IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF PIMA

ESMERALDA O. TRIPP, by and through her Conservator, ROBERT B. FLEMING, Plaintiffs, vs. THE ARIZONA BOARD OF REGENTS; UNIVERSITY OF ARIZONA, COLLEGE OF MEDICINE; et al., Defendants	) CASE NO. C20144811

BEFORE THE HONORABLE GUS ARAGON

OFFICIAL COURT REPORTER'S TRANSCRIPT OF PROCEEDINGS
JURY TRIAL DAY TWELVE
CLOSING ARGUMENT BY MR. SMITH AND REBUTTAL ARGUMENT BY MR. KEENAN
OCTOBER 27, 2017
TUCSON, ARIZONA

ORDERED BY: Christopher Smith, Esq.

REPORTED BY: Maria Lourdes Geare
Official Court Reporter, RPR,
Certified #50555

A P E A R A N C E S:

CHRISTOPHER SMITH, Esq., Counsel for the Defendants

BRYAN R. SNYDER, Esq., Counsel for Plaintiffs
KEVIN W. KEENAN, Esq., Counsel for Plaintiffs
DAVID A. WENNER, Esq., Counsel for Plaintiffs

I N D E X

EXHIBITS

None

P R O C E E D I N G S

CLOSING ARGUMENT

BY MR. SMITH: All right. Thank you, Your Honor, counsel, members of the jury.

I want to thank you for your time, your attention and what I'm confident you'll ultimately give is your fairness.

This is our last chance to talk with you, if for that you're grateful, I will not hold it against you. But what I would like to do is just say a few things.

Number one, I am not going to tell you the facts of this case, that's your job, that is why you are here.

Number 2, I am not going to tell you who to believe. There's been testimony on both sides of the case, there's been experts on both sides of the case. Why? Because that's your job.

Third thing is, I am not going to stand up here and pretend to tell you how to decide this case. I am going to ask you to rule in favor of my clients and I'm going ask you to consider all of the evidence, but that ultimately is going to be your job.

A few observations before I get to the heart of the matter here. A phrase was introduced into this

case with the testimony of Dr. Schwab. That phrase was before the lawyers got involved. Before the lawyers got involved.

We know from the testimony of Mr. Serrano, Sr., that he got in touch with lawyers in November of 1013, just after Mrs. Tripp got home. So these lawyers have been involved for almost four years now.

So what I'm going to ask you to do is consider the opportunity they have had in their four years of their time and three weeks of your time to prove, to meet this burden of proof of clear and convincing evidence. If anybody tries to suggest that that is an easy burden of proof, I'd like you to consider otherwise.

The usual burden is just preponderance of the evidence, more probable than not. It tipped the scale this much, whoever does, wins.

Preponderance -- excuse me. Clear and convincing is just that. All right. I'd like you to consider those two words in the operative phrase that you use to evaluate this case. When you consider this case, the prism of your duty here as jurors, look at it and ask yourself, did they put on clear evidence of that? Did they put on convincing evidence of that?

And ask yourselves why after four years in

this case, it was yesterday, the first time that plaintiff's counsel said, you know, Esmeralda never had any heart attacks, never had DVT's, clots in her lung, never had P.E., clots in her lung, never had stints put in her heart, never had the inferior vena cava put in.

Why not tell Dr. Alter and Dr. Gokova, who relied on that history when they took their deposition and say, you know what, everything you relied on, everything that you took at face value, everything that you thought was true and on which you based your treatment, was entirely wrong.

It had been repeatedly and deliberately said to different doctors and nurses and other healthcare providers over the years, but why not tell the defendants here? They're not defendants, but Dr. Gokova and Dr. Alter. Why not tell their own experts?

I went flying all over the place to take depositions of these doctor and said, have you ever seen the source documents for this? The same question I asked them here.

Have you ever seen any source document, forget the history, but where there was a diagnosis of a heart attack, myocardial infraction. And I just used that colloquial term, heart attack, but I'm going to ask you in your evaluation of this case to remember the

testimony, and to be a little more exacting than just throwing around the term heart attack. We're going to come back to that because there's a significant difference.

Why not tell their experts? Then my experts get up here and they mock my experts saying, you relied on this history? Plaintiff's counsel, one of them said, this is totally and completely unreliable. They're talking about their own client.

Well, call me old fashion, but when I hired these experts, I said, will you please read the records, give us your opinions based on the records. Don't take my word for it. I want to know what you think based on the records. Turns out there's not anything in there on what they base their treatment of this patient that was true. And it took four days and three weeks of your time to get to that point.

Well, one of you asked, who are the parties in this case? Good question. Judge Aragon told you who the parties are. One of the things, though, I'd like you to consider is who is this case about?

Plaintiff's counsel at one point said, my clients. And he mentioned Mr. Serrano, Sr., and Mr. Serrano Jr., and Jamaica Serrano. This case is not about them. They do not have a claim. Two of them

actually had made claims and I'm going to talk about that in a minute, but they withdrew them for reasons I'll talk about in a minute. They are not plaintiffs and have no claims whatsoever. So this case is about Esmeralda Tripp and it is about Dr. Gokova and Dr. Alter, okay?

As much as we heard at Dr. Gokova, let's be clear, I said to Todd Alter, were you the only decision-maker here? And he said, yes, of course. He's the attending doctor, he's the professor, he's the member of the faculty.

But I almost got the feeling, I mean, they were talking so much about Dr. Gokova, I mean in between, it was like a self-target, they keep getting in and they're saying, hey, you know, you were just out of medical school, hey, you were really young. She didn't make the ultimate decision. Why do they keep going after her?

Well, you can ask yourself that too because you heard the same testimony I did, that Dr. Alter said he was the one ultimately responsible. He saw the patient before she did. He saw the patient and talked with her about her options, just like Dr. Gokova did. So when they tried to pin this on Dr. Gokova, I think they're under estimating.

But let's talk, though, about this lawsuit. What is it? We talked about how they are not making claims out of the family members. Remember they were making a claim at one point, you heard me cross-examine them, about the claim that was withdrawn. They wanted to be paid for the times they alledgedly spent caring for Mrs. Tripp.

MR. SNYDER: Your Honor, objection. Can we approach?

THE COURT: Sure.

(Bench conference.)

MR. SNYDER: They dropped their claim in the case.

THE COURT: We talked about it before and I've indicated and maybe not on the record, but I did put on the record that it's fair game. Prior statements that were made and, of course, in litigation, I said if he wants to, he can read the complaint and we can talk about the complaints and you argued that it's not relevant and I overruled it.

MR. SMITH: All right. Thank you.

(Bench conference over.)

THE COURT: Go ahead, counsel.

MR. SMITH: All right. Thank you.

The claim was they wanted to be paid for the

care they were providing. That claim was withdrawn and was only withdrawn after I determined that all three of them when they were testifying under oath, that Jamaica was living in Tucson and caring for her mother in 2015, was in fact, in Las Angeles. The testimony under oath had been that she was there living at home, caring for her mother. It turns out that's not true, the claim is withdrawn. But then they substituted this round the clock care, we'll talk about that in a minute, though.

But the question is -- you know, your job, one of your jobs is to decide the facts, and decide whether or not there was a breach of the standard of care.

But your job is also to determine what do we expect of not only Mrs. Tripp, who is in this role, a patient. You have to decide what is expected of a patient? Should a patient comply with reasonable recommendations? There's no testimony, whatsoever, no allegation that Dr. Harris, the primary care physician, who told her to take 3 milligrams of Coumadin, when her INR was off the chart, that that was bad advise, nobody is saying that at all. And yet we know when she got to the hospital, she was taking 12 milligrams a day and has this off the chart INR.

The question is, what do we as a community

expect with somebody in that position? And whether there's any fundamental fairness to not following recommendations and then turning around and suing your doctors. Or not giving the correct information to your doctors, and turning around and suing them. Is that the sort of thing that we're all about here in town? We're not.

It's also about, as I mentioned, Dr. Gokova and Dr. Alter. What do we expect of the doctors, who are the teachers? What do we expect of the doctors who are the students, who are learning?

You know, one of the things about the physician/patient relationship, we didn't really go on about it, but it came up a little bit during the trial, is that it's a two-way street. What is the first thing doctors do and what did they do in this case when they met with Mrs. Tripp? They took a history. They asked her why are you here, what are your problems? They go to know what they could and then they went to the old records and got what they could. And they got the history of the heart attack at 29. They got the history of recurring pulmonary emboli. They got the history of these venous thrombosis and everything else that we now know is true -- excuse me, untrue.

The question is, if we can go back for a

moment and we consider why the claim by the family members was withdrawn? Was because after as I mentioned they testified under oath that Jamaica was here when it turns out she's not, right?

Then there was the testimony when Jamaica was on the stand, her lawyer said to her, did you withdraw your claim because you were feeling guilty about being in L.A.? She said, yes. And then we all sat here and waited to hear if she was going to say she felt guilty at all for not telling the truth under oath. And ask yourself if that ever happened.

You know, one thing that you might hear when plaintiff's counsel -- because they have the burden of proof, and because they have the burden of proof, they get to go last.

But, one thing you might hear in response is, well, how about the defense's witnesses? And how they changed their testimony. And let me ask you, as I said, they keep asking these questions.

Let me ask you to consider this, how many times did one of the plaintiff's lawyers ask a defense witness a question, and then they said, please, turn to your deposition and read that question, and try to give the impression that the witness had changed his or her testimony. When in fact, what really changed was the

lawyer's question.

Why would they do that? This isn't a show game. This is supposed to be a search for the truth. They have the burden of proof. And ask yourself this, are they changing their testimony or are the lawyers changing their questions? And why do they feel the need to do that?

The standard of care. Right off the bat, opening statement, I asked you to consider your evaluation of whether or not Dr. Gokova and Alter met the standard of care, based on what they knew at the time. You took an oath to follow the Judge's instructions, that's good enough for me. You heard the definition of the standard of care. You did not hear anything that you should judge what they did, based on what was determined later.

And yet, how many times -- this was another phrase that was introduced during the trial, how many times did we hear, we now know the doctors didn't take her to surgery, we now know, fill in the blank?

Wait a minute. That's standing back and saying, after the fact, we're going to judge you by something that did or did not happen. That's not how the standard of care is evaluated. But that happened every day during every of these three weeks of this

trial.

Well, I think when they do that ever and over again, you know what the standard of care is. You know you're suppose to be judging it prospectively, they're trying to get you to do otherwise, hum, they're probably underestimating you.

So let's talk about what's clear on what's clear and convincing. Dr. Talan is their standard of care expert. What's clear, because he admitted it, is this expert has never used Profilnine or any 3 factor PCC.

When we talk about standard of care, one of the things that the doctors had to do was evaluate risks versus benefits. There was so many questions about, did she have serious bleeding, yes or no. Did she have this or that, yes or no. Well, wait a minute, you can look at the records that Dr. Gokova did and what Dr. Alter did and Dr. Galson did, I'm going talk about that in a while.

And when you look at that record, ask yourself if they were just going down the barrio trade, a check list, yes, no, yes, no, yes, no, or is there a little more to it than that? Everybody has said, this was a complex case, this is a difficult case, based on the history, based on the findings.

So you heard, when they finally got a chance to testify on direct examination, what went into their decision-making; right?

One of the things, as we heard the evidence, that balance is risks and benefits. What's the risk of using Profilnine, what's the risk of using FFP, what's the risk of using Vitamine K? They're still saying we could have given Vitamine K. Let's stop and think about that for a minute.

Mrs. Tripp says, I've had -- well she didn't use anaphylactic reaction. She said, my throat, my airway starts feeling funny the last time I had that, which in doctor speaking, it's an anaphylactic reaction, which that can kill you.

Plaintiff's counsel is saying, they could have given her Vitamine K. I said, are you kidding, she said, I don't want Vitamine K. If these doctors had given Mrs. Tripp Vitamine K and anything had happened, these same lawyers with the same experts, would be in here suing them, suing for medical battery, saying you did not have consent to do that.

So we get back to, what's the risk and the benefit? The first medical witness plaintiffs called was Dr. Witt, the pharmacist from Utah.

Remember I stood up, I read to him from his

article so that you could hear it. The article that he wrote with his colleague in 2011, two years before this -- and let's just segway for a minute. How many times did we hear, off label use, off label use, off label use? So what.

Dr. Witt said, there are 1000 of medications that we use off label all the time. It's recognized. Not a problem. Okay. So that's off the table now. But I stood up and I said to Dr. Witt, let's talk about this article that you wrote with your colleague after you scoured the literature, studied 26 or 27 other studies, involving over 1000 people. The first sentence of it is PCC's are the treatment of choice for reversing Coumadin elevated INR.

I've never seen lawyers run so fast from their own expert testimony. That didn't come up again -- well, it didn't come up from them ever. But they have spent the entire case trying to tell you that PCC's are just bad and going on and on and on.

Well, let get back to Dr. Witt. Based on all of these people, who they've evaluated through these vigorous scientific med analysis, as they call it.

What is the risk of thrombol embolic event, getting a clot, after using PCC? 3 factor is 0.7, less than one percent. Okay. That's pretty low. At least

in my way of saying it.

Because then I said to him, well, what is the risk of taking FFP? And he said, I can't quantify that. But then when plaintiff's counsel asked him, he said, it's a 60 percent greater risk of thrombol embolic event with PCC over FFP.

So then I asked somebody who do the math. I said, how do you figure out to get to 7 percent versus 0.7 percent, we work backwards, that's 50 percent greater than what? And he came back with .43 percent, so less than one percent. So we're talking about the difference -- if we just take Dr. Witt's testimony at face value. The difference between FFP and PCC and something that -- I'm not even going to do the math in my head, it's 0.7 percent versus 0.43 percent, which I think most people would say is not statistically significant.

But that is their own expert. And the rest of this trial, the last three weeks, the plaintiffs have been trying to tell you to get your eye off that ball and consider these articles to which they refer.

And then yesterday, finally, brought up one of them. Well, let's come back to that. So the standard of care, they spent most of their time trying to get you to disregard Dr. Witt's clear and convincing

statement in his article that PCC's are the treatment of choice for what we have here.

They wanted you to disregard their expert's testimony, they're clear and convincing comment, conclusionises it. That 0.7 percent is as high as it goes when it comes to risk of getting a thrombol embolic clot, following the use of Profilnine.

Then I said to Dr. Witt, let's forget about all the other 3 factor PCC's, when you get down to Profilnine, there were zero complications in the study that you evaluated. That's true.

Well, I'm not sure if it still is the theory, I think it is, but that Profilnine caused a myocardial infarction, I said to Dr. Witt, you look for that too. Tell me how many myocardial infractions there were in all those over 1000 patients, the number is clear and convincing, zero.

So one of the other things that I'd like you to consider, you can consider what is said and what's not said. So they put on their standard of care expert, Dr. Talon, right? He basically says, you shouldn't have used Profilnine. I mean, that's about it.

Plaintiff's counsel, though, spent a lot of your time asking questions like, why didn't you order a CT scan with contrast? And then they wrote it down on

the board, on the easel. Why didn't you get a lumbar puncture? And they write it down. Why didn't you get an endoscopy, get a GI doctor to come in and look for GI bleedings and then write it down? You didn't do any of those things; did you? Dr. Alter said, no.

Well, when Dr. Alter had a chance to explain it, he said, well, I didn't order contrast because I did not want to delay the study, given this off the charts INR. I did not want to order contrast without knowing what her kidney function was, because if you order it and the kidney function is bad, there can be bad things that can happen from that. That contrast can be toxic to the kidnies. He didn't want to do that.

I mean, that's not on the guideline that plaintiff's counsel keeps putting up there, but that's clinical judgment, and that's good clinical judgment. There's no box to check for that, you just have to know that if you're a good doctor, and Dr. Alter does.

But then he says, well, how come you didn't do the lumbar puncture? Do a lumbar puncture? Yes, to rule out the subarachnoid bleed. This is going to go from bad to worse, with an INR that's still off the chart.

And when you think about the contrast, the point that Dr. Alter bought up, that remains to this day

uncontradicted by anybody.

Dr. Alter saying, I wasn't about to do a lumbar puncture, in a patient with an off the chart INR, that remains uncontradicted, nobody said that's a bad idea, you should have done it anyway.

And then we get to, well, you didn't order an endoscoptomy either, to check for the GI bleeding. Given a chance to tell you why? Remember what he said? Put a scope in there, you could tear -- you can puncture, that's a risk with anybody. You can perforate going down. And a patient with an off the chart INR, okay, we have a real problem now because it hasn't been reversed. If it hits a blood vessel going down and it bleeds, we have a real problem. That's not on the checklist, as plaintiffs called the guideline. That's just good medicine.

Did Dr. Talon take any of your time getting into any of those issues? Short answer is no. Then the question is, why do they? I mean, really. If you have a good case on the one issue in the case, you don't waste your time beating around every other bush you can find or try to make up. You focus on what you think your good issue is.

They spent more time talking around things. When they talked about Dr. Gokova and when she prepared

her note. Okay. She left work, came back three days later, prepared the note. They say there's a credibility issue. Okay. Fair game, that's why we're here. They didn't point to a single line in Dr. Gokova's note, where they said this is not true. But it's all this innuendo. It's like, wait a minute, we're four years and three weeks into this and that's the best you can do is say, no, she did that note three days later. What's wrong about it? Was incorrect? What's not true? Nothing.

One of the things that Dr. Alter said, and this is against the backdrop of if anybody had ordered PCC, one of the things that Dr. Alter said was, he was concerned with was the history. Four days earlier Mrs. Tripp had a seizure and then had a headache right afterwards, it was different than any headache she ever had before. He's thinking that could be a subarachnoid bleed. The problem is it's now four days ago and the CT scan is not going to pick up on it. The problem is, you can't do a lumbar puncture if you had this blood in the cerebral spinal fluid because she's going to bleed out if he does that. Anybody contradicts that? I don't thing Dr. Talan is going to speak to that. Ask yourself if Dr. Talon did.

The other thing that he talked about was,

their differential diagnosis included appendicitis. The reason they got the surgical consult was appendicitis. And did you hear during the course of the trial, one of the Hallmark signs of appendicitis is right, lower quadrant pain because that's where our appendix is, that's where all of our appendix are. All right.

Well, what's another hallmark of appendicitis? It's an elevated white blood count, leukocytosis. Mrs. Tripp had left, lower quadrant pain, she walked in the door with that. She had the leucocytosis, walked in the door with that. And then had the CT finding that a resident radiologists said were consistent with, we're concerned for appendicitis.

So they got a surgical consult. That's medical decision-making. There's no check the box on the guideline for that either, nobody criticized that decision during the entire course of this trial.

And instead plaintiff's argument was, well, we now know the surgeons didn't take her to surgery. Well, we've talk about, and it's undisputed, we're supposed to be looking at this prospectively. They're trying to get you to look at it retrospectively, looking back on things. But you took an oath to follow the instructions, and as I said before, that's good enough for me.

One of the other things that Dr. Alter said was that when you have a bleed, a subarachnoid bleed, number one, it doesn't take much blood to cause a lot of pain. And number two, even if it stops, if it rebleeds, that's when it's catastrophic. And let's get back to -- these are just facts, as we heard from the witness stand.

Go back to Dr. Witt for a minute. 0.7 percent risk of thrombol embolic clot after PCC. Zero risk, based on the numbers, of myocardial infractions. The risk of a bleed when you're on Coumadin is 1.1 to 1.5 percent, that was a quote from one of the articles plaintiff's counsel brought up.

So the risk of bleeding is twice the risk of any thrombol embolic event. And it's, I don't know, 1.5 over zero, if you're talking about myocardial infraction, based on the Witt article.

So based on those facts alone, Mrs. Tripp was at significant risk for bleeding, when you look at those most basic numbers. Anybody on Coumadin, whatever your INR is, they have a risk of 1.1 to 1.5. That risk only goes up when your INR goes up.

And Dr. Witt says, I mean, this is one of these things, I mean, I brought in Dr. Sacher, the hematologist, we're going to talk about him in a little

bit. But this is plaintiff's own expert talking about the risk of the INR -- rather, the risk of bleeding going up with the INR. So that's the context of the decision-making. There's no check box on the guideline for that either.

So one of the things that they have to consider is these -- the history of uncontrolled bleeders, that's a given, at least according to the medical records, at least according to what Mrs. Tripp told these doctors.

She had uncontrolled seizures, she admitted not taking her anticonvulsants that day, for reasons that she couldn't explain. And these doctors are dealing with a patient who has this off the chart INR, who's had a seizure just the night before, where she's incontinent of urine and bowel. And we know from looking at the prior records, this is a lady who's fallen a number of times, even in hospitals, that's something to consider.

There's not a box to check on the guideline about what do we do if we have somebody with uncontrolled seizures with an off the chart INR. Well, that's where we say, what do we expect from doctors? Do we expect them to just check the box? If there's no box to check, you take their position, there's nothing to

do. And you just have to say, well, I hope nothing bad happens, but according to the guideline, there's no way to treat that. Well, that's not, you know, that's not the way these doctors practice, it's not the way they practiced then.

So that's another factor that goes through this, what's the backdrop against this, which, you know, you need to consider the standard of care.

It's undisputed that it was going to take more FFP than PCC. It's undisputed that it was going to take longer for the FFP to even go in. And there's no dispute that it's going to take longer for the FFP to reverse or start to lower the INR.

And here's the thing. Whenever anybody says, what's the rush. Well, you have the facts, you can evaluate whether or not these doctors were concerned about something that could spiral out of control fast if they didn't do something.

So against that backdrop, when they say, they didn't have to do anything, or, first do no harm. Would it have been appropriate for doctors -- and I asked this of Dr. Pike yesterday. Does that mean they could just have stood back and said we're not going to do anything, we really shouldn't do anything because there's nothing on these guidelines. Would it be a good

defense if anything bad happens and they got sued? He says, absolutely not, they have to do something.

You know, one of the other things too is, both doctors testified that they expected Mrs. Tripp to go to surgery because the findings; right? The appendicitis, the CT findings; the blood count. I mean, this is an opinion of a radiologist. It's the objective findings of the white blood counts, it's the patient's responding to where they're pressing, they're confirming to what she said to see where it hurts. But they come back to the guideline.

Do you remember I read it to a couple of different witnesses, Hoyt Yee, the pharmacist at UMC said, in response to a question that plaintiff's counsel posed to him at his deposition. They said, doctors expecting the patient to go to surgery qualifies under this guideline, he said, yes.

He essentially signed off on this. He is the one who released the Profilnine so that it could be administered to Mrs. Tripp. Nobody is saying that he was negligent, nobody sued him.

So what do we know? How did this decision come about? I mean, I'm glad you're here because I was thinking I didn't attend the same trial as plaintiff's counsel. They were making it sound like it was Dr.

Gokova that came up with this idea and decided to give it.

She said several times, it was discussed during signoff. Discussed with Dr. Alter. She says Dr. Valenzuela was there. She talked with the pharmacist, Hoyt Yee, about it. We have a number of people in on this; right?

Then we think of -- one of the things plaintiff's counsel said during his opening statement was, the surgeons never knew about the order. Well, they said, hold him to it, that's your job, that's for you to do.

But do you remember the testimony, Dr. Venkat, the surgical resident, signed in, logged in to the EMR at 28 minutes after midnight, what's in that EMR, it's the order, the order and lab result. At 12:38 he sees the patient. He puts it in his note, he discusses the situation where Dr. Rhee. And the conclusion is continue to reverse the coagulopathy, which was then done at 12:47 to 12:57. Those are facts.

The order for the Profilnine was in before Dr. Venkat logged into the EMR, which is right there. Well, what are the possibilities? We heard -- and in fact, I asked Dr. Talon this. A surgeon in that situation, knowing the orders can't recommend something

else; right? Can recommend whatever. And we saw -- they made some recommendations, like start antibiotics, get additional labs. One thing they did not do is say recommend anything other than Profilnine.

So then we get to Dr. Rhee. Why? Because Dr. Talan said, all they had to do was talk to the surgeons. So we bring in a surgeon. And I'll come back to that. Why did we bring in Dr. Galson, why did we bring in -- well, number one, if we brought in everybody to prove what's in the record, I wouldn't be standing in front of you talking to you right now, we'd be adding another week on to this trial, because there would endless cross-examination about what they said in the record, what the facts are.

Dr. Rhee, though, testified that if he would have been called, he would have said reverse with Profilnine. Why? Because it's safer, he uses it. Those are facts.

So we're up to everybody who's involved in this decision right now, Dr. Gokova, Dr. Alter, Dr. Valenzuela, Dr. Venkat, Dr. Rhee.

No one is saying that Dr. Venkat was negligent. Nobody was saying that Dr. Rhee is negligent. And nobody has ever said that the person who handed out the Profilnine was negligent.

You know, one of the things that I'm sure you picked up on, Dr. Rhee is on the stand, and he's one of the most renown dedicated trauma surgeons in the county. His curriculum vitae or resume is about 60 pages long. I asked him about articles, he's written a ton of articles, he written book chapters, he's done everything.

After he leaves, plaintiff's counsel confronts Dr. Gokova with an article by Dr. Rhee, do you remember that? Doesn't show her the article, but just asked her if she's familiar with it. And then asked Dr. Pike about a different article by Dr. Rhee.

Why wait? I mean, where I come from, if you want to challenge somebody, you question them. You say, hey, look, I want to talk to you about something. Why wait until Dr. Rhee is gone to ask other people about his work, about what he has said regarding any thrombol embolic rate, if any, in all the studies he's done on Profilnine? They didn't do that.

When I asked Dr. Pike about one of his studies, Dr. Pike said, yeah, I'm looking at one of these studies by Dr. Rhee, there wasn't a single embolic complication using Profilnine and no heart attack.

Then there was the article that plaintiff's counsel brought up yesterday with Dr. Pike, that factor

9 article. No testimony about a single heart attack referenced in that article, no testimony about any embolic complication. How about that?

You know, ask yourselves, if Dr. Rhee, in any articles that he's written that shows up anywhere in his 60-page resume that said anything other than Profilnine is safe and effective, they would have been waving that around, front and center from the beginning of this trial. We're now three weeks into it and we still haven't seen anything, to the contrary of what he said. He would have recommended it and what we know from the articles that were testified about, that it's safe and that nobody has ever had a heart attack with it.

So, you know, we get back to the guideline. They keep talking about serious bleeding. One of the things that the guideline says is that Profilnine can be used to prevent bleeding in hemophiliac. And if we come back to Dr. Witt, I said to him, a hemophiliac is missing one factor, one clotting factor. And he said, that's right. Somebody who's on Coumadin is missing four factors, not more likely to bleed.

Their argument is, you can't prevent bleeding unless you're a hemophiliac. Well, I try to always thing, well how does it play out at a practical

matter, because Dr. Witt was then asked, how do you quantify serious bleeding? And he came up with a number. I started to think to myself, how would that play out if we're not talking about GI bleeding, but we're talking about bleeding in the brain and using Dr. Witt's number, you know, the serious bleeding number?

And if you took his number at face value, somebody's head would explode before you could actually prevent -- or not preventing, by the time you could treat somebody?

And so then I think, well, how does that play out as a practical matter if we're applying what they're saying, if you have to get to some number that's serious bleeding in a patient who's in the ER with a bleed, I mean, is the doctor supposed to say to that patient with the intracranial bleed, I'm sorry, I can't try to save your life right now because your bleeding isn't to the point that's been established by an outpatient pharmacist in Utah and so there's nothing we can do. But even if we did get him on the phone, he would recommend a treatment that's going to take 12 to 24 hours. So before you lose consciousness, please get you affairs in order because otherwise, if I try to save your life now, a lawyer is going to sue me for allegedly violating the guideline for not checking the box. As

yourself if that's what you would expect for doctors in our community to do.

You know, we heard that Dr. Schmidt supposedly said that we didn't meet the guideline. Remember when I did the redirect and I said, what about the inability to rule out a subarachnoid bleed because they can't do a lumbar puncture? He said, that's the reason to reverse it with PCC, you have to rule it out. And I said to him, well, how about if we can't rule out a GI bleed because we can't do an endoscopy with these number that high? And he said, that's the reason to administer PCC. That's why I said I'm glad you were here to hear the testimony.

Then the argument was, well, we now know Mrs. Tripp didn't go to surgery. That's, again, underestimating you, because that's asking you to do something that you're not suppose to do, and that is to evaluate this case retrospectively.

But then when you look at the record and you see -- remember Dr. Rhee's testimony? Did he say this patient doesn't have appendicitis, period, we're signing off? No.

They said, she's a very high risk for surgery. And I said to him, was one of the reasons the high INR? And he said, yes, you can't take somebody to

surgery that way. And what he went down by saying is we are going to follow her with serial examination, one after another. We're going to keep seeing her. We're going to stay on as her doctor.

Let me just digress for completely for a moment. Yesterday for the first time in this three-week trial, we heard a question raised about whether or not Mrs. Tripp could have had mesenteric ischemia. Something going on down on the bone.

Ask you to keep in mind, Dr. Schwab didn't suggest that, Dr. Talan didn't suggest that. Who else did they bring in? Dr. Witt, I don't know if he would know much about it. Not a single one of plaintiff's expert, during trial or for that matter, during deposition, ever brought up this mesenteric ischemia. I mean, that's like the legal equivalent of the Hail Mary pass. We're three days into this and they're trying to come up with a new theory to try to explain this right, lower quadrant pain. When every single one of plaintiff's experts, when I took their deposition, I asked them the same question at trial, what caused the right, lower quadrant pain? They said, I don't know, I don't know, I don't know, across the board.

One of the things, though, that was said was, well, if you have mesenteric ischemia, you're going

to have a surgical abdomen. We had surgeons in there twice.

Dr. Rhee and Dr. Venkat evaluated Mrs. Tripp initially regarding the appendicitis. And then when she became tachycardiac, her heart rate went up, her blood pressure went up and then when it went down --

THE COURT: Mr. Smith, slow down just a little bit.

MR. SMITH: Sorry.

They came back, that's right in the medicine team's note, they came back and evaluated her again. Not a word about a surgical abdomen, not a word about mesenteric ischemia, not a word that would support this eleventh hour, we're going to try a new theory on the jury approach.

So then the question is, when are the facts going to matter? One thing that plaintiff's counsel told you, I think it was to just try to get you inflamed about something, is Dr. Gokova ordered the Profilnine and then left the hospital. Turns out that's not true. The Profilnine was administered at 12:47 to 12:57. Dr. Gokova went back and checked out the patient.

I don't know if you can see this. Well, actually, can everyone see that?

So Dr. Gokova goes back after the

administration, Mrs. Tripp is saying, I still have this right, lower quadrant pain. So Dr. Gokova orders this pain medication for her. That's in the record, that's a fact.

So at this point to try to be inflaming you against Drs. Gokova, who want to say just ordered it and left, I ask you again, when are the facts going to matter?

The question comes down to is what a reasonable and prudent physician would do under the same or similar circumstances? So you can ask yourselves, was it reasonable for Dr. Gokova and Dr. Alter to have different -- having the differential diagnosis, appendicitis. One of the hallmark signs for it is right, lower quadrant pain, elevated white blood count and CT finding.

You're going to ask yourself, whether it's reasonable for a doctor to think that when a patient has a seizure, it seemingly causes a headache, it's worse than the patient ever had before, is it reasonable to think we might be dealing with an intracranial bleed here, a subarachnoid hemorage, bleeding in the brain.

You can ask yourself if it's reasonable when patient comes in and she's reporting bright red blood, which is coming from the lower GI tract. Dark stool,

which comes from the upper GI tract. Whether it's reasonable to say, we need to rule out GI bleeding, gastrointestinal bleeding. And then ask yourselves whether it's reasonable for these doctors to consider that a rebleed could be catastrophic with these types of numbers on the INR. Those are the issues that they were facing.

So let me just -- I apologize if I'm repeating myself, but there are four years of their time and three weeks of your time into this case. And plaintiff's counsel stood up and said twice, a clot formed and went up to Esmeralda's heart.

I wasn't going to ask you to consider that argument. In the context of when are the facts going to matter. Because, number one, the question is, where did it form? If we go back to before the lawyers got involved, there's not a single doctor at UAMC, who said there was any indication of clot in the legs. No complaints of pain, no color changes, no swelling, no nothing.

So where did this clot form? But when I get to the next point, that point is purely academic. Because the testimony was clot that is in the legs doesn't go to the -- inside the heart, it goes inside, but it doesn't go to the coronary arteries.

What plaintiff's counsel said to you in the last day of a three-week trial, four days into it, it is anatomically impossible. Dr. Pike said that yesterday and the first time he was here he drew this diagram, blood coming back to the heart. The venous blood that's coming from the leg, comes up through the inferior vena cava. From the rest -- from the upper body it goes back to the heart from the superior vena cava. It goes into the right atrium, down to the right ventricle, goes up to the lung.

If there was any clot at all, just for the sake of argument, it had to come from some place; right? Again, for the sake of argument, if there had been any clot in the leg, it would have gone to the right atrium, right ventricle, lungs, then it would be called a pulmonary emboli.

The problem is, the doctors in this case ruled a pulmonary emboli, with that CT of the chest, CT angiogram of the chest done a few hours after this incident.

So then we get back to clot formed and went up to Esmeralda's heart. The only clear and convincing evidence on that issue is that it is anatomically impossible.

Once the blood, you know, if there is a

clot, it's going to go to the chest and then run to the lungs and it's going to get stuck there, the lungs are a filter, if anything. There's no way that a clot could have gotten from the lung into a coronary artery.

So when plaintiff's counsel says to you, is it coincidence? We're so far beyond coincidence right now, it's not even funny. There is no way a clot could have gotten into a coronary artery from anywhere else. This is not the way the body works. And no doctor ever testified that can happen.

In fact, when I asked Dr. Schwab -- remember I started asking him about a coronary artery is a hard slow blood vessel? Same thing Dr. Sacher said, arteries are hard slow vessels.

And even in response to plaintiff's counsel question, when they said to him, Doctor, how does a clot form -- Dr. Schwab, how does a clot form in the coronary artery? He said, oh, well, that involves hybrinagin and he went on.

And I said to him, when I stood up, what you're describing is where somebody has arteriosclerosis, or coronary artery disease, plaque breaks off, clot starts forming around where the plaque has broken off, and the next thing you know there's a clot that's blocking artery. And he says, yeah.

Plaintiffs in the beginning of this trial, one of the things they acknowledged was, she never had coronary artery disease. And in the records that were offered from St. Mary's, you can look in there in the coronary angiography, they did myocardia infusion studies, clean bill of health, in terms of any coronary artery disease.

And here's one more thing to consider too, if any doctor at UMC, and keep in mind, nobody is alleging that anybody else was negligent in this case, if anybody there at UAMC back in September, October, early November of 2013, thought, even suspected that Mrs. Tripp had any coronary artery disease, once the -- the fact that the TPA was off, they could take her to the cath lab, they could put a catheter up there, look around. They didn't. Nobody suspected coronary artery disease because there was not reason -- she didn't have it, period. That's it.

So we get to -- is it coincidence? The clear evidence from Dr. Schwab is that the only way a clot forms in a coronary artery is if you have coronary artery disease, plaque breaks off and we go through this clotting cascade.

As long as this case has been going on and in the three weeks of this trial, you know, we heard,

did you produce any literature? Nobody has testified that clot just formed on its own, in a perfectly clean high flowing coronary artery, doesn't happen, period.

Well, lets just get back -- if the doctors had done nothing and if Mrs. Tripp's appendix had burst in the emergency department that night and the surgeons could not take her to surgery because of the high INR, these same doctors would -- excuse me, the same lawyers with the same doctors would be in here suing them for that.

The last thing I'll say about when we're talking about causation, was there any clot? Plaintiff's counsel yesterday flashed through a number of records when Dr. Pike was on the stand, saying, do you agree with this? Do you agree with that? Whatever. And he put a problem list, was I think one of the last documents he put up on the screen, remember that problem list, it listed, it's about this long. And they said, look, it says pulmonary embolism there, look, it says, deep venous thrombosis there.

I'll tell you what, you have 8,000 pages of records from the main campus on Campbell. You will see problem list galore there. And what you will see that if something was mentioned on year one, it's going to be carried forward through the last time you were there.

There remains -- I mean, the last slide from there was interesting, but nobody diagnosed DVT at UAMC, regarding Mrs. Tripp. Nobody diagnosed pulmonary embolism there either.

And let me just ask you to consider one more thing because plaintiffs says, one of our experts says she didn't have a heart attack. I'm going to ask you to use the medical terminology in your deliberations here. Because everyone of our experts said, a myocardial infarction can happen because of the rate at which the heart is beating. So it can basically, it's like you're running and you're certainly out of breath, you outstrip your oxygen supply. That can happen to the heart. That can cause the release of these troponin, the enzymes when they affect and damage the cells. That's undisputed. We get into heart attacks versus myocardial infarctions. Let's keep our eye on the ball.

Before the lawyers got involved in this case -- tell you what, let's go back to Dr. Schwab for just one minute. Putting aside the impossibility of the anatomy, that you heard about in closing arguments here. Putting aside that Dr. Schwab said the only way it can happen, a clot in the coronary artery can happen is if it's a condition that Mrs. Tripp didn't have.

When I said to Dr. Schwab, there's no

evidence of clog, he said, true, but there's indirect evidence. I said, what are you talking about? He said, EKG.

Well, there's a reason why he said Mrs. Tripp had an inferior wall EKG because he was trying to say there was a heart attack in the bottom valve of the heart and that caused, quote, epigastric pain, which is up here. They have to shoehorn this heart attack theory into something.

The problem is, before the lawyers got involved, the medicine resident admitting Mrs. Tripp would was at the bedside said the pain that worsened, that had her screening, and when she had 10 out of 10 pain was the right, lower quadrant, wasn't epigastric, point number one.

Dr. Schwab, when I said to him, okay, indirect evidence, tell us which coronary artery, he said, the right coronary artery.

Before the lawyers got involved, Dr. Albert, the cardiologist, said if there are any changes, they're on the lateral wall. Dr. Schwab is on the wrong side of the heart.

So then he said, well, that's indirect evidence of a clot, Dr. Schwab did. Well, I keep going back to, before the lawyers got involved, Dr. Albert,

the cardiologist, who evaluated Mrs. Tripp that day, has in his note -- and you'll remember this phrase, rate-related myocardial infraction.

So it's one of these situations where, if you don't want to take Dr. Pike's word that an MI can happen without a clot, if you don't want take Dr. Sacher's point on that either, there's Dr. Albert, who said, rate-related, doesn't say anything about a clot. The rate, because it was working so fast, heart rate up to 180 at one point.

THE COURT: Mr. Smith. You let us know when a good time to break is in the next five minutes or so.

MR. SMITH: I'm up for a break right now, it's up to you.

THE COURT: Right now?

MR. SMITH: Sure.

THE COURT: Okay. So ladies and gentlemen, we'll take the afternoon break. Everybody has been at it for about two hours. So we'll take 15 minutes.

Please remember the admonition. The Clerk/Bailiff will exit you out. And we'll see you back in 15 minutes.

(Jury not present.)

THE COURT: All right. Show the jury has exited. We'll be at recess for 15 minutes.

(Break taken.)

THE COURT: Thank you, ladies and gentlemen. We'll go back on the record at this time.

Mr. Smith, are you ready?

MR. SMITH: Yes, I am, Your Honor.

THE COURT: Okay. We'll send for the jury.

BAILIFF/LAW CLERK: Jury entering.

(Jury present.)

THE COURT: Please be seated, members of the jury. We'll continue with the defense's closing.

MR. SMITH: All right. Thank you, Your Honor.

You know, one of the things that plaintiff's counsel said was a lot of the defense doctors said, I don't know. If they didn't know an answer, isn't that what you wanted to hear? I know if I go to a doctor, I want somebody to tell me they don't know an answer, rather than, you know, try to pass off something on me that it's anatomically impossible.

But let's get back to one more thing about Dr. Schwab. Remember I said to him, if I'm hearing you right, there was a clot in the artery that was there for an hour and 15 minutes before the TPA was given, and he said, well, yeah. And enough to cause what you're saying is cardiogenic shock, and he said, yeah. But the

problem is, there's no damage to the heart.

When we get to echocardiogram that's done, I think on September 14th. Remember we talked about, if there's significant damage to the heart, it's just not going to pump as well as it use to. There's the walls, the contractions, that wall motion, it's not going to be what it use to be. It's not going to be normal. The ejection fracture, how much the heart is pumping out to the rest of the body, it's not going go be the same.

What do we know? This is another fact before the lawyers got involved. The echocardiograms, the last two they did, entirely normal. No evidence, wall motion problems, no evidence of ejection fraction problems. It's a good heart. How does that square with their theory? Ask yourselves. Well, maybe it doesn't.

Then there's the other thing, and this is where there's so many disconnects in this case. They made the argument that, when they read from Dr. Galson's note, Dr. Galson, the resident, I'm sure was well intended when she says, this is what we were thinking could possibly be the case. She mentioned pulmonary embolism, she mentioned myocardial infraction, she mentioned ischemic stroke. And she said the oxygenation went up after the TPA. That was before the CT scan ruled out any pulmonary emboli.

Why is that important? We heard that the only reason there would be -- not the only reason, but if there's going to be the decrease in oxygenation and it's because of a pulmonary emboli, well, there has to be a pulmonary emboli. There has to be a clot in the lung that's affecting the oxygenation.

Remember they talked about, we can't get a good reading on the pulse oximeter, it's on the fingertip. It's in the peripheral circulation. That's going to be the first thing to go when the body starts shutting down to help out with the blood pressure. And that's really is not an issue, not a factor when the pressures are giving too because that's just clamping down, constricting, constricting all the way, clamping constricting all the way up so the cord is preserved, the vital organs are preserved.

So then the question becomes, was there an issue about oxygenation? Well, we heard a reference to blood gasses, so we really don't know if the blood gasses reflected any difficulty with oxygenation. All we know is that the pulse oximeter at the peripheral end of the -- or the most peripheral end of the circulation couldn't pick up something, which can be because of low blood pressure, or it can be because the patient is cold. Patient had both. It's reflected in the

handwritten nurse's note here.

And then if they want to play out this theory that, well, there was a pulmonary embolism, there's a clot that caused that degree in the pulse oximeter. You know, okay, it's time for clear and convincing evidence. Where is the evidence of the clot? It's not there. It's not in the CT angiogram.

So yesterday we heard the to do with Dr. Pike, did you bring a single article that says, what you say, they say, I don't know, 30, 40 years of being an ER doc, did you see clots after a TPA has been administered? And he said, no, that's my practice.

Remember my redirect list? Who's needs an article when we have Dr. Schwab, who said, if TPA works at all, it does not completely dissolve clot, it will still be there. And it's not. It wasn't. Wasn't then, isn't now. There's zero evidence of any clot in this case. No clot in the legs, no clot in the lungs, no clot in the heart.

The one thing that's kind of interesting, though, is, we heard TPA can breakup clot. Let me ask you to talk about this one when you go back. We're concerned about GI bleeding; right? If there has been a bleed that stopped based on the dark stool, based on the bright red stool, if there was a bleed that stopped

because it clotted, could the TPA have actually dissolved one of those clots?

What you'll see is in the handwritten nursing notes from the ER, they pumped out 100 millimeters of blood from the stomach that wasn't there before. What's that? There's some evidence of GI bleeding that had been going on and clotted. It began with the TPA that was administered that caused bleeding and oozing from the mouth, the IV site from the catheter.

In any case, it turns out that, you know, this concern about GI building is proven after the fact, based on the TBA, the blood that came out.

MR. KEENAN: Objection, Your Honor. Can we approach?

THE COURT: Sure.

(Bench conference.)

MR. WENNER: Judge, Mr. Smith is arguing that the fact that the GI bleeding, after the fact that there's GI bleeding before the fact. There's no expert evidence that you prohibited that expert from testifying to that missed case, and he's doing exactly what you prohibited asking an expert.

There's no evidence that there was GI bleeding because there was found after the fact. It's

clearly from the TPA it causes bleeding. We discussed that --

THE COURT: Well, I concluded a certain doctor from talking about it, I forget who it was, but the lawyers are free to argue whatever the reasonable inferences might be from the facts when you get up in your reply argument, you can argue that's not reasonable and no evidence of it, no scientific evidence. But I'm not going to stop the argument (Bench conference over.)

THE COURT: Thank you.

Go ahead, Mr. Smith.

MR. SMITH: So we have the dark stool and residence of manala, remember, I think it was Dr. Schwab that said they missed that diagnostic of the GI bleed. And then we had the last lines of the handwritten nursing note falling everything that happened the early morning hours of September 14th.

The last couple of things on the causation side of the case. I put Dr. Sacher up here on the stand. He's obviously the counterpart of the hematologist to Dr. Schwab. I'm not going to say anything different now then I did before. You get to decide who you put more weight in, Dr. Sacher, Dr. Schwab, it's your job.

Let me ask you, though, just to consider

this. Nobody challenged the Dr. Sacher's qualification. I shouldn't say that. He was Board-Certified in Canada and South Africa, this might not be good enough for plaintiff's counsel, but it was good enough for George town and the University of Cincinnati.

Nobody challenged what he had to say about how clots formed in the venous system. Nobody challenged him when he testified about how clots are formed in the arterial system, if they do, it's related to damaged to the wall from osteosclerosis, nobody challenged him on that one bit.

Nobody challenged him on how much FFP would have taken or how long it would have taken to administer it. When they got do the point where they're not really laying a glove on, what do they do? They're saying, Doctor, you're charging to be here. Well, let me stop there for a minute.

Ask yourself if anybody was giving it away. I didn't get into that with plaintiff's experts. They didn't get into it with us until Dr. Sacher, the last witness -- the second to the last witness. But they asked Dr. Sacher what he's charging to be here. He said what he charges to be here, he said he charges $5,000 a day. Then they try to keep me, though, from giving you the information that their expert charges $10,000 a day.

What's that about?

So with that all on the table, you can decide who you put more stock in. You can decide how you're going to do that. You can do that based on their credentials, you can do that based on their opinions, or you can do that based on who makes more sense. Ultimately you can do that based on who's basing their opinions on the record, who's basing their opinions on the most fundamental basic anatomy.

You know, let's get into when they talk about, is it a coincidence? Profilnine, we heard undisputedly, it's most effective, in other words, it reaches its highest, its peak affect is 15 to 30 minutes after administration. Administration was finished at 12:57. The second INR at UAMC was obtained at 1:30 in the morning, it was 2.1, undisputed.

One thing we agree on. Mrs. Tripp was within the therapeutic range. That's the range that everybody wanted her to be within all day, every day. But she is still within that therapeutic range when one other point we agree on is that she's still anticoagulated. So that's a good range because it's going to keep her from forming clots.

But what's undisputed is that when you have peak effectiveness, 15 to 30 minutes, the lowest INR is

going to be within that 15 to 30 minutes. After that, it's going to start to gradually go up. And as the INR goes up, it means the blood is getting thinner. And what does that mean?

It means as time goes on, there's 15 minutes, 30 minutes, 45 minutes, 60 minutes, 90 minutes, 120, two hours down from that, her blood is getting thinner, she's less likely to clot.

And so when did Mrs. Tripp start screaming about the right, lower quadrant pain, which nobody said was caused by a heart attack, it was 3:15, I mean, over two hours, after the administration of the Profilnine. After, if it was going to clot, it would have clotted. After we would have expected to have -- sometimes there's clot in the legs, sometimes they clot in the lungs, that didn't happen. So keep that in mind when you're asked about what's coincidence.

But consider this too. These are facts. And I mentioned in my opening statements and it is undisputed. In the records that we've offered, you will see if you want to look through the UAMC Main Campus record, UAMC South Campus, the Marana Health Center records, there are INR's that are obtained.

Mrs. Tripp over the years had over 60 INR's that for a person on Coumadin would be in the

subtherapeutic range. Any of us who are not on Coumadin, we are around one, plus or minus. She had over 60 that were .8 .9 1 1.1 a little bit above 1, but 60 below 2.

And you know what happened during each one of those? Absolutely nothing. There is no evidence, zero evidence, that Mrs. Tripp ever clotted during any of those times when she was supposedly in her therapeutic range.

When I say supposedly is because the therapeutic range we heard, for people who are in Coumadin, who presumably are hypercoagulable, who have some sort of underlined state that for some reason they are prone or predisposed to forming clots.

In the context of this case, we now know, to borrow the phrase, that the myocardial infraction, the DVT, clots every where, never happened. And you heard me refer to that factor five test, to look for genetically clotting, she didn't have it. The acquired clotting, that being determinant by that lupus anticoagulant study. Negative.

So there's, number one, zero evidence that Mrs. Tripp was ever hypercoagulable or predisposed to forming clots. There's zero evidence that when she was on Coumadin, even when she went below to those 60 plus

times that she ever formed a clot. There is zero evidence that on September 13th through the 14th, she formed a clot.

So we get to, then, what happened? And, you know, they asked Dr. Sacher, is there a single record that says what you say. And I had to go through that with him. We went through the record of the medicine record to describe the pain. The heart rate goes up, the blood pressure goes up, and it goes up to the point where there's that vasal vagal response. Mrs. Tripp passes out from the pain, even after getting Dilaudid, which doesn't affect the pain, but we heard that Dilaudid can expand blood vessels. What happens when blood vessels expand, the blood pressure goes down.

Like, you can take your garden hose and you can put water through it and you can stand there and water your lawn. But you substitute a fire hose and hook it up to your hose, you're not going to get the same water pressure.

THE COURT: Mr. Smith, you're a little fast.

MR. SMITH: Oh, sorry.

So that happened. And then the blood pressure drops, the heart rate drops after going so fast, it outstrips the oxygen supply.

And then what do we know? We go back to Dr.

Albert, we have this rate-related myocardial infarctions causes the troponin enzymes to go up, but no long-term damage. It does, though, cause hyper profusion, not enough blood going to the brain.

What do we know? Plaintiff's counsel said, is it coincidental? Well, I'll tell you what's not coincidental, that during this, Mrs. Tripp had tachy cardio, it's a response to pain. And when you look at her diagnosis, supraventricular tachycardia was one of the pre-existing conditions.

What also happened during this time frame, she went into atrial fibrillation, an arrhythmia of the heart. The heart can be beating fast as anything, but it's not efficient, it's not pumping oxygenated blood.

Any coincidental about that? No. When you look, you'll see that is one of the diagnose pre-existing conditions that she had before September 13, 2013.

When they ask, what's coincidental? We say, there's nothing coincidental about that right, lower quadrant pain getting worse, that's what she had when she walked in. All of that, all of that, all of that, can happen without a clot.

So then we get to the last day of evidence in this case. And plaintiff's counsel, after alluding

to or had a referring kind of a bleakly throughout the course of this trial, to some article that's going to say 9.1 percent risk of thrombol embolic event, brings it up with Dr. Pike. Cross-examined him for a long time on that. It's that 2015 article.

And when all is said and done on the cross-examination, I stand back up and asked Dr. Pike to turn to the last page, where they have a table that shows what were the complications related their use of this PCC. Plaintiffs all along had been saying she had a STEMI, an ST elevated myocardial infarction. And I said, okay, doctor, let's go with that for a minute. Take a look at this study that involved 209 patients. Nowhere near as many as Dr. Witt's thousands plus, but it's the most recent article that we have.

So I said, how many STEMI's did they note, in the, I think it was like zero to 72-hour time frame? None. How about 72 hours to whatever the next time frame was, like, three days, three weeks, whatever? None. What's the overall number of STEMI's that anybody had following the use of this PCC? None.

So they've been at this four years, you've been at this three weeks and none of us has heard anything about any PCC ever causing a myocardial infarction.

They want to talk about coincidence? I want to talk about fact-based evidence, fact-based medicine. We've been at this a long time and there is still, at the end of the day, the clear and convincing evidence is that there's been no reports in any literature, not in Dr. Witt's, not in Dr. Rhee's, not in, I can't remember the name of the author from 2015, nobody has reported what they're say happened in this case.

Which then raises one other question. If what they're saying is true, that this is the first time it's ever happened, doctors would have been climbing over each other to be the first to publish about this, to get a report out there saying, low and behold, we've had something happened that has never been reported before and is, in fact, anatomically impossible. Didn't happen.

Let me -- so two more comments about this. We heard Profilnine is a known cause of heart attacks. Not based on the literature that they produced.

The other thing is, what is the likelihood of Profilnine causing an MI? Based on the clear and convincing evidence they produced? Zero.

The one thing -- and I'm just going to touch on this briefly and then move on to damages, and then I will sit down.

The issue of comparative negligence. You can decide, as members of the jury, members of the community, whether Mrs. Tripp was comparatively negligent. That is your decision. The issue there is not whether she met the standard of care, but just was it unreasonable for her to not follow doctor's recommendations regarding Coumadin she was taking. Because that puts her in a position where -- it's undisputed in this case, her INR was so high it had to be reversed. Disagreements on how it had to be reversed. But even for the sake of arguing, if you consider what the plaintiffs have said, use of FFP, everybody who's been in here says there's a risk of clotting with FFP. So there's no, you know, go free or whatever card, you don't get that. There's a risk. If you put yourself in that position, there's a risk.

And plaintiff's counsel said, well, anybody can end up with an elevated INR, however compliant you are. Ask yourself if Dr. Harris' note is clear and convincing evidence that Mrs Tripp was noncompliant, when he charted, I told her to stop and she's been on 3 milligrams since, at least that's been the history, since I told her to stop, she never stopped.

Ask yourself if there's clear and convincing evidence of noncompliance, when Mrs. Tripp showed up at

the hospital and said she wasn't taking 3 milligrams, she was taking 6 milligrams, twice a day for a total of 12.

We have clear and convincing evidence -- our burden of proof on the comparative negligent side, is the preponderance of the evidence, we tilt the scale at all, we win on that.

But -- and part of the, you know, part of the two-way street that we've been talking about this, physician/patient relationship, they relied on the history they got. What it's -- and I'm not going to go through it again, all INR's and all that. But they relied on the history of the anaphylactic reaction with Vitamine K. I've never seen that in the record.

I spent the last few weeks before this trial reading through every page of the 15,000 pages, I couldn't fine that either, but doctors relied on that, though, in making their treatment decisions.

They also relayed on the fact that Mrs. Tripp said, I didn't even take my antiseizure medications. And I didn't take my antihypertension, antihypertension, anti-high blood pressure medication. All of which affected their levels of concern, all of which affected how they went about treating Mrs. Tripp. So that's all you get to consider.

Let me just go switch topics, and I'm going to talk about damages. And I'm going to talk about the damages side of this case for one reason and one reason only because I'm going to ask you to return a verdict in favor of my clients.

You can learn a lot about what the plaintiffs are claiming in the rest of their case by what they claim in the damages side.

For example, it came out only when crossed-examined that for the past four years all of the care has been covered by AHCCS. When the question is, well, what's the cost that they're proposing, versus what the actual cost has been, you don't get to know that. They didn't tell you that. And so I just ask you, what's fair here? Because there's this question of she's been getting treatment now for four years, Dr. Doherty says it is adequate treatment. She's actually been to the doctor fewer times than they would have expected. There is no doctors who is caring for Mrs. Tripp now who walked into this court and said, I can't get access to pay for something that Mrs. Tripp needs. Didn't happen. There's no record of any doctor caring for Mrs. Tripp now who says in that record that's been introduced in evidence, she needs more.

So then we come back to, well, wait a

minute, the care that's being provided now is good care, we don't see problems related to it. What we do see is the plaintiff's withdraw their claim for compensation, substitute this claim by Tracy Albee, which is astronomically higher. And at the same time when I asked about, you know, what's the offset here? Mrs. Tripp went to doctors, doctor's visits, went to ER visits, went to the hospital, a number of times in 2013, 2012, 2011. And they want to say, well, the defense has to pay for everything going forward. And isn't the question, well, wait, what's the real cost of going forward? Because if none of this had never happened, presumably, Mrs. Tripp would be going to doctors as often as she was before, going to ER visits, being hospitalized as often as she was. And what's the cost of that?

If we're being fair here, that should be taken off the top of what they're claiming now. But when I tried to get that from Tracy Albee, what has the cost been to date? I don't know. What was the cost before? I don't know. How much is covered by insurance? I don't know.

They come up with this number. So then the argument is, well, we didn't put on our life care planner. Well, it's like I said before about Dr.

Galson, we can put on a lot of witnesses and if we'd like we'd say, tell your family you're not going to be with them till -- we'll try to get you out of here by Thanksgiving.

Instead, the only reason I would have called my life care planner is if the plaintiffs had changed their story. If there was a change where they claimed, oh, no, the care being provided now is not adequate. If they said, we need more that's not being picked up. If there's something that is medically necessary that's not already being provided. If the family had changed their story, their sworn testimony, that they're no longer going to care for Mrs. Tripp. Yeah, then I would have had to have brought in a life care planner. You talk about, well, if they're not going to do it, here's what's going to be done. But that didn't happen.

Instead we have a claim being made, and this is why I asked for clarification on who the parties are. It's Mrs. Tripp. And when you've just been told now what the evidence was before, and that is, the reason to provide this round-the-clock care, not by somebody like Debbie, who's helping out now, but by the R.N. at probably a multiply for four or five times, if not more, of what's being paid for now it's Debbie.

The only reason is then, so the family is

saying, they don't have to do it, if they say that. But I'm not trying to be unduly legalistic here, but they are not parties to this lawsuit. They do not have a claim for anything.

So just ask yourself, put that into the context of these claims that are being made now. Where they're saying, well, you have to buy a house, you have to buy a van, you have to do, fill in the blank.

And ask yourself, how does that compare to the care that's been provided the past four years? How does that compare to the cost of -- well, we don't know the cost, but how does that compare to the amounts of treatment that Mrs. Tripp got even before this? They didn't give you any of that.

What we know is, Ms. Albee, nice lady, but she does this for a living and it's all litigation. And I'm kind of a practical man, I go, okay, do you ever actually do this outside of litigation? Are you ever a case manager where you have to go out and figure out, what's the care that your client needs, how can we get it paid for and what's going to do the job? When I took her deposition, she had done that once. Otherwise it's going to litigation, going to a lawsuit, testify at trial, and put these numbers up on the board.

And the other thing, and I'm just, you know

what, what I'm saying now, you can say, Chris, okay, that's important or you can say, Chris, forget, you know, we really are not interested in that, it's not a big deal.

But the claim was made that by all accounts Mrs. Tripp had a low IQ. And I apologize in advance for getting into this, but they make the argument and I say by whose account?

We here a lawyer that says one thing about a document that you will not find in evidence. And what we otherwise heard was that Mrs. Tripp was driving all over town with the kids and the grandkids, and that she's counting money at the Rodeo, making change, dealing with cash, dealing with credit cards, she's organizing a quinceanera and wedding. I'm not sure by whose account they're talking about.

I'm not sure if they're trying to say, well, there's a reason that Mrs. Tripp was not a good historian. I don't know, but you haven't been instructed to evaluate her in this comparative negligence or any other way by any means other than you would judge anybody else.

Now, on the last expectancy, the only thing I would ask you to consider there is we've had two different experts come in. Dr. Martin based on the

paper by the American Association of Neurologist, broad studies looked at life expectancies, he said two to five years.

Plaintiff's counsel stood up here and said Dr. Doherty has been doing this for 20 plus years. But do you remember what Dr. Doherty said, she did not base life expectancies in this case. She did not base her opinion on any of her patients. It would be wrong to do that.

So instead she did the same thing that Dr. Martin did. She looked at the literature. And you can ask yourselves, are we dealing with apples and apples?

Dr. Martin said, you know, what Dr. Doherty looked at, one of the studies involved traumatic brain injury patient. Mrs. Tripp did not have a traumatic brain injury. She had a different injury. That's a hypoxic-ischemic encephalopathy, different mechanism of injury, different outcome.

What's the other thing Dr. Martin said? Dr. Doherty was dealing with one study where 75 percent of their patients were under 20 years old.

The only across the board study is the broadest and most scientifically bedded is the one Dr. Martin relied on. So something you can keep in mind on that issue.

So then when we come down to what is our response for the damages claim? Well, in one sense we're not responding to it because I'm going to ask you to not get that far when you're evaluating this case. But when you do, if you do consider that, our backs stop is your common sense, all right?

Last couple of things. Plaintiff's counsel, as I mentioned, is going to get up here and is going to have a chance to do what's called a rebuttal argument. It's supposed to be just that, a rebuttal to what I just said. So I'm going to ask you to keep in mind the points I made. And then at the end of the plaintiff's argument, ask yourselves if he rebutted, based on the facts, a single point that I made, all right?

As I've been going through this, I have said several times now and I thought it to myself during the trial for three weeks now, when will the facts matter?

You've heard the facts, you've heard the testimony, you're going to see the evidence. I am confident that the facts will matter once we lawyers stop talking and you get the case and go back int the jury room and deliberate.

One other thing and it's the form of verdict. This is the one I will ask you to fill out. We, the jury, duly impanelled and sworn in the above

entitled action, upon our oaths, do find in favor of -- oh, this isn't the right one.

Okay, take two, we'll do this again.

It says, we, the jury, duly impanelled and sworn in the above and entitled action, upon our oath, do find in favor of defendants.

I want to, again, thank you for your time and thank you for participating in this most important of your civic duties. Thank you.

THE COURT: Thank you, counsel.

Reply argument?

MR. KEENAN: Yes, Your Honor. If we could have a second to setup here?

THE COURT: Sure.

REBUTTAL ARGUMENT

BY MR. KEENAN: I promise you, I promise you, that I'm not going to be anywhere near as long that I was the first time or that Mr. Smith just was. But I am going to respond to some items he brought up, because we obviously have a disagreement on some things here.

I told you in this case that you'd be confronted with a lot of distractions. And, in fact, Mr. Snyder mentioned that in his opening statement, if I recall correctly. And you have, you have throughout this case.

The defense has tried to make this case really, really complicated. So I may not hit them all, but I'm going to hit the ones that stick out in my mind, the ones that we just listened to.

We've heard that phrase over and over again, before the lawyers got involved. Well, I think it should be before the doctors, Dr. Gokova and Dr. Alter got involved, before they got involved, Esmeralda Tripp didn't have the heart attack, didn't have brain damage. She could walk, she could talk, she could pick up her grandkids, she could have a relationship with her family. Before the doctors got involved, Esmeralda Tripp didn't even need a lawyer, she didn't need a conservator.

One of the things that Mr. Snyder said on his opening statement that applies in light of what Mr. Smith has been up here talking about is, you, as jurors, are allowed to use your commonsense, we all want you to use your commonsense, and listen to what you have heard and pay attention and remember it and look at the evidence in this case.

In this case we continue to get by the defense distraction, after distraction, after distraction. And it really makes no sense, whatsoever.

One of the examples is the fact that

Esmeralda Tripp said this or said that or give a history of having a heart attack when she's 29 years old and on, and on, and on, an on. But let's look at, in the record, that Dr. Gokova had for the note that she made, which is Dr. Gokova's note of the history.

But in that note, Dr. Gokova specifically puts in there that she was trying to take this history down from Esmeralda, and she noted right then and there, she's a poor historian. So the import from that is that she wasn't relying on anything Esmeralda had said at the time.

She was relying upon her observations. She was relying upon what her examination was, and relied on the fact that Esmeralda had a highly elevated INR at the time. And she was trying to make a decision what to do.

Unfortunately, unfortunately, she made the wrong decision. She made a decision that was below the standard of care. She made a decision that violated UMC's own guideline at the time. The guideline that talked about when this drug should be given and when it shouldn't be given.

You heard a lot of other things in Mr. Smith's closing argument. A lot of things that we certainly don't agree with. I think what it comes down to, it's kind a late hour, but I've got to tell you

this. This case has been made so difficult by the defense in terms of bringing up everything in such a confusing matter that it comes down to three things, A, B and C. ABC. A Bad Choice. A bad choice was made by Dr. Gokova and Dr. Alter here.

The bad choice was that they had everything available to them, at the time, to make a good choice. They had the records available. They're on the computer. They can see that she's had a high INR before. But instead of going with that, instead of giving her fresh frozen plasma, they picked a very dangerous drug to treat her with, one that their own guidelines say that she was not an appropriate candidate under the circumstances. It's as simple as ABC.

But what the defendants have tried to do throughout the trial is rewrite their own guidelines. They've tried to expand them. They're trying to say, yeah, you know what, I know it says that, I know it says you have to have some serious or life-threatening bleeding, I know it says that, you know, you're supposed to be going to surgery, but, you know, they really, yeah, they really don't apply here, so on and so forth. Does that make any sense at all?

Why do you have guidelines? It's their job to know what the guidelines are. Before the lawyers got

involved, these guidelines were developed by a group of doctors, in a room where they decided what can we do to make sure when this drug is given that it's safe? What do we do? Let's listen to our combined knowledge, at the time, and come up with something this makes sense.

So they come up with this guideline and the fourth item in here, under safety, at the bottom, it talks about use of this product has been associated with thrombosis and disseminated intravascular coagulation, especially in patients undergoing surgery and in patients with no liver disease. Patients initiated on this product should be monitored for these complications.

They, whoever comes up with these guidelines, it's their reason to believe that there needs to be some safety guidelines associated with the use of this product. But what do we hear from the defense in this case is that, eh, they really don't apply, you know. And, you know what, it's not really for this situation. And, you know, it's okay under the circumstances because maybe, maybe, maybe she was going to go to surgery and we're just not sure. That's not what the guidelines say.

They can't win this case without rewriting the guideline. That's what it comes down to. It's all

about the guideline. And they know, they know, they can't win unless that guideline is rewritten for their purposes. That's not how it works. This guideline was written before the lawyers got involved in this case.

This case is also as simple as ABC, because it's clear in this case that because Esmeralda got Profilnine, she got clots. Because she got clots, her heart has a heart attack. Because of that, she ends up suffering brain damage. It's as simple as ABC.

And it's also as simple as ABC as to why the imaging studies that were done and the days afterwards didn't show clots. You heard about this from Dr. Do, you heard about this from others.

There's a medicine that's used that you're all familiar with, at least now, you may have been before, it's called TPN. It's called, as Dr. Martin, their own expert testified to, it's called the clot buster. Hello? The clot buster? Everything gets all busted out after it's taken. This is why there's no evidence of clots on the imaging studies done afterwards.

In fact, let me tell you about an item here, another item that's before -- on the same topic, before the lawyers got involved. This is in the discharge summary and you can find this in Exhibit 5, and it's

page 34. This is what's done when Esmeralda finally gets out of the hospital, bear in mind, she's not walking out of the hospital, she's being transported home, where she's been ever since then.

If you're focused on rhyme and reasons for visits, this is what is in the discharge, it says, reason for visit. Your primary diagnosis was heart attack. Dr. Pike, it says heart attack right here. Your diagnosis also included elevated INR, blood clot in vein, blood clot to lung, heart failure that is caused by inadequate blood supply, subdural hematoma, persistent vegetative state, comatose. This is what their records say. Again, they're trying to rewrite the records, rewrite the guidelines to suit their purposes. This is what's written when she's discharged from the hospital at the beginning of November, 2013. To say that clots didn't happen, come on.

On the same point, I mentioned that Dr. Do talked about what this clot busting medicine does. You remember that Dr. Do was from Stanford, and he testified -- and let me show you a piece of his trial testimony on page 39 of his testimony.

Remember Mr. Wenner asked him questions.

Question, if a patient, such as Esmeralda Tripp, receives TPA on September 13th, 2013, would that

have any affect on whether you could visualize clots, blood clots in the brain on the MRI two days later?

His answer, yes, it would.

Most likely the clots would not be seen two days later after having been given TPA. In addition, your own body internal system of licensing its own clot, would also be working at the same time. So the likelihood of seeing any clots that are two days later after a stroke, probably is low.

Question, so using the word licensing, for us lay people, could you tell us what licensing means?

Answer, licensing means resolved. So the TPA would resolve the clot in smaller to smaller pieces. Eventually the blood then would -- it's like a dam breaking open. And all the particles get disbursed.

Makes sense. Makes sense. So, no kidding, you can't see the clots with the imaging studies afterwards. They'd already been broken up and dissolved at that point in time because of the TPA that was given.

Mr. Smith talked about prior emergency room visits, and there's evidence of that in this case where Esmeralda had an elevated INR. She needed to go to the emergency room to get treatment for the elevated INR. Well, there was no clots at that time.

Of course there was no clots at that time.

She was given the fresh frozen plasma, or she's given Vitamine K. She's not given Profilnine. The argument makes no sense. The reason why she didn't get clots is because she was given the appropriate medication at this time. She wasn't given Profilnine.

Folks, I'm not going to try to, as I say, rebut everything here, but there's a few other items that I want to address.

One of them is Jamaica. She's not a party to this lawsuit. She was and she dropped her claim. But you hear on the witness stand, where she testified, and, you know, Mr. Smith has repeatedly, throughout this trial, paint her out to -- try to paint her out to be a liar. And you have to judge her credibility about from what you heard here. She's not a liar, but it isn't bad enough that she has, in essence, lost her mother, it's not bad enough that she had to be the primary person taking care of her mom for the next year and a half, it's not bad enough that she's continued to drive back and forth from L.A. to Tucson to help her family, to take care of her mom. It's not bad enough that she can't have her mom to help her, but she has to be told that, look, we've checked out through Face Book, and you're a liar.

You know -- and if you think about it, it

really doesn't matter, it doesn't matter because she's not a plaintiff in this case. And whether it is Jamaica, Julio or Julio, Jr., or Julio, Jr.'s girlfriend, somebody has been taking care of Esmeralda, and they've been taking care of her 24/7, and it sure hasn't been the defendants. Somebody has been taking care of her. So whether it's Jamaica eight hours a day or sometimes 12 hours a day or nothing one day, who cares?

Their own life care planner in this case didn't come here to testify. And it's not for the reasons that Mr. Smith indicated. The reasons were that her numbers were not that far off those of Tracy Albee. As a matter of fact, the biggest component of Ms. Albee's life care plan was the home care, the home care. That's two thirds of this some $600,000 per year, it's the home care, the nursing care.

You know what, their person, Nurse Yetcalf had the same number, the same number. That's why she's not here. She's not here because it doesn't help the defense. They can't rewrite her report. All they can do is try to rewrite guidelines or rewrite discharge summaries to make it look like she wasn't having clots.

Another argument they raised was on damages. They talked about how Esmeralda's care to date has been

paid for by AHCCS. Well, that's true, to some extent, because seeing doctors, getting medications, things of that nature is covered by AHCCS.

However, as plaintiffs in this case, we don't feel like the State, which is AHCCS, should pay for that. The people responsible for putting Esmeralda in this condition should be paying for that.

And, you know what, the State only covers so much. There's only 30 hours per week they cover. The remaining part of the week for the in-home care is not covered. Even their own expert, Nurse Yetcalf, didn't take that into account because she knows that home care is not paid for by AHCCS. And they need to have that, before this family gets burned out, before this family has a tough time taking care of her. There's no guarantees that any one of them can continue doing that.

But Esmeralda deserves to have as good as quality of life as she can possibly have for the end of her life. Who knows what she feels or thinks. But the family is trying to do the best they can to take care of her. But Esmeralda needs help doing that.

I thought about a couple of things about this case, primarily because, as I said earlier, I sat as a juror on a case a few years ago. And a couple of things to take away from this case, and one of them is,

I assume, that all of you will feel like in the future, before you have any procedure by any doctor at a hospital, you might be more inclined to ask how much experience they have.

MR. SMITH: Your Honor, let me object. This is improper argument.

THE COURT: Come on up.

(Bench conference.)

THE COURT: That is improper because you're asking me to vicariously put them off as their point in view? You need to get off that track.

Are you asking for any repleviable damage action?

MR. SMITH: Yes.

THE COURT: What do you suggest?

MR. SMITH: Ask the jury to disregard those last remarks.

THE COURT: Okay.

(Bench conference over.)

THE COURT: So members of the jury, lawyers sometimes get so wrapped up in their work that they might forget what's permissible or impermissible.

The last comment by Mr. Keenan is impermissible, so I'm instructing you to disregard it.

Go ahead, Mr. Keenan.

MR. KEENAN: Thank you, Your Honor. I apologize.

Let me try to wrap it up this way. We go through a lot of times in our lives where we kind of have some doubts about what's the right thing to do. We go through periods of time where, you know, we hear things from our politicians or we hear things from anybody, T.V. or whatever, and we just cause us some doubts about what's right to do or really whether it really makes a difference about our vote.

You've got to vote here. You each have a vote. You have a vote where you're trying to decide what the right thing is to do for Esmeralda Tripp. And it's an important vote. It's not something that's going to get watered down by the numbers. Every vote here counts.

And the one thing I've been impressed by, in fact, my co-counsel has commented about this throughout is that everyone of you, everyone of you has really seemed to pay attention throughout the trial. Which is pretty amazing and you should be applauded for that. But because you've paid attention, I've got a feeling that you just feel like you need to do justice in this case. And I feel strongly that you want to give justice to Esmeralda Tripp here. And I ask you that you do your

job and give her justice.

Thank you.

STATE OF ARIZONA)
) SS.
COUNTY OF PIMA)

I, MARIA LOURDES GEARE, Certified Reporter #50555, Official Court Reporter for the Superior Court, in and for the County of Pima, do hereby certify that I took the shorthand notes in the foregoing matter; that the same was transcribed under my direction; that the preceding pages of typewritten matter are a true, accurate and complete transcript of all the matters adduced, to the best of my skill and ability.

_____

MARIA LOURDES GEARE, Certified Reporter
CR-505555,
Official Court Reporter,
Pima County Superior Court

DATED: December 27, 2017

I N V O I C E

TO: Mr. Christopher Smith, Esq.
RE: Transcript for C20144811, Closing Argument by Mr. Smith and Rebuttal by Mr. Keenan,Day 12

DATE OF INVOICE: December 27, 2017

CASE: ESMERALDA TRIPP V THE AZ BOARD OF REGENTS

DATE OF HEARING:	TRANSCRIPT COST:
10-27-17	$840.00
PAID	-0-
TOTAL OWED	$840.00

PLEASE SUBMIT PAYMENT TO:

Maria Lourdes Geare
1883 West Grubstake Drive
Tucson, Arizona 85746

T H A N K Y O U !