
8 doing that is for it to be accurate?

9 A. Uh-huh.

10 Q. And you believed at the time that it was
11 accurate?

12 A. Yes.

13 Q. All right. I mean, if it's not, if it's some
14 mistake that you put in, that you came into the room at
15 8:00?

16 A. I mean 8:00 was probably more of a guesstimate
17 than anything. Like I said, I don't know the exact
18 time. The -- I think it's more reflective in the chart
19 with the starting of masking. I remember the events
20 vividly, but the times I do not.

21 Q. Well, again, your -- your intention at the
22 time, before you knew that there was going to be a
23 lawsuit, was for the time that you entered to be
24 accurate?

25 A. Yes.

1 Q. Okay. No question about that?

2 A. I guess not, no.

3 Q. Okay. And I understand that, you know,
4 there's been a lot of water under the bridge in the
5 last five years -- all right -- but, again, this was
6 literally 30 minutes after you had come in the door,
7 you are standing at that terminal intending to be
8 accurate?

9 A. I intended to be accurate with the events that
10 I noted, and I think I thought it was about 8:00, so.

11 Q. All right. Okay. But now you're telling us
12 you were wrong?

13 A. I guess -- yes.

14 Q. And you -- how was it -- you figured out that
15 you were wrong once this lawsuit got filed?

16 A. The time had gotten changed -- Donna went in
17 and changed the time to more accurately reflect the
18 sequence of events.

19 Q. Well, let's talk about that for a second. So
20 you didn't actually know until this lawsuit was filed
21 that she had done that?

22 A. No, I did not.

23 Q. You didn't even realize that changes to the
24 anesthesia narrative, like she made, you didn't even
25 know that those were allowed; right?

1 A. I guess not, no.

2 Q. No. I mean, remember, you know, I had a
3 chance to take your deposition. I think it was last
4 Summer, maybe last Fall. And we talked about this.
5 And you remember telling me that you didn't even know
6 that it was possible for her to get into the system and
7 change your entries?

8 A. If that's what I said -- I mean I -- I
9 honestly don't know a lot about this computer system,
10 so.

11 Q. And you hadn't had any conversation with her,
12 and she hasn't had any conversation with you, the
13 subject of which was the entries need to be changed?

14 A. No.

15 Q. You didn't think that they needed to be
16 changed?

17 A. I probably -- I honestly didn't think about
18 it.

19 Q. Well, you had had an opportunity to review
20 this record; correct?

21 A. Yes.

22 Q. All right. And that was not long after these
23 entries had been made; correct?

24 A. Which entries?

25 Q. All of these entries? I mean, you had a

1 chance to sit down and look at the entire record, and
2 that was maybe a couple of weeks after what had
3 happened. And then at that point in time, you didn't
4 think that there was anything inaccurate or that needed
5 to be changed?

6 A. No, but I probably didn't look real closely at
7 all the times and everything.

8 Q. And you didn't even discuss the changes that
9 she made, and you certainly didn't authorize the
10 changes that she made to your entries?

11 A. No. It was never discussed.

12 Q. Now, you -- you would agree with me, really,
13 we talked about this a little bit before when I had a
14 chance to take your deposition. And at that time, you
15 agreed that what probably happened to Mr. Mikell was
16 his airway collapsed because of his sleep apnea and he
17 desaturated; do you remember that?

18 A. No.

19 Q. You don't --

20 A. You'd have to show me the deposition. The
21 initial time, before we put the nasal cannula -- or the
22 nasal airway in, I know that was what happened, but....

23 Q. This is from page 39 of your deposition. And
24 we were having a discussion about the 47.5 oxygen
25 saturation value that's shown somewhere on these

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1 records. So I asked you, "Well, so why were his sats
2 at 47 and a half" --

3 A. So -- what time was this?

4 Q. What time was this?

5 A. Yeah, was this when we -- is this when we put
6 the nasal airway in -- before we put the nasal airway
7 in?

8 Q. Well, it's at whatever time his sats were at
9 47 and a half. Okay. And I asked you why his sats
10 were that low. And you said, "Well, he desaturated.
11 That's what 47 and a half means". And you said, "He
12 most likely had an airway collapse necessitating an
13 oral airway". So I guess, Dr. Nelson, perhaps to
14 answer your question, this is at the point in time
15 where the oral airway is going in. And I asked, "And
16 that was a function of his obstructive sleep apnea?"
17 And you said, "Most likely".

18 A. Okay.

19 Q. So that was -- one of the comments that you
20 had about the likely origin of this desaturation. And
21 I asked you about it another time. And this was your
22 answer that time --

23 MR. COOKE: What is the page on that, please?

24 MR. RANSOM: This is page 44.

25

1 BY MR. RANSOM:

2 Q. I said, "I'm sorry if I'm asking you this a
3 second time, but what was it that had caused him to
4 desaturate initially?" And you said, "It was most
5 likely his tissues collapsing into his airway. The
6 obstructive sleep apnea most likely, yes".

7 "So when he's put to sleep, his muscles relax
8 and his airway closes off?" And you said, "Yes".

9 A. Yes. And so that was, like you said,
10 initially. So that was when we put the nasal airway
11 in.

12 Q. Right. Well -- and it's interesting, because
13 you know, I asked you, so when he's put to sleep, his
14 muscles relax, and that happens right away, doesn't it?

15 A. It's not always right away.

16 Q. Well, it's what happened with Mr. Mikell,
17 isn't it?

18 A. Yes.

19 Q. Yeah. I want to talk with you a little bit
20 about some of these values. And while I was sitting
21 here at counsel table, I tried to put this together.
22 Mr. Cooke did a nice job piecing this record together.
23 Hopefully, I've done an equally good job. So, now from
24 the standpoint of the scale, I mean, we can keep in
25 mind that this is the oxygen saturation part of the

1 graph; right?

2 A. Right.

3 Q. Okay. So I'm going to slide it over, and
4 we'll just remember that the top line is the oxygen
5 saturations. So what we see there is at 7:49, his O2
6 sats are 75. Now, let me just ask this question so
7 that maybe the jury can get some sense of this. I
8 mean, suppose I'm like an ill behaving child and I get
9 mad and I'm -- I'm just going to hold my breath. Okay.
10 How long do I have to hold my breath before my O2 sats
11 get to 75?

12 A. A couple of minutes probably.

13 Q. Yeah. A couple minutes.

14 A. So he somehow went from 97 to 75 in one
15 minute, though.

16 Q. Right. And that's -- that's a pretty
17 precipitous decline over a one minute period, isn't it?

18 A. Yes.

19 Q. All right. And then you see that at 7:50,
20 it's gone to 69 -- it's gone even lower?

21 A. And then he comes right back up to 90 by 7:51.

22 Q. And then he goes right to 80.7?

23 A. And then back up to 88.

24 Q. Yes. So it's kind of going up and down?

25 A. Yeah. We see that pretty often, actually,

1 with patients under sedation. They desat a little bit,
2 then they come back up. People with sleep apnea kind
3 of stop breathing. They will hold their breath for a
4 minute, desat a little bit, then come back up again.

5 Q. So, this is -- is this what you would call a
6 stable patient, up and down?

7 A. None of these numbers are very, very
8 concerning. I mean number 75 and then -- I think
9 that's when we put the nasal airway in. He came back
10 up to 90 and then he was in the 80s, and so...

11 Q. Well, you know, it's interesting because I
12 don't think you were here for Donna Embrey's testimony,
13 were you?

14 A. No.

15 Q. So you don't know what she said about the O2
16 sat levels in which somebody needs to start doing
17 something?

18 A. No.

19 Q. Okay. But in any event, what we know is that
20 at 7:49, when his O2 sats are at a level where I would
21 have to hold my breath for two or three minutes, we
22 know what you're doing? Do you remember?

23 A. Is that when we were putting the nasal airway
24 in?

25 Q. No. Do you remember what you were doing?

1 A. No. It was six years ago.

2 Q. Okay. You didn't go over that prior to your
3 testimony this morning?

4 A. No. I would have to look at the chart, the
5 rest of the chart, the lower part of the narrative, I
6 guess.

7 Q. So the audit trail tells us what you were
8 doing?

9 A. Is that -- oh, that's when I charted that I
10 was in the room?

11 Q. Right. So at 7:49, when Mr. Mikell's 02 sats
12 are at a level where I would have to hold my breath for
13 three minutes, you're at the keyboard?

14 A. Right. And Donna is most likely attending to
15 the patient.

16 Q. And then we also know from one of these
17 entries -- well, I don't know if we know it, but
18 there's actually an entry in the record then that tells
19 us that you then left the room. And if it's to be
20 credited, that entry shows -- and I'm pointing to page
21 494 here. And I'm -- I'm not sure if this is the one
22 minute or the 15 minute, but what we see is Donna
23 Embrey has made an entry in the record that at 7:51,
24 you're out the door?

25 A. Yes.

1 Q. Okay. And we can probably agree that if she
2 charts at 7:50, she's at the terminal entering that,
3 you are probably already gone?

4 A. Well, it was at 7:51, so I was probably -- as
5 I was leaving, she documented it.

6 Q. Okay. So what we see there is that Mr. Mikell
7 takes a pretty steep decent on his O2 sats, pops back
8 up a little bit, 90; it's not great, and you're gone?

9 A. Well, at that point in time, we put a nasal
10 airway in, and he was maintaining his airway and he was
11 stable, so.

12 Q. So 7:52, a minute after you go out the door,
13 now he's back at 80?

14 A. Right. But I mean this -- this --

15 Q. Three minutes after you've left, he's at 73.
16 Four minutes after you've left, he's at 62. Now, you
17 wouldn't try to tell this jury that an O2 sat of 62 is
18 nothing to be worried about, would you?

19 A. No. That's bad.

20 Q. Right.

21 A. And that's probably about when I cycled back
22 into the room to check again.

23 Q. Well, unless we believe your entry in the
24 record, which says that you don't come back into the
25 room until 8:00. And by the time you come back into

1 the room, he's gone into this junctional rhythm. He's
2 in pulseless electrical activity. And by that time, as
3 far as Mr. Mikell is concerned, it's sort of ballgame
4 over, isn't it? I mean, he's -- he's done?

5 A. I came in the room, and we started coding him,
6 yes.

7 Q. Right. And by the time you get back into the
8 room, if we believe your entry that you made 30 minutes
9 later, he stays in this pulseless electrical activity
10 until he's returned to a normal sinus rhythm that
11 doesn't happen until 8:12. He's in this defib -- this
12 is where you're shocking him at 8:11. And he's gone
13 from 7:58 until 8:11, where his heart is not really
14 effectively pumping any blood at all?

15 A. Well, that's why we started chest compressions
16 at probably, what, 7:56?

17 Q. Well, that's what I mean when I say that by
18 the time he goes into this junctional rhythm, which
19 this record reflects took place at 7:56?

20 A. But that may not be accurate because that's
21 not entered. That's not just coming across from the
22 vital signs. The heart rhythm isn't coming across.
23 That's somebody else putting it in. And so based on
24 your argument, it could be somebody just changed the
25 time to it.

1 Q. Well, listen, I -- Dr. Nelson, all I'm --
2 these are not my records and these are not my values.
3 All right. But what we see is that by the time -- from
4 the time he goes into this junctional rhythm, until the
5 time his heart returns to sinus rhythm, that's a period
6 of four, ten -- I mean, basically 15 minutes?

7 A. Right.

8 Q. And during that period of time, Mr. Mikell's
9 body is not getting accurate -- adequate circulation?

10 A. That's not true because we were doing chest
11 compressions.

12 Q. Okay.

13 A. And so chest compressions are to adequately
14 circulate blood to the body.

15 Q. Is it safe to say that his circulation is at
16 such a level that when they take him out of the room,
17 they are putting him in this thing to lower his body
18 temperature down to 90 degrees, to try to keep him from
19 suffering irreversible brain and organ damage?

20 A. Right.

21 Q. Okay. You had said, when Mr. Cooke was asking
22 you questions, he was asking you whether the
23 administration of Propofol was at about 7:41, you said
24 that sounded about right to you?

25 A. Yes. Well, I mean, that's what's charted, so.

1 Q. You weren't in the room at the time that that
2 happened, though, were you?

3 A. I can't remember if I was or not.

4 Q. And you also weren't in the room when Donna
5 Embrey was sending these text messages and taking these
6 phone calls?

7 A. No.

8 Q. And so you really don't know anything about
9 how, if at all, that may have interfered with her
10 ability to manage Mr. Mikell, and you don't know
11 anything really about what his condition was when all
12 of that was taking place?

13 A. I can't speak to when I was not in the room.
14 However, it's not uncommon to send a page or have a
15 conversation with somebody else, and still be able to
16 monitor the patient, multitask.

17 Q. All I'm saying is, since you weren't there,
18 you don't know?

19 A. Correct.

20 Q. But what we do know is that -- and I'm
21 pointing to the real time graph -- what we do know is,
22 that after she does whatever it is that she's done to
23 get this equipment to start to work properly, as soon
24 as it starts plotting, Mr. Mikell's oxygen saturations,
25 I mean, they are headed down the Matterhorn into Death

1 Valley, aren't they?

2 A. It appears that way, yes.

3 Q. And you can't tell us, because you weren't
4 there and you don't know, what numbers go in any of
5 these boxes?

6 A. No. It wasn't coming across.

7 Q. All we know is that once it starts, it looks
8 pretty bad?

9 A. Yeah, I mean, it starts at 7:48, so.

10 Q. Do you remember what setting the audible tone
11 was set on that morning?

12 A. Can you clarify the question?

13 Q. Yes. Mr. Cooke had asked you about the --

14 A. Pulse ox?

15 Q. Yeah, the tone (indicating)?

16 A. Yeah.

17 Q. And you can turn the volume down?

18 A. Yes.

19 Q. And you don't know where it was set that
20 morning?

21 A. I think it defaults to three, if I remember
22 correctly.

23 Q. But you can turn it down?

24 A. Yes.

25 Q. And you don't know where it was set?

1 A. No, but I know you could hear it, so.

2 Q. Can you hear it from across the room?

3 A. Yes.

4 Q. Were you on the faculty as an assistant
5 professor?

6 A. Yes.

7 Q. At the time of this event?

8 A. Yes.

9 Q. When had you first gone to work for the
10 Medical University?

11 A. July of 2009.

12 Q. In 2009. Okay. Have you seen what we've
13 marked as Plaintiff's Exhibit 8, these are the basic
14 standards of anesthesia?

15 A. I've seen them.

16 Q. Okay. Yeah, I wanted to just ask you a little
17 bit about a couple of these. This is Plaintiff's
18 Exhibit 8, and it's page four of six. And this is the
19 part that talks about -- prior to administering
20 anesthesia, the practitioner administering anesthesia
21 will check out the working condition of all the
22 equipment?

23 A. Correct.

24 Q. Okay. And that's your job; right?

25 A. I mean, I double check it when I come into the

1 room. But typically, the nurse anesthetist or resident
2 in the room checks it in the morning. And when they
3 turn it all on, they do a machine check.

4 Q. And, no, but what I mean is -- and we can turn
5 to it if we -- if we need to.

6 A. Uh-huh. I'm ultimately responsible for the --
7 for making sure the equipment works, yes.

8 Q. Your -- this is your responsibility?

9 A. Yes.

10 Q. And part of your responsibility in making sure
11 that the equipment works is -- is making sure that all
12 of the information is being accurately recorded in the
13 record?

14 A. Yes.

15 Q. Okay. And so if there's some sort of a glitch
16 or -- I don't know what you call it -- malfunction or
17 whatever it is -- if there is some sort of an issue
18 with the PICIS system, so that it's not accurately
19 recording Mr. Mikell's oxygen saturations in the chart,
20 your job is to check that equipment and make sure it's
21 working; right?

22 A. No. My job would be then -- we should have
23 used a paper chart and documented it on paper.

24 Q. Right. But I mean you -- your job, as the
25 attending physician who is supervising and directing

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1 this case, is to ensure that there's an accurate
2 record. And if there's some problem that's going to
3 prevent that from happening, that's one of the things
4 that you're supposed to get figured out?

5 A. So, we should have used a paper chart instead
6 of continuing with PICIS because it wasn't working.

7 Q. And listen I -- I'm sure that, Dr. Nelson, if
8 you had realized that the system wasn't working, that's
9 what you would have done; right?

10 A. Yes.

11 Q. But as it turned out, because the equipment
12 wasn't checked, and because this policy was violated --

13 A. Well --

14 Q. -- it wasn't until after Mr. Mikell -- well,
15 it wasn't until two or three minutes before he was
16 given the anesthetic, that y'all realized that there
17 was a problem?

18 A. So, the PICIS and the anesthetic record is not
19 part of our anesthesia equipment quote/unquote that we
20 check beforehand. The equipment we check includes the
21 monitors that monitor vital signs, the machine --
22 things that we actually use to keep the patient safe.
23 The anesthetic record is totally separate and it's not
24 under the purview of something we check in the morning
25 to make sure it's working. Because, like I said, if

1 the computer doesn't work, we just go to a paper chart
2 and chart by hand.

3 Q. But, again, this sort of begs this question,
4 Dr. Nelson -- and I accept your testimony that, you
5 know, you can -- you can do paper charting. I mean,
6 it's a little stone age, but you can do it. But you're
7 not going to know that you need to do that if you
8 haven't checked the equipment to make sure that it's
9 functioning properly? So that by the time you've
10 knocked the patient out with the Propofol, you've got
11 the paper chart and the pen in your hand in order to
12 make those entries?

13 A. Right, which is what we do anyways when we
14 paper chart.

15 Q. So this was your responsibility to make sure
16 that this was all working correctly?

17 A. I don't believe so, no. This is a computer
18 and it's a computer system. It doesn't fall under the
19 attending anesthesiologist. I could have gone back and
20 taken a paper chart, and hit the vitals trend, and
21 looked at all the vital signs that were recorded on the
22 vitals. Because it records them, and just charted that
23 way, and it would have been accurate.

24 Q. And so that's the paragraph that says it's got
25 to be accurately recorded, and these same standards

1 say that all anesthetics administered will be the
2 responsibility of the anesthesiologist assigned to the
3 case --

4 A. Correct.

5 Q. Or his designee -- and the certified nurse
6 anesthetist and house staff will be under your
7 direction and your supervision, and you're responsible
8 for making sure that an accurate record is correct, and
9 you do that by making sure that all of your equipment
10 works?

11 A. Not necessarily. Again, having a working
12 computer charting system has nothing to do with patient
13 monitoring and safety.

14 Q. Thank you, Dr. Nelson. I don't have any other
15 questions.

16 THE COURT: Any redirect?

17 MR. COOKE: Briefly, Your Honor.

18 **REDIRECT EXAMINATION BY MR. COOKE:**

19 Q. I think you were asked something about the
20 sats being on the Matterhorn and going down to Death
21 Valley?

22 A. Yes.

23 Q. Just to confirm, when you left the room at
24 7:51, what does that show that the sat was when you
25 left the room?

1 A. At 90 percent. And I believe that Donna had
2 documented also, that when I left they were 94 percent.
3 So these are one minute intervals. And we actually see
4 your oxygen saturation with every heart beat. So his
5 heart rate was in the 80s, we'll see 80 different
6 numbers every minute, so. We had seen -- I mean, like
7 I said, this was six years ago, but I wouldn't have
8 left the room if I thought he was teetering on the
9 edge. I would have had to see consistently his
10 saturations were in the 90s before I would have stepped
11 out of the room.

12 Q. All right. And looking at even after you left
13 at 7:52, 7:53, 7:54, is Death Valley a fair
14 characterizations of those saturations?

15 A. Maybe 73 it's starting to go down to Death
16 Valley, but usually not until you're lower than that
17 even.

18 Q. And I'm going to show you part of the audit
19 trail. You were asked a question about when you left,
20 and Donna Embrey charted that she -- that you left at
21 7:51. Does that mean she was there typing on the
22 computer when you left -- and I'm going to show you
23 part of the audit trail. Do you see that?

24 A. Yes.

25 Q. It says that at 7:50 and then 7:51, "Memo:

DR. NELSON -- REDIRECT

1 Nelson out" -- do you see that?

2 A. Yes.

3 Q. And you see that that was actually created
4 at -- on the -- on October 2nd; do you see that?

5 A. Yes.

6 Q. So she was not actually entering that on the
7 computer as you were leaving the room, was she?

8 A. Correct. Also, I think I said, too, that not
9 every time I -- or an anesthesia attending comes in and
10 out of the room, it's documented. We're kind of
11 present in and out of the room, popping our heads in,
12 making sure everything is okay throughout, and not
13 everybody documents every time we do, so.

14 Q. All right. And, again, are you -- are you
15 comfortable with what the PIP and the FI02 showed was
16 happening at 7:55 and 7:56?

17 A. Yes. As I said, I don't necessarily remember
18 times, but just through the nature of events, I
19 remember the events very specifically, in that I came
20 into the room and kind of initiated the whole --
21 everything getting the ball rolling, start masking the
22 patient. Let's start chest compressions. And so the
23 number 27 under PIP would represent, to me, the first
24 breath that was given with a mask. And so I would have
25 been in the room when that occurred.

1 Q. All right. And then what does the increase in
2 the percentage of oxygen show you?

3 A. It shows that we are actually masking the
4 patient and have a seal on his face. Because as I said
5 before, you can't deliver that high of a percentage of
6 oxygen with just a nasal cannula. You have to have a
7 mask on and oxygen flowing into the mask and a seal on
8 it.

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

10 THE COURT: Any recross?

11 MR. RANSOM: Nothing, Your Honor.

12 THE COURT: Okay, Doctor. You may step down.

13 Thank you very much. Can I see the attorneys up here
14 just a second.

15 (WHEREUPON, a bench conference was had.)

16 THE COURT: All right. Madam Forelady, ladies and
17 gentlemen, the next witness is going to be rather
18 lengthy, so we're going to take a lunch break at this
19 time. It's 10 minutes after 12:00, if you'd be back in
20 the jury room at 1:30, we'll get started at that time.
21 Please don't discuss the case amongst yourselves, and
22 leave your notepads in the chair. See you at 1:30.

23 (WHEREUPON, the jury leaves the courtroom at
24 12:11 p.m.)

25 THE COURT: All right. Anything from either party

1 before we break for lunch?

2 MR. RANSOM: The -- the matter of the redaction.

3 THE COURT: Yeah. We can -- we can tend to that.

4 Ms. Fleming, I believe you had went through it and
5 marked it?

6 MS. FLEMING: I have not had an opportunity to
7 even look at what he's given us, so -- are you
8 referring to the deposition?

9 THE COURT: I'm talking about the deposition of
10 Jewel Mikell.

11 MS. FLEMING: Oh, yeah. That's right.

12 THE COURT: I thought we could deal with that real
13 quick -- or we might, well, never mind. Do you have
14 that handy?

15 MS. FLEMING: I do.

16 THE COURT: All right. Go to page six, line four
17 through 12.

18 MR. RANSOM: Judge, if I may, if I could get --
19 maybe we could -- Ms. Fleming and I can be looking at
20 it together.

21 THE COURT: That will be fine, if -- if she
22 doesn't mind.

23 MR. RANSOM: Because I've only got it --

24 THE COURT: Do you mind him watching it with you?

25 MS. FLEMING: I might.

1 THE COURT: Maybe you do, tell me. I'll make him
2 stay over there where he belongs.

3 MR. COOKE: We'll be fine. I'll stand between
4 them.

5 THE COURT: All right. Looking at page five -- I
6 mean, page six, lines four through 12. I was going to
7 strike that. Mr. Ransom, tell me why that has anything
8 to do with this case? That's about her husband.

9 MR. RANSOM: Yeah, and that is what Ms. Fleming
10 had designated. I'm the one asking for that to be
11 stricken.

12 THE COURT: I was going to strike it.

13 MR. RANSOM: Thank you.

14 THE COURT: Okay. All right. Let me -- go to
15 page 14, lines 15 through 19; who wants that stricken?

16 MR. RANSOM: I don't think anybody does.

17 MS. FLEMING: Nobody does.

18 THE COURT: All right. You -- apparently, I
19 thought you had marked that with your pink marker.

20 MR. RANSOM: Judge, I apologize. The technology I
21 was using failed me apparently, and I didn't mean to
22 indicate that.

23 THE COURT: All right. Page 17, line 2 through 6,
24 that's marked by pink.

25 MR. RANSOM: Actually, it was -- I had objected to

1 line 7 through 17 on that page.

2 MS. FLEMING: And I agree to take that out.

3 THE COURT: Okay, 7 through 17?

4 MS. FLEMING: Yes.

5 THE COURT: Okay. All right. That's out. What
6 about page 21, line 7, 8, and 9; who asked for that?

7 MR. RANSOM: Nobody's objecting to that.

8 THE COURT: Okay. Well, who put all these pink
9 markings on here?

10 MR. RANSOM: I didn't have a pink marker, Judge.
11 I had yellow. I'm sorry if we've made this
12 unnecessarily difficult.

13 MS. FLEMING: We can take out 21, 8 & 9.

14 THE COURT: All right. Ms. Fleming, the next pink
15 -- I thought you had it marked with pink?

16 MS. FLEMING: I did. We did.

17 THE COURT: Well, that's what I'm going through,
18 page 22, line 10 through 23, who wants -- who has a
19 problem with that?

20 MS. FLEMING: We marked our designations because,
21 in his version, they were incorrect. So what you see
22 in pink is what we were designating, correct.

23 THE COURT: So you want that out?

24 MS. FLEMING: No. I want -- I want 22, line 10
25 through 23 in.

1 THE COURT: You want line 10 through 23 in?

2 MS. FLEMING: Yes.

3 THE COURT: Why should we exclude it?

4 MR. RANSOM: I haven't objected to it.

5 THE COURT: You don't?

6 MR. RANSOM: I do not.

7 THE COURT: Okay. All right. Page 23, line 8
8 through 18, who want that's out?

9 MR. RANSOM: Plaintiff has no objection.

10 MS. FLEMING: Yeah, that's fine.

11 THE COURT: All right. Page 26, line 22 through
12 25.

13 MR. RANSOM: I object.

14 THE COURT: Who wants that out?

15 MR. RANSOM: I object.

16 THE COURT: Why? You just want to know -- that's
17 what I want to know, when you relied, did he check it,
18 okay, yes -- what happened after he checked it -- went
19 directly to the procedure room.

20 MR. RANSOM: Right. And, yeah, I just don't
21 really understand what that's proving.

22 MS. FLEMING: Well, I guess at this point we can
23 take it out. There's been a lot of --

24 THE COURT: Okay. Take it out, then, if y'all
25 agree.

1 MS. FLEMING: Well, actually no. I mean--

2 THE COURT: No? Okay. What -- you don't agree?

3 MS. FLEMING: We can take it out.

4 THE COURT: Pardon?

5 MS. FLEMING: We can take it out.

6 THE COURT: All right. Page 27, line 4 through --
7 it looks like 12; who wants that out?

8 MR. RANSOM: That was my objection that it's
9 hearsay.

10 MS. FLEMING: I think we can take that out,
11 because, again, we're sort of narrowing the issues
12 here.

13 THE COURT: Okay. That's out. All right. Page
14 28, lines 12, 13, & 14, who wants that out?

15 MR. RANSOM: I don't think anybody does.

16 THE COURT: Okay. That's in.

17 MS. FLEMING: Hold on a second.

18 THE COURT: Pardon? All right. It was just
19 marked. I don't know who marked it.

20 MS. FLEMING: That's fine.

21 MR. RANSOM: That was her designation, I don't
22 object to it.

23 THE COURT: All right. Page 30, I got line^a 1
24 through 25 on page 30.

25 MS. FLEMING: Hold on. Hold on. Can we back up?

1 THE COURT: Line 1 and 2 on page 31.

2 MS. FLEMING: Can we back up a minute?

3 THE COURT: Yeah.

4 MS. FLEMING: We can take out 28, 12 through 14
5 for the same reason we can take out the one before.

6 THE COURT: You're talking about line 13 through
7 17?

8 MS. FLEMING: No, no, 28, 12 through 14; what did
9 he designate?

10 THE COURT: Tell me, line 12 through 14? You want
11 that out?

12 (PAUSE.)

13 MR. RANSOM: Page 28, I designated nothing.

14 MS. FLEMING: Then we can take 28 out.

15 THE COURT: You want page 28 out all together?

16 MS. FLEMING: That's fine, yes.

17 THE COURT: You got any problem with page 28 out
18 all together?

19 MR. RANSOM: I have no problem.

20 THE COURT: All right. Now, on page 30, it looks
21 like the whole page of 30, and line 1 and 2 on page 31;
22 who wants that out?

23 MS. FLEMING: We do. It's hearsay. It lacks a
24 foundation, unfairly prejudicial.

25 THE COURT: Well, it's your doctor -- she's

1 talking about. So, I mean, there's an exception there.
2 But do you want it in or out?

3 MR. RANSOM: I want it in.

4 MS. FLEMING: But she doesn't know who, she
5 doesn't remember anything about that person.

6 THE COURT: Talked to him the next day and the
7 next evening, I asked --

8 MS. FLEMING: She goes on to say that he was put
9 on 31, which is part of that -- she goes on to say that
10 he was supposed to have some blood work that wasn't
11 done. I mean, she has no way to know that. That's
12 hearsay.

13 THE COURT: I mean, she can't even identify who it
14 was or what it was about.

15 MR. RANSOM: Well, she can't remember who the
16 doctor was. And keep in mind, this deposition was
17 given in January of 2014 --

18 THE COURT: I understand. It wasn't given for
19 purposes of trial and --

20 MR. RAMSOM: That's true, too.

21 THE COURT: That makes -- that makes it even more
22 difficult. I mean, I don't see what -- she can't
23 identify who she was even talking to, whether he was a
24 doctor or a nurse or what.

25 MR. RANSOM: Well, but you may recall the

1 testimony of Dr. Payne, I think on Monday, that after
2 the procedure, he went out to the waiting room and
3 spoke with Mrs. Mikell. So this is her recollection of
4 what that conversation involved.

5 MS. FLEMING: No.

6 THE COURT: Well, but she says it's the next day
7 on line 13 and 14. It's apparently -- it's after he
8 was in ICU. Because she says the next day on line 13
9 and 14, so it could be Dr. Payne's testimony.

10 MR. RANSOM: Assuming her memory is not getting
11 jumbled and she's getting --

12 THE COURT: I understand. I'm going to exclude
13 it, primarily because she can't identify anything.
14 Okay. Page 31 through -- 24 -- and line 1, and 2, on
15 page 31.

16 MS. FLEMING: Same as this -- that's the same part
17 of that, what you just --

18 THE COURT: What about page 34, line 9 and 10, who
19 wants that out?

20 MS. FLEMING: I do -- we do.

21 THE COURT: It wasn't anything that made me feel
22 happy; what's wrong with that? She was just describing
23 how she felt.

24 MS. FLEMING: No. But she goes -- she's talking
25 about a conversation she had about -- with some doctor,

1 again, who she can't identify telling her about
2 Mr. Mikell's condition. She, again -- she can't
3 identify the person. She doesn't -- and the way that
4 she felt about it is totally irrelevant to any damages
5 in this case.

6 THE COURT: All right. I'm going to leave that
7 in. Okay. She was just saying that -- she just said
8 "However, it wasn't anything that made me happy". She
9 was describing how she felt. All right. What about
10 line page 35, line 22 through 23.

11 MR. RANSOM: Eleven through 23?

12 THE COURT: Eleven through 23 -- who wants that
13 out?

14 MR. RANSOM: That's Ms. Fleming's objection.

15 THE COURT: She's just talking about her son,
16 whether the son recognized her or didn't recognize her.

17 MS. FLEMING: You've allowed witnesses to talk
18 about their observations.

19 THE COURT: I'm going to let that in. Okay. All
20 right. Page 41, lines 14 through 25; and page 42,
21 lines 1, 2 and 3.

22 MR. RANSOM: That's my objection, Your Honor.

23 THE COURT: Pardon?

24 MR. RANSOM: That's my objection. Bear with me as
25 I try to read through this --

1 THE COURT: I mean, before you wanted it -- she
2 wanted it in and she didn't know who the doctors were.
3 Now, that she didn't know who the doctors were, you
4 want it out, which is it?

5 MS. FLEMING: I want -- I think I designated this
6 in the event that he was allowed to get the other stuff
7 in, so we can take it out.

8 THE COURT: All right. It's out. Page 48, lines
9 3 through 8, who wants that's out?

10 MR. RANSOM: No objection from me.

11 THE COURT: You want it in?

12 MS. FLEMING: That was something I designated to
13 be in.

14 THE COURT: You want it in?

15 MS. FLEMING: Yes.

16 THE COURT: You want it in?

17 MR. RANSOM: Fine. I have no objection, Your
18 Honor.

19 THE COURT: That's fine. All right. Page 51,
20 lines 8 through 25; page 52, line 1 through 13; who is
21 objecting to all of that?

22 MR. RANSOM: No objection. It can stay in.

23 MS. FLEMING: I think we can take it out.

24 THE COURT: I'll tell you what -- this copy y'all
25 gave me has got so many colors on it, we ought to put