

1 jury decided, and that's what the citizens of
2 this county have decided, or the citizens of
3 the jury have decided. And we believe if
4 there's an error in the case, which we do not
5 believe there's any error in the case, then
6 the Court of Appeals can address that error.

7 But we would ask the Court to approve
8 the jury's verdict in this exceptional case.

9 THE COURT: Thank you, sir.
10 Anything else?

11 MR. GIDEON: Just some responses
12 to what Mr. Smith said.

13 There's a reason why I like to show my
14 homework, basically, so that we don't get
15 down to an argument about is that what
16 someone said or not.

17 Page 726 of the transcript, I will read
18 it to you literally. Mr. Smith, who I've
19 known for a long time, made a representation
20 that there was no evidence at all that this
21 change in the policy had been approved, this
22 old policy had been approved by the powers
23 that be. Question --

24 THE COURT: Who is the witness?

25 MR. GIDEON: Terry Gunn, former

1 CEO at the time this occurred.

2 "All these groups we've talked about,
3 the ERICU Committee, the Medical Executive
4 Committee, the Board of Directors, the Board
5 of Trustees, did all four of those groups
6 understand and approve the new process put in
7 place in this ER that allowed nurse
8 practitioners to see patients?" Answer,
9 "Absolutely."

10 So it just isn't a legitimate argument
11 by lawyers to say there's been no approval.
12 The approval occurred. And as Mr. Wiseman
13 said, the only thing that didn't happen was
14 taking the document out of the policy and
15 procedure manual.

16 Second point, Mr. Smith's
17 representation was that in a case like this
18 it's really up to the jury to define what
19 they would have liked to have seen, what you
20 think the standard of care should be. That's
21 wrong. That is clearly what they did, and
22 that's clearly how they pitched the case.

23 THE COURT: Well, essentially,
24 what the jury does in any negligence case
25 where there is competing evidence regarding

1 causation or standard of care, whether when
2 you're driving down a particular highway or
3 whether you're treating someone who presents
4 in the ER, it is true that they have to
5 decide which witnesses and which proof they
6 believe as to what the standard of care is,
7 true?

8 MR. GIDEON: Absolutely.

9 THE COURT: And in doing so, they
10 voice their opinion as to what the standard
11 of care is.

12 MR. GIDEON: But there's an
13 absolute distinction. The law requires there
14 be a determination of what the standard of
15 care was --

16 THE COURT: Correct.

17 MR. GIDEON: -- in a community or
18 in a similar community. Your instructions to
19 them on standard of care determined by
20 experts was you must determine the standard
21 of professional learning skill and care that
22 was required of the defendant. You must
23 consider only the opinions of the
24 professionals who have testified as expert
25 witnesses as to that standard.

1 THE COURT: I don't disagree with
2 that at all.

3 MR. GIDEON: It is a historical
4 view of what the standard of care was based
5 on the evidence presented.

6 But clearly, as we have submitted to
7 you, the presentation by counsel just a few
8 moments ago and the excerpts that Mr. Wiseman
9 read to you at the beginning of this
10 presentation reflect that this was presented
11 to the jury as an opportunity for them to
12 decide, Don't you think that everybody should
13 be seen by a physician in an emergency room?
14 Stand up for America, and in the process,
15 award a substantial amount of money to this
16 fine man.

17 THE COURT: Instead of saying you
18 need to determine what the appropriate
19 standard of care was.

20 MR. GIDEON: At that time. A
21 focus --

22 THE COURT: Instead of making a
23 forward looking verdict, you make a finding
24 of what the facts actually were.

25 MR. GIDEON: Yes. And it's

1 clear, as this is presented to you, sometimes
2 lawyers will trip themselves up and honestly
3 tell you what the presentation was.

4 We've shown from the transcript and you
5 heard Mr. Smith say, As we decided to present
6 this case, we were going to ask them what do
7 you want. And that's how the case was
8 presented.

9 Mr. Smith, third point, Your Honor, Mr.
10 Smith said that there was absolutely no proof
11 that there was any duty by Dr. Weeks to
12 oversee. I want to just put this up, because
13 I don't make representations out of a record
14 unless I've seen it. And here is the
15 testimony, "When you say you were the medical
16 director overseeing the care, isn't it true,
17 Dr. Weeks, that you were responsible for
18 overseeing the care of the physicians and the
19 nurse practitioners? Yes, sir."

20 Remember he came in, in January of '99.
21 We've established today that there is --
22 policy and procedure isn't enough either way.
23 We can't come in here before you in the next
24 case and say, Your Honor, we complied with
25 policy and procedure, therefore you must

1 dismiss the case. That isn't the standard of
2 care. Likewise, it wasn't the kiss of death
3 either in and of itself.

4 But the reason I bring this up is
5 because if you accept the plaintiffs' proof
6 as you weigh it that the standard of care at
7 the time required every patient, even that
8 one, to be seen by a doctor, you cannot --
9 and I'm returning to what Tom said earlier --
10 you cannot reconcile the jury's decision that
11 Dr. Weeks bore no responsibility. It makes
12 no sense.

13 If the standard of care is for the two
14 oldest lawyers to only do certain things
15 under certain circumstances and the two of us
16 didn't do it, it doesn't make sense for a
17 third party to be found a hundred percent
18 liable when Tom and I didn't do something the
19 standard of care required. That's the same
20 thing here.

21 Weeks, Two years new patients were not
22 being seen by physicians. If the standard of
23 care required that to occur, he cannot be
24 acquitted. And secondly, if Rosa Stone is
25 complying with the standard of care, she had

1 to see the patient. Maybe her percentage is
2 only 10 or 20 or 15, but she had to see the
3 patient.

4 Next point. You asked me a question a
5 few moments ago and it's a good one, and that
6 was, Well, what if the jury figured I'm going
7 to acquit Kinkade and Stone because they knew
8 of this hospital policy? Mr. Smith just
9 pointed out there's no genuine issue. Both
10 of them testified they didn't know anything
11 about any policy either way. They just knew
12 what they did, and that was non-urgent
13 patients were seen by nurse practitioners who
14 would then present the case.

15 If that was wrong, if that's health
16 care malpractice, they can't both be
17 acquitted. They both were in a logic driven
18 thoughtful as opposed to emotional decision
19 making process.

20 THE COURT: And you may not know
21 this. The record is so long.

22 What was the proof, if any, regarding
23 their treatment of an ER patient and how they
24 went about it, whether or not the patient
25 would be seen by a physician or whether the

1 patient would be seen by the nurse
2 practitioner?

3 Was there any proof by the doctor and
4 the nurse practitioner about why they did
5 what they did?

6 MR. GIDEON: Yes. First, the
7 evidence in the record establishes that this
8 was designed as a means of accommodating
9 volume patients in the emergency room to
10 allow people to be seen sooner. The triage
11 process was that somebody would be triaged,
12 as you'll remember, non-urgent, urgent,
13 emergent. And then the files would be put in
14 one of two racks or drawers. But there's
15 safety valves all along the way that goes
16 into the non-urgent rack. Nurse Practitioner
17 Kinkade picks it up, does the evaluation, but
18 has to present the case to the ER physician
19 before disposition occurs.

20 THE COURT: If they didn't know
21 about the policy, my question is: How did
22 they know what to do? How did they know
23 whether the doctor saw an emergent patient or
24 a non-urgent or urgent?

25 I don't recall if there was any

1 testimony by the doctor and the nurse
2 practitioner about why they did or did not do
3 certain practices in the ER.

4 MR. GIDEON: As I recall the
5 testimony on that point is, it was an
6 individual judgment at that stage whether or
7 not this individual needed to be seen by the
8 physician or not. And you'll remember Rosa
9 Stone's testimony where she was asked in this
10 case if you had been told that this man, as I
11 recall, Judge, smoker, father had died, high
12 cholesterol, those factors and there are one
13 or two others, what would you have done? I
14 would have reassessed. Not that I would have
15 admitted, put him on a monitor, I would have
16 as a result of that discussion reassessed.

17 But my understanding is the standard
18 was to bracket the patients into non-urgent
19 triage. Non-urgent goes to nurse
20 practitioner. If she thinks more needs to be
21 done, she will present it to the ER
22 physician. If the ER physician at
23 presentation time decides more needs to be
24 done, ER physician gets involved.

25 But it's a practice that's been

1 underway for two years in this community,
2 over 12,000 ER visits per year approved by
3 Dr. Weeks, the medical director who was
4 separately compensated by Phy America or
5 whatever it was, the name of the ER staffing
6 company, to manage the ER.

7 THE COURT: But you're saying
8 neither of these two actually knew about any
9 particular policy?

10 MR. GIDEON: No.

11 THE COURT: They just did it.

12 MR. GIDEON: That's their
13 standard of care.

14 THE COURT: That's the way they
15 operated.

16 MR. GIDEON: Their standard of
17 care in terms of what I've seen in the
18 record. I've read I don't know how many
19 pages. I could well have missed something,
20 and if I did, I'll stand corrected.

21 The last thing I want to point out is
22 this: I want to return to the example I gave
23 you earlier. There are certain limitations
24 on how much evidence a trial court can and
25 should accept.

1 If you heard somebody who came in here
2 with all kinds of credentials and said Warren
3 County is negligent because they didn't get
4 this patient to Vanderbilt in 15 minutes by
5 ambulance, you just know it's impossible.
6 Doesn't make any difference what the guy says
7 or what his criteria is. He's just wrong.

8 Well, it may be because he doesn't know
9 anything about Warren County. And that is
10 fundamentally the problem here. We don't
11 raise these issues about qualification of
12 witnesses lightly, but all the testimony was
13 from Keys is that here is my community. And
14 contrary to Mr. Smith's representation, there
15 is not one statement in Keys' testimony where
16 he said this community in Ashland, Kentucky,
17 are similar.

18 What he did say in response to Mr.
19 Smith's testimony was, Page 570, Line 14,
20 Page 575, Line 14, all he was asked was if
21 the standard of care was similar, not the
22 communities were similar.

23 The same problem holds true with
24 respect to Dr. or Mr. Markcowitz, the
25 administrator. Granted everybody sees a

1 physician because they don't use nurse
2 practitioners. But the evidence that was
3 presented that is unrebutted is that in all
4 of these other fine hospitals in this
5 community, the very same thing occurs that
6 occurred here, use of nurse practitioners
7 under these circumstances.

8 I'm not suggesting that because we use
9 nurse practitioners under these circumstances
10 we're immune from liability because others
11 do. What I am saying is this: The only
12 valid claims in this case would be did the
13 nurse practitioner deviate from accepted
14 standards of care in her assessment, in her
15 work-up of this patient, in her presentation
16 to Rosa Stone? Did Rosa Stone deviate from
17 accepted standards of care and fail to
18 recognize or get an adequate history and know
19 that this pain might be suggestive of a
20 cardiac problem? Was the health care below
21 the accepted standards of care and did it
22 cause an injury which would not otherwise
23 have occurred?

24 THE COURT: Having said that,
25 would you concede that if those two things

1 were found, which they were not in this
2 case -- and this may be a mute point -- that
3 the hospital could also be found liable?

4 MR. GIDEON: Sure. Sure. But
5 you can't tag it all on me as an only fireman
6 taking the hose into the building when there
7 are five or six other firemen and make me
8 responsible for the speed of the fire and
9 collapse of the building when everybody else
10 is involved in the same decision making.

11 That's why in this one opportunity we
12 ask the Court, we respectfully request the
13 Court, to weigh the evidence, and when you
14 weigh it, the conclusion, we submit, that
15 must be drawn is you can't be satisfied with
16 the verdict itself looking at it
17 independently of the verdict, looking at it
18 as a constitutional officer, which is what
19 you are. Thank you.

20 THE COURT: Thank you, gentlemen.
21 One thing I wanted to just say very briefly,
22 Mr. Essary did a very good job during the
23 trial. I don't know him personally. I don't
24 have any reason to say that other than
25 sometimes good attorneys get bad results in a

1 tough case. But he and the other gentleman
2 that tried the case, as far as I'm concerned,
3 I found no error with anything that they
4 argued or any way that they tried the case.
5 Just for your sake, I wanted to say that.
6 Okay?

7 MR. GIDEON: Thank you.

8 THE COURT: Thank you, gentlemen.
9 I should have an order in a week.

10 MR. SCHMIDT: Your Honor, we do
11 have a motion for discretionary costs. I
12 don't think oral argument is really
13 necessary. I'm going to just submit it to
14 the Court.

15 THE COURT: Okay. Do you
16 gentlemen want to address that?

17 MR. ESSARY: Our position is
18 pretty clear, Your Honor, the things that are
19 recoverable and are not recoverable, and the
20 rest of it's put in your discretion based on
21 referring to the verdict. The size of the
22 verdict should be weighed and considered in
23 light of the discretion.

24 THE COURT: Okay. I'll take it
25 into consideration. Like I said, if there's

1 no problem with that, it will be next
2 Wednesday or Thursday. Thank you.

3 MR. GIDEON: Thank you.

4 MR. SCHMIDT: Thank you.

5 (Court was adjourned.)

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I certify that the foregoing is a true and accurate transcript of the proceedings taken by me and transcribed to the best of my ability.

Jackie Wisinger

July 31, 2006

Jackie Wisinger, RPR
Court Reporter

Date