JUNO v. AMARE, et al.

Trial Beginning December 4, 2012

Judge Robert Wilters
Court Reporter: Paula
Judicial Assistant: Tammy
Second Assistant: Leslie

OPENING STATEMENTS

PLAINTIFF - GWF – OPENING:

Safety of hospital patients depends upon accurate medical records, especially when it comes to drugs.

When hospitals create inaccurate medical records, it places patients at risk of harm, especially when it invokes drugs.

Hospitals should never give false and inaccurate patient records to another medical facility or doctor.

Needless medication error; never should have happened.

Issues will be for you to decide whether the facts of this case go beyond the needless and tragic loss of a single life.

FACTS:

π Ex's

B-24 Death Certificate – encephalopathy due to hypoglycemia and anoxic injury to the brain.

Levemir – brain consumes oxygen and glucose to stay alive; even though brain is only 2% total weight of the body, it consumes 20% of all glucose.

G-77 Timeline –

Levemir administered 9:00 p.m. 3/19/2008 at Mercy Medical. By early morning she was in full distress.

Sharron was a brittle diabetic.

Sharron at Thomas March 4th through March 18th

Home, then <u>rehab</u> at Mercy Medical.

G-53 Timeline re: info transfer: (shows progress of info transfer from Thomas to MM)

3/19/2008

<u>11:08 a.m.</u>	<u>12:30 p.m.</u>	<u>1:05 p.m.</u>	<u>1:15 p.m.</u>
MM 59	MM 11-12	MM 3	MM 16, 76
MM 51-3	MM 60-1		MM 100

B-23 Medical Reconciliation Document. Never went to MM through Thomas. Admits it should have done so.

B-17 Patient Transfer Form – physician admission form (Px 104).

B-21 Discharge Summary, p. 4. Px 107.

B-16 MM was not given the medication doc (B 23). Instead it got (B 16) "verbal order Dr. Amare s/ Cindy Pierotti" that was later backdated.

If it's a verbal order over the phone, then SOC "universally" requires nurse/doctor to read back order over the phone.

GT-37 Cindy Pierotti testimony (p. 22, lines 7-21). * chart was in medical records being scanned.

GT-36 She heard Kristen, social worker, talking to Dr. Amare on the phone (p. 20, lines 14-17). Pierotti did <u>not</u> hear Kristen reading medical summary and medication over the phone.

B-16 Inferences: Shouldn't have been permitted to be created by Thomas Hospital's employees.

G-203 Px. 103 – JCAHO standard now embodied in Thomas Hospital's P&P. "The nurse '<u>shall</u>' write down the order as given and read it back to the caller for verification." This is a <u>nurse</u> order, not a <u>social worker</u> order.

GT-27 Nurse Rowell confirms reason for this P&P.

GT-54 Carrie Roberts, Chief Nursing Officer at MM, depo. pages 201-02.

GT-301 Another policy (P. Ex. 90) – JCAHO accreditation standards also impose duties re: access to accurate medical records.

So, where did “80” units order come from?

B-21 Discharge Summary

B-19 Discharge medical summary

We obtained the audio re: Dr. Amare’s dictation for discharge summary –
Discharge medications
Levemir insulin “8” units

So: who typed up “80” instead of 8?

Dr. Amare thought it was Thomas Hospital who did dictation.

2002-03 Thomas <u>did</u> have its own dictation.

Thomas answers that <u>it</u> didn’t do the dictation. “We have a contract with company in Atlanta.”

G-37A Precyse says we have a contract with Thomas Hospital, but we didn’t do transcription – our overseas contractor did.

G-37B Precyse International, but it has no employees.

Precyse Solutions, through Precyse International, enters subcontract with Medusind.

G-37C Medusind, in turn, says it really wasn’t us, it was Sam Tech.

Amit Pandey, in Fardisi, India, 400 miles east of New Delhi, did the transcription.

G-38A (whose who) Satish Palani is quality assurance 2 (“QA2”) reviewer.

Supposed to have <u>at least</u> 98.5% accuracy.

Shows names of each in the chain.

Is there a standard for accuracy they were supposed to adhere to?

G-84 (Sexton depo. p. 4) – shows contract warranty.

G-85 From Precyse to Thomas Hospital: <u>at least</u> 98.5% accuracy.

G-86 Medusind P&P manual – each report must be <u>at least</u> 98.5% accurate.

G-16 AAMT standards – (Px 25 Sexton). "Critical error" is a term of art in transcription industry. A critical error is universally defined as "an error in medical transcription that can place a patient's safety at risk." Examples include incorrect medication dose and incorrect lab values.

G-17 (Palani depo ex Px 25). Critical errors are given highest negative point value. "<u>If a report contains a critical error, it should not pass quality assurance</u>."

G-52 AHDI, MTIA, AHIMA standards are the same.

G-12 Precyse Solutions quality defines critical errors similarly. (Palani depo Px 26). 100% accuracy in critical errors.

G-13 (Palani depo Px 26) same

G-14

GT-69 Pamela Goans depo p. 116, head of operations for Precyse – "These are the standards that applied to Precyse, Medusind, and Sam Tech."

GT-73 Goans: Document correctly states the standard. "When in doubt, leave it out." Don't just skip the word; instead, leave a blank to be filled in later. <u>No guessing</u>.

Documents need to be either correct or blank.

G-354 Former Precyse employees.

Sherry Taylor
Lisa Beck
Connie Wood
Glendus Dowell
Margie Hill
Frankie Amiss

Former Precyse transcriptionists

G-355 Each gives their impressions re: standard for accuracy in critical errors: 100%

G-51 Ms. Juno's chart actually contains <u>3</u> critical errors: "80" units instead of "8." Also: 2 critical errors in lab values: 2.9 potassium value instead of 3.9 293,000 platelet count instead of 282,000

GT-163 Brenda Hurley (depo pp. 64-65) – 3 critical errors in transcription means it scored 93 or 93.5%. This is <u>not acceptable. It's a failing report</u>.

G-61 (MEDU 000104) Diagram of witness locations

Amit Pandey – medical transcriptionist
Sunita Bhardwaj – QA 1
Satish Palani – QA 2

We hired former FBI and CIA agents to find these people, and we went there too. We obtained an order from Judge Wilters to let us depose them and see where they work and what their equipment looks like.

GT-133
G-39 Sharon Fremer: head of Precyse's medical transcription department. She admits Precyse doesn't even do any audits, even though they say they do monthly audits.

G-356 Summaries of 6 former Precyse employees: International transcriptions when compared with Domestic transcriptions were:

"dangerous quality"
"very poor"
"very poor"
"kind of scary"
"majority of reports had errors"
"critical errors were abundant"

Who knew about these problems?

G-357 Each of the 6 former employees notified their Precyse superiors constantly, but each of their positions were eliminated.

"We would talk till we were blue in the face."
"We got nowhere."
Etc.

GT-33 Marguerite Hill – former Precyse team manager 2007-08 (depo pp. 30-32).

GT-8 Stacey Sexton – money was the motivation. Saving 2 cents per line in cost of transcription.

GT-33 Doctors had gone to Thomas's administration and were complaining daily that quality of transcripts were terrible. Margie Hill and Debbie Monroe conversations: Monroe was "pretty much yelling at me" because doctors were complaining.

GT-34 Delay was never an issue; quality was the problem.

GT-35	Margie Hill depo. p. 35 – problems started ramping up immediately when Precyse started doing the work “2 weeks at the most.”	
	From depo of Satish Palani and document production, we were able to learn about his prior job performance.	
G-42	QA 2s are supposed to be highly qualified – the safety nets.	
	Satish hired Feb. 10, 2008 – one month before this tragedy occurred.	
	Review of blow-ups of actual e-mails about Palani’s poor work quality.	
G-71	Palani (MEDU 1784)	critical error 3/4/2008
G-72	B2 (Px. 35)	critical error 3/14/2008
G-73	B3 (Px. 35)	critical error 3/16/2008
G-74	B5 (Px. 35)	critical error 3/19/2008
G-75	B6 (Px. 35)	critical error 3/20/2008
	Break	

	Resumption
	What information and standards does Precyse/Thomas use in choosing business partners?
G-05	Px. 207 brochure – uses highest standards? “carefully select”
G-25	ASTM standard establishes standard for selection of vendors in medical transcription (Px. 85 of depo of Pam Goans), including site visit.
G-08	Precyse’s brochure says its vendors are located in several cities in India.
G-60	Vendor locations (MEDU 000104).
GT-128	Precyse’s head of operations, Pam Goans, has never met with <u>any</u> Indian vendor (p. 56) – never even seen a photo; (p. 68) – never did any investigation of Samtech. She says instead Medusind did.
GT-131	(p. 70) – Precyse never did anything to assess competencies of Samtech

or others.

GT-122 Next deposed head of international operations (Pamela Goans) of Precyse: Never met Multani and knows nothing about him.

GT-124 No proof anyone from Precyse ever went to Samtech (depo. 96-97).

GT-125 Precyse left it all up to Medusind.

GT-17 Stacey Sexton – Health Info Director at Thomas (depo. p. 89). She is the one who authorized overseas transcriptionists. Had never heard of Medusind or Samtech, and still today doesn't know who they are.

GT-108 Deborah Monroe – Thomas transcriptionist coordinator. Doesn't know them either (depo. pp. 15-16).

GT-11 Sexton admits Thomas never told doctors that foreigners were doing their transcription (pp. 69-70), and never asked doctors for permission to do that.

G-25 We made the commitment to do what should have been done. We were going over there to see them and check them out.

B-11 (Px. 217) – ASTM standard before outsourcing. 10 questions:

Who will do the work?
What law?
What P&P?
What training, etc.?

G-31 (Px. 352) – This is what Samtech says about itself. "Noida, India, growing at an exuberant pace with professionals with hands-on experience with working in United States."

G-45 "150 seat, state-of-the-art facility and state-of-the-art equipment."

G-46 "7,000 sq. ft. building with aesthetically designed interior" (Px. 84).

G-49 "All employees backed by 4.5 years experience."

G-48 "Complete customer satisfaction."

G-50 "If you have any questions or issues, please get in touch with us."

We got an order to go over and see for ourselves. Precyse didn't bother to send its lawyers, but everyone else went.

Photo 01 Photos: We will offer those into evidence

Photo 02 Samtech of Noida, India

We got an order from an Indian court to make witnesses appear for depo, but they refused to show up.

Defendants at first refused to even let us in and refused to acknowledge court's order.

Equipment not hooked up. Cafeteria deplorable condition.

Photo 10

Photo 09 Chandigar office of Samtech

Photo 13 Amit Pandey

Question: Who did what wrong?

Samtech/Medusind/Precyse – prepared inaccurate medical records

Precyse says it carefully selects, but it doesn't.

Precyse didn't audit despite what it says.

Precyse kept Palani on even when it knew he was safety risk with history of problems.

G-80 Audit of Samtech by Medusind.

G-80 (Px. 33) shows number of critical errors.

G-82 In the hundreds (on audit)

G-83 And in the <u>thousands</u> company-wide.

G-54 Comparison chart re: quality scoring. Defendants purposefully underscore their critical errors when compared to AAMT metrics for scoring comparisons.

GT-135 Sharon Fremer, Precyse's transcription coordinator, says defendant uses AAMT scoring guide, but in reality Precyse and its contractors do not.

GT-135 Precyse has: 46 clients/78 locations (Fremer depo. p. 62). Says <u>nothing</u>

would convince her that critical errors cannot be in a medical transcript.

GT-18 Sexton depo. p. 93 – she did not know that Precyse was going to outsource to them in India.

GT-132 James Matas – never any employees in Precyse International, LLC, even though it had contract with Thomas and other hospitals.

GT-68 Mikkel Dinker – Standard of Care in U.S. is not applicable to his work.

GT-82 AAMT standards do not apply to Medusind's employees.

He also says Medusind is not accountable for critical errors.

GT-71 Goans – Precyse says it made Medusind aware it was subject to U.S. standards.

GT-23 Dr. Thomas: No due diligence – had no clue who did its transcription and gave false info to Mercy Medical, and it acted below the standard of care in giving false information, and it violated the oral read back policy, and it falsified a doctor's record.

GT-47 Nurse Pierotti didn't even know the SOC when acting for Thomas ("I don't care what the standard of care states").

What are the expected defenses?

G-101 **Precyse** says: there was no error. Precyse's answer to π's interrogatory denies any error. Says it audits to ensure quality.

GT-133 Transcriptionist reports are not the responsibility of Precyse because not signed by the doctor; but Stacey Sexton and defense expert Sharon Barnicle says preliminary reports are used every day.

* Video clip from Precyse's boss about each of the former employees; she would believe each.

Thomas says: Mrs. Juno wasn't our patient, and rules keep people safe. They need to be followed regardless.

G-200 Thomas P&P (Px. 110) says and commands that a complete list of medications will be provided.

Defense Attorneys' Opening Statements

<u>MEDUSIND</u> – by Rod Cate

– You didn't hear anything wrong done by Dr. Amare, Mercy Medical, and Debbie Davis.

– I don't know if they did anything wrong or not.

– I'll tell you why they're no longer here in my closing statement.

– Discharge summary should have said 8.

– Function of a transcription company is to do the best they can and to send it back to the doctor for accuracy.

– Transcription companies are not health care providers; make no medical decisions.

– Impossible to be 100% accurate 100% of the time.

– Mistakes are going to be made.

– Not catching 80 instead of 8 is at best a <u>mistake</u>.

– Dr. Amare admits that sometimes mistakes can be made.

– Dr. Culpepper, an expert witness from USAMC, hired by Dr. Amare's lawyer, also says mistakes are possible. "I don't expect transcriptions to be perfect."

– Contract between Thomas and Precyse anticipates that mistakes will be made (§ H).

– "If mistakes are made, send them back to us and we'll fix them for free."

– Thomas' acceptance is final accuracy of the document.

– There was a final level of quality assurance that should have happened in this case, but it did not (Amare's signature).

– π's expert, Dr. Blond, says transcription is only a <u>draft</u> until physician signs it.

– JCAHO says the “author authenticates.”

Δx 127 – Book of style for Medical Transcription § 3.4.2 (obj. Thomas Keene) not authenticated and Medusind will call author as an expert.

Δx 129 – AAMT – accuracy and completeness of document is the responsibility of the author.

– Even though we sent back just a draft, and even though Dr. Amare had responsibility, π is blaming us.

Facts: Mrs. Juno had lots of medical problems: stroke, brittle diabetes, etc.

Δx 90 Discharge summary should have gone to Mercy Medical.

– Kristen Bedsole depo testimony re: conversation with Dr. Amare (pp. 26-27).

– Dr. Amare will testify about this conversation too. “Information should be available on discharge summary.”

– Kristen Bedsole then writes in “80" units of Levemir, even though its never been reviewed.

– And, compounding the problem, Bedsole gets Pierotti to sign “voice order,” even though there never had been a read back of the Levemir script on the patient transfer form.

Px 4 – Amare also testifies that a discharge summary is not to be used as an order, and that he’s never used a discharge summary for that purpose.

– Amare depo., p. 32, it would have been improper to take info re: medications from discharge summary and put that information into a patient transfer form.

Summation, i.e., Thomas is guilty and Amare is guilty, but Medusind did nothing wrong.

Dx 51 Medusind has been doing transcription work for over 10 (?) years.

Dx 52 Photo: Operations area

Dx 53 Photo: View down hallway

Dx 54 Photo: Actual room where Palani did his work

Dx 55 Photo: Conference room

India:

– Has a young educated workforce

– English is principal language

– Everybody in India speaks English

– It was formerly a British colony

– "A lot of times we can't understand what they say, but they don't have any trouble understanding what we say."

Medusind does all its work for Precyse; it has none of its own clients.

Precyse and Medusind were originally a joint venture (80/20), so it did have employees.

Medusind uses several subcontractors in India and Samtech was one of them.

Medusind reviews 100% of the work done by the subcontractor.

100% voice detect – Medusind listens and looks at screen for accuracy.

Δx 57 We produced photos of inside of Samtech:
Δx 58 (MEDU 1821)

If Samtech doesn't perform according to its contract with Medusind, there are serious financial consequences.

– If accuracy drops off, Samtech doesn't get paid.

– Finkbohner didn't show you the number of lines of transcripts relative to the number of errors. Medusind did quite well, in fact, in 2008.

– Samtech chose not to participate for business reasons. We have no control over it. That's between π and that defendant.

– Precyse Solutions is one of largest transcription companies in the world. It's known throughout the world for the quality of its work. That accuracy

is attributable to the work we do at Medusind in India.

– An apples to apples comparison:

Precyse – 1 critical error per 832 lines
2008 – 1 critical error per 953 lines.

Employees Finkbohner commented upon were all disgruntled former employees and were all fired.

They each were flown to Mobile, put up in a hotel, given a meal.

I hope he brings them here so you can judge their credibility.

Quality is governed by the marketplace.

Deborah Monroe will testify that there were no problems with the accuracy of the transcripts.

Sexton will also say there was no quality issue.

If the work is so bad, then why are these other hospitals still using Medusind?

Baptist Citizens
Baptist Princeton
Baptist Shelby
Baptist Walker
Lemak Group

Δx 59 Voice recognition software text generated on VHS, edits made by Amit Pandey on the VHS (from Samtech).

59-4 Edits made by QA 1

59-5, 6, 7 Edits made by QA 2, Satish Palani, at Medusind.

Only errors in this transcription were numbers; the complex medical terms were all accurately transcribed.

Audio of potassium value played. Can't tell what he dictated.

And no one knows better than the dictator, Dr. Amare, and that's why it's just a draft until he confirms the accuracy.

– AAMT standards are only for transcription companies to gauge internally their performance. They were never meant for use by the world to measure the performance of transcription companies.

Re: Satish Palani:

– Hired Feb. 2008 by Medusind

– Before then he had 6 years experience. Sound software tech.

Δx 35 – His character was exemplary.

– He was working on 5 different accounts when this occurred in 2008.

Δx 41 – The e-mails that Finkbohner referenced in his opening were all for Baptist Princeton, a new client; so it was new format and all were audited.

– 240 jobs/8,600 lines for Baptist Princeton.

– One critical error to each 1,000 lines. So, no reason at all to take him off the job.

Cause of: Death: Cause of Mrs. Juno's death was the completely unforeseeable events that occurred upon her transfer. Medusind had no relationship with Mrs. Juno and did not participate in her care.

If hospital wants to take the risk of using a draft discharge summary for patient care, then that's a risk the hospital can take if it wants.

* Undisputed Facts

"Transcription companies are not perfect – errors, including critical errors, will happen."

I will ask you to return a verdict for Medusind, Inc.

PRECYSE DEFENDANTS (by Regina Cash)

"We're saddened"

"I have a mother, I'm sure you all do too, and none of you would want this to happen to yours."

Medical transcriptionists are secretaries; they are there to assist the doctor, not to replace him.

"They don't know the patient." They never see the patient.

"Are there errors? Yes." It's subjective.

Mistakes happened. An array of experts will tell you that no one expected 100% accuracy.

The contract between Thomas and Precyse doesn't talk about 100% accuracy.

"We have a lot of clients," "we're a large company."

Clients can choose not to have international and instead use only domestic. Here, Thomas made the election for international. All savings is passed back to client.

Thomas knew transcriptions were being done in India.

Thomas also knew from a contract provision that work would be done by subcontractors.

Thomas made these choices.

It's not reasonable to expect 100% accuracy. We expect the professional to check. It's the least we expect from Dr. Amare.

When Amare later pulled the discharge summary, he recognized the error immediately.

Had Dr. Amare checked the discharge summary, none of us would be sitting here.

The only party in this case that didn't know the true accurate # for the Levemir were the transcription companies.

Had anyone just told Ms. Juno, she would have corrected them.

Medication Reconciliation Record is “The Source of Truth.” Always the most up-to-date and always correct. Thomas had this; only the discharge summary had the incorrect Levemir entry.

Exhibit 15A, ¶ G Precyse Contract with Thomas Hospital
“Precyse will make all reasonable efforts to accurately transcribe”

She asks: What more could we have done? Voice recognition software and 3 sets of human ears. What else could we do?

Exhibit 15A, ¶ 14 If you do find an error, send it back to us and we’ll fix it for free.

There was in fact no error because no one ever sent it back to us. No one ever brought the error to our attention.

Ref to AHDI (formerly AAMT) puts out “Book of Style” which teaches college and junior college medical transcription materials.

*** This book discusses authentication issues. Authentication cannot be delegated.

*** “The responsibility for accuracy falls on dictator and not transcriptionists.”

Transcriptionists make $30K per year; we don’t know what Dr. Amare makes.

It’s a shame we are being targeted in this case.

As we grew and grew and got more clients and had quicker turn around times (sometimes 6 hours) we had to hire more transcription companies as we learned the field of medical transcriptionists was shrinking. Average was 55 y.o. and it’s especially hard to find people willing to do it on 3d shift with quick turn around.

So we discovered India; <u>and</u>, their day is our night – so we had a remedy for 3d shift problem.

How do you go about creating this company in India? That is how Medusind came into existence. It took years to put it into place.

Many trips to India, many inspections, many phone interviews, many phone calls. This was not an overnight thing. And we set up Precyse International and made Medusind a part owner.

Precyse sought out an established Indian transcription company and worked with them a long time before bringing this <u>joint venture</u> together.

It took several years wherein 100% of Medusind's work was reviewed. Only after years of such due diligence did Medusind's work come off of 100% review.

Medusind, in turn, as an owner of Precyse, sought out and found quality companies like SamTech.

Less than 1/10 of 1% of all work coming out of India in 2008 had critical errors.

Defendants' Theme:

This case is not about an 8 or an 80. Instead, it's about the misuse of an unreviewed, unauthorized, discharge draft that should never have happened.

Defendants' Theme:

This would never have happened except for the social worker and Nurse Pierotti giving the appearance the patient transfer form was authorized thereby making it seem to be a physician's "voice order" when it really wasn't.

Defendants' Exhibit 13 Side-by-side comparison of the discharge orders

"Fact that Precyse made an error is <u>irrelevant</u>"

It's the misuse of the unsigned discharge summary order that caused Ms. Juno's death.

"I would have no problem using an unsigned discharge summary." No one will get on the stand and say this. It's unreasonable. A physician must always sign.

Defendants' Theme:

It was <u>impossible</u> for Precyse to foresee that anyone would use the draft of a discharge summary in providing medical care.

Customer satisfaction – 2009, 2010, 2011 – Precyse was given awards for customer satisfaction (#2 in 2009, 2010) and (#1 in 2011) as reputable as any company in the world

"Nuance" now does Thomas's work and the quality of the work is just as good as with Precyse

We would hope in the end you would find for Precyse; it wasn't foreseeable and we did the best we could do and we relied on the physician.

THOMAS HOSPITAL (by Joseph Fanchione)

Two errors made in opening statements I want to correct:

#1, as to Regina Cash:

She said Precyse was <u>un</u>aware of the error. When Ms. Cash said in Precyse's interrogatory answer that no error was made, it was because Precyse was <u>un</u>aware of any error. However, Dr. Amare called Sexton and said, I think we've got a problem here. Sexton called Precyse and said lock down this audio. So Precyse <u>did</u> know about it when it answered the interrogatory.

#2, as to Skip Finkbohner:

When Plaintiff's counsel read from Sexton depo and said it was below the standard of care, he was taking it out of context of her overall testimony. Therefore, only if there was falsity in the preparation of the record would these be a deviation from the S.O.C.

Finkbohner objects: This is improper argument because it mischaracterizes the evidence and Plaintiff's contentions. Objection sustained.

So these two errors tell us we must listen carefully and read carefully.

Plaintiff's case attacks the good character of our hospital and our personnel.

Kristin and Cindy were good people. Stacy Sexton too. (Review of their qualifications, education and training and dedication)

These three employees' conduct are being called into question for acts of March 19, 2008, and for acts related to relationship with Precyse and Thomas.

Once Ms. Juno she was discharged from Thomas, she's no longer a patient; she's an ex-patient. Her records then went to be scanned.

DGW _____: Voluntary Assumption:

> "Kristin had no obligation whatsoever to help Dr. Amare. There was no reason to help. But she chose to do so. When she did, she assumed a responsibility to act reasonably under those circumstances."

Fanchione: Issue #1 as to Thomas: Kristin and Cindy acted upon the request by Dr. Amare to help get Ms. Juno into Thomas.

Dr. Amare will testify that he's never seen a critical error in

any transcription.

Medications are never listed on discharge summaries.

This is really a unique situation for Kristin and Cindy – never previously happened. She (Cindy Pierotti) wrote "V.O." ("verbal order") because she didn't know of any other words to use.

Were Kristin and Cindy below the standard of care? Did they do what a reasonable transfer team would do under the same or similar circumstances?

Retrospectively, we might do things differently. From a prospective point of view, however, no one can criticize what they did.

Bottom line is that the 80 units was there because the system at Precyse had broken down.

Issue #2 as to Thomas: Due diligence and quality assurance.

Prior to 2003, Thomas did its own transcriptions, but it became an overwhelming problem and turnover was high.

Due diligence was done when Sexton and two others went to Atlanta and checked on Precyse and evaluated them

2003, 2004, 2005, 2006 there were no critical errors from this relationship

It cost Thomas more and more money to employ Precyse than doing it as previously

2007 – Precyse Solutions contract is renewed; Sexton continues in talks with them and Precyse International and Sexton decides to use International in November 2007.

There's no criticism in this case of outsourcing to India or of the Quality Assurance provisions in the agreement.

Defendant Thomas's Criticism of Precyse

Thomas was not told about SamTech or Medusind because it was indicated in the contract provision that Precyse was going to be the exclusive provider. It was represented that

Precyse Solutions and Precyse International were essentially the same.

The Q/A system at Precyse is not below the S.O.C. ((Even experts, including Plaintiff's expert) will confirm this).

Fanchione states that unconfirmed medical documents <u>are</u> often used in patient care; examples include history and physical and consultations.

Plaintiff's criticism isn't with the Q/A structure; it's with the implementation of the Q/A in this case – E.g., Satish Palani, the QA #2, was a new hire, and had been on 100% review as a new employee.

Criticism of Palani – "I find focus missing completely" But no offer by Medusind to help. Medusind continues its criticisms of Palani, but never offers any kind of assistance or asks if he needs help with equipment or software.

He's reprimanded repeatedly rather than given assistance or additional training to get him better equipped to do the job without critical errors.

"They let him keep running red lights."

There will be no criticism whatsoever of the Q/A put in place; instead, the criticism will be that the transcriptionists didn't curb Palani's repeated errors.

Thomas didn't do anything wrong in its due diligence at any time.

Kristin and Cindy met the standard of care.

Sexton met the standard of care.

DEFENDANT DR. AMARE (by Tommy Keene)

Dr. Amare is sued for medical malpractice.

He denies that.

He met the standard of care in all his treatment.

Dr. Amare and Ms. Juno go back a long way.

He used reasonable care, skill and diligence.

Proof of deviation must come from a doctor not from a transcription company's lawyer.

FACTS:

Dr. Amare is a Board Certified Nephrologist.

Began practicing in this area in 1999.

He's focused in Baldwin County, lives in Fairhope.

Medical Education:

- Duke, Wayne State, UAB
- 14 years of training in medicine – after high school
- been treating Ms. Juno since 2003
  one of his first patients; one of his <u>favorites</u>
- She had a kidney transplant in 1992
- 2006 transplant began to fail, so he put her on dialysis 3 times a week
- she wanted a second transplant and he was helping her
- she gave herself shots of Levemir
- Ms. Juno was well-educated and knowledgeable re diabetes
- Amare saved her life in 2007 when she stroked
- From 03 to 08 there was <u>never</u> any error or miscommunication or mistakes in her care
- From March 4 through March 18, 2008, there were no problems in her care either; he cared for her and prescribed a whole host of medications
- No one will allege or suggest any deviations from SOC from 2003 through March 18, 2008

Exhibit 04 Lists 32 page numbers of medical [prescriptions] with 8 units Levemir ref'd

Exhibit 04A Categories of types of [prescriptions] containing references to 8 units of Levemir

Exhibit 40 Evidence is undisputed that as of 3/17 he (Dr. Amare) had signed off on 8 units in a Medicine Reconciliation Statement (day before fatal incident)

- You will hear from medical transcriptionists, people who do this for a living say he clearly said 8 (he's a 9.5 out of 10). You and I don't have this training; but those who are so trained say it's <u>crystal clear</u>.

- It's interesting to me: I can't tell what the defense is – we made an error, we didn't make an error, etc; but we got good voice recognition software. It's so good it called Levemir "labrum tea." It's no wonder they made an error.

-- They made an error, question is whether they'll take responsibility. We know the answer to that. They'll do anything to avoid liability.

-- Mr. Cate said he wanted to confront the disgruntled Precyse former employees but we won't hear from any Samtech employees or from QA #1 because they won't honor court orders and sit for their own depos. So he wants to confront Precyse employees, but his own employees refuse to be confronted.

-- The medical transcription standards do not apply to Dr. Amare.

-- The contract between Thomas and Precyse does not apply to Dr. Amare either; he is not QA #4.

-- He didn't know Thomas had sent it out to India or that they were having trouble with Satish Palani. He was head of Medical Executive Committee in 2007 and he still had no knowledge of it.

-- There was no meeting of the doctors at Thomas telling them to be on the lookout because transcription is now being done in India by a new company.

They say: – He could've stopped it; but, if they'd have just done it right there wouldn't have been anything to stop.

All Dr. Amare [said] to Kristin was that the discharge summary could be used as a reference for medication. It wasn't an order. Couldn't be because Kristin was a social worker. He can't give her any order and she as a social worker cannot take one.

Exhibit 43 -- Dr. Amare hangs up and hears nothing further. Afterwards, Kristin wrote in info re medications and Cindy Pierotti wrote in "v.o." without ever talking to Dr. Amare. She will say I didn't intend for that to be an order as it was never read back to Dr. Amare.

-- At time list of medications was conveyed to Mercy Medical, he knew he dictated 8 units and had not seen discharge summary, did not know about 80 units and did not know that Cindy had entered "v.o." on the discharge summary.

-- Everything therefore that Dr. Amare did was correct.

-- Remember: Standard of care must be proven by a medical doctor. Plaintiff has an expert Dr. Blond, who says if he dictated 80 then that would be below S.O.C.; and if he told Kristin to violate hospital P & P that would be below S.O.C. None of those things will be proven in this case.

Dr. Amare is here because Ms. Juno, through her counsel, wanted him to be able to tell his story rather than leave an empty chair that those who are truly responsible could

point at.

MERCY MEDICAL DEFENDANTS (by Michael Upchurch)

We are happy to see you so we can defend ourselves after 4-1/2 years of waiting.

There will be no expert testimony about any deviation from S.O.C. by Mercy Medical.

No lawyer in the opening statements today even alluded to such a thing.

Mercy Medical was on the receiving end of the transcription. When we received it initially, we didn't know then what we know now.

Each juror has copy of transfer form to hold and examine; same with copy of discharge summary. These are just as they were delivered to Mercy Medical upon Ms. Juno's admission.

When Mercy Medical received the patient transfer form containing the "v.o." notation (containing 80 units Levemir), we knew Dr. Amare had given the order, and had had it read back to him for confirmation, and had reviewed the record too. We therefore had no reason to question it at all.

Also had 3 different people from Thomas attesting to the forms and the information in them.

Also had the discharge summary which included the list of medications which matched exactly what's on the transfer form.

He is the living picture of "no good deed goes unpunished." He has to come here and listen to people trying to pin it on him. Totally unfair, he did nothing wrong.

Plaintiff's attorneys have gone nearly to the ends of the earth to get to the bottom of what really happened and we thank them for it.

Likewise, Fanchione, for Thomas, tells us about people who were involved with Ms. Juno's case, and we thank him for that.

Dr. Chance, with Debbie Davis, C.R.N.P., reviewed the orders on the discharge summary and confirmed they were the same as on the patient transfer form. She did everything according to Mercy Medical's policies and procedures. She's terrific and she did absolutely everything correctly. We claim her as our own even though she is not an employee of Mercy Medical.

We didn't know the full story at first; only now, from all the digging and digging and digging of these gentlemen (Plaintiff's counsel) do we now know the full story.

Mercy Medical is a product of Sisters of Mercy. They do good things. It's unsettling to be in a courtroom. But we're glad we're here because our voice needs to be heard and we get our opportunity to explain what happened.

DEBBIE DAVIS (DEFENDANT) (by Mike Florie)

-- I'm the end of the train. The caboose.

-- I've watched you, you've paid attention, it's appreciated; and let me tell you what it means to Debbie Davis.

-- It's now 4-1/2 years; it's the first time someone can stand up and tell Debbie's part of this case.

-- Dedicated, highly trained, well-qualified, and saw her (victim) only one time. She was caring, attentive, and met the standard of care in every respect.

-- She took what looked like a perfectly appropriate order from Dr. Amare, and she had no reason to know that a critical, life-threatening error had been made over in India.

-- She took an order from a well known and highly respected doctor and did what the order said.

-- She did <u>nothing</u> below the S.O.C.

-- B.S. in Nursing; was an R.N.; took four more years of specialized study at USA to earn certified nurse practitioner degree.

-- NP's can do primary care; histories and physicals; can take care of patients and work in conjunction with collaborating physicians like Dr. Chance.

-- She presently works at South Baldwin Medical Partners on McKenzie Street in Foley.

-- You've today in 7 hours not heard one thing suggesting that Debbie Davis did anything wrong. She was not the reason Ms. Juno died.

-- She's not proud for being here, it's a great burden; but I have great respect for these lawyers bringing this case before you.

-- You won't hear even one expert witness say she was negligent.

-- 4-1/2 years, 40 witnesses, 46 depositions, and not one witness has said anything about Debbie.

-- The law: if a case is brought against a health care provider, special laws apply under Medical Liability Act. Plaintiff has burden of proof. Plaintiff has to prove case by substantial evidence. Have to prove the case by expert testimony from a substantially similar health care provider; someone in the same specialty. Only a CRNP can give expert opinion testimony against Debbie Davis; Plaintiffs haven't named one against Nurse Davis.

SDF1 – MM "Physician Visit Protocol" (skilled nursing facility) "physician must see pt within 48 hours of admission; and then weekly"

USUAL routine: introduce herself, do physical exam, review orders, reconcile them and ensure everything was in order.

MM58A – When Debbie examined Ms. Juno, she had:
-- Patient Transfer Form (Thomas document)
– Procedure notes from vascular surgeons
– Discharge Summary
– Did a physical exam; hemodynamically stable
– Ms. Juno was lethargic that [evening]; mostly just tired from a long day

MM8A MM Admission and Physical Examination (3 pages)

MM58A Medications Summary and rest of the patient transfer order <u>appears</u> to be complete and authentic and appropriate. It appears to be signed and complete.

"V.O." means and meant to Debbie that:
(1) Nurse Pierotti spoke with Dr. Amare
(2) There was a readback by the nurse
(3) That Amare gave her (a) the medicine
(b) the dose
(c) the method or route of administration

SDF3 – Debbie does a Medication Reconciliation

MM personnel, like Debbie, could not have known that Pierotti never spoke with Dr. Amare; and could not have known there was no readback; or that Amare had never even seen the patient transfer order; much less <u>not</u> prescribed 8<u>0</u> units of Levemir

Q. Is 80 units of Levemir out of line?

It's not, especially for brittle diabetics. It's highly individualized and depends upon many factors.

Has to [be] titrated for each patient and can change too.

Dr. Blond and Dr. Amare will testify, like Dr. Chance and Debbie. All testify that 80 units, while high, is not extraordinarily so. It's not out of line.

Debby went home that evening with Ms. tucked in and knowing that she, Debbie, had done everything she was trained to do.

First thing Debbie learns about Ms. Juno having any problem is at 6:30 next morning when MM Nurse Supervisor tells her she was found unresponsive.

Conclusion:

- -- Dr. Amare didn't do anything wrong
- -- Mercy Medical didn't do anything wrong
- -- Debbie Davis didn't do anything wrong