1 * * * * *
2 MR. PANTER: May it please the Court.
3 Ladies and gentlemen, life is about
4 choices, choices and consequences for those
5 choices. Every action that one takes -- every
6 action that one takes has a consequence.
7 Medicine is also about choices; that's
8 what we were here for. A trial about medicine
9 and a standard of care. Dr. Martinez-Alba
10 chose to be a physician. He chose to be a
11 physician. He chose to accept a consult and a
12 call for a surgical patient on May 7th. He
13 chose not to call Tina, Clementina Brown, on
14 the telephone himself. He chose not to get all
15 of the medical information about Tina Brown's
16 background and medical history. He chose not
17 to inquire about her condition upon coming into
18 the emergency room. And he chose, most
19 importantly, for the Brown family, for these
20 two boys, Anthony and Bryan Fontalvo, he chose
21 not to come in and see this patient on Saturday
22 afternoon at about 4:00 p.m. on May 7th. He
23 chose not to witness and look at her in the
24 eyes and see the agonizing pain that this woman
25 was experiencing that Ralph, her brother, saw.

1 The family chose to go in and see her
2 every single day. What Tina Brown did not
3 choose, Clementina Brown, did not choose, she
4 did not choose to have abdominal pain that
5 evening in the middle of the night,
6 excruciating ten over ten abdominal pain. She
7 didn't choose to have that. She didn't choose
8 her doctor. She didn't have a choice about
9 Dr. Martinez-Alba. She did not choose to have
10 an internal hernia. She did not choose to have
11 an ischemic bowel. She didn't choose to come
12 into the hospital in the middle of the night
13 with an ischemic bowel causing pain ten over
14 ten. She didn't choose to have a consulting
15 surgeon who decided to wait till the next day
16 to see her. She did not choose to have a
17 cardiac and pulmonary arrest, which caused her
18 death, her withering death, in front of her
19 family and her two young children for almost
20 two years. She didn't choose to end up in a
21 fetal position with her fingers grasping
22 whatever life was left in her body. She didn't
23 choose to leave her two children, her twin boys
24 at age eleven without a mom. She didn't choose
25 to have those boys have to live with Thelma

1 Leon, her sister. She didn't choose that.
2 I want to stop a minute and thank you,
3 ladies and gentlemen, thank you. I could sit
4 down now, but I won't because I am going to
5 take you through the evidence in this case.
6 And I thank you not to curry favor. I thank
7 you for the court system; for the Honorable
8 Judge Schlesinger; for our clerk Joe; for our
9 court reporter Diana and for the other lawyers
10 in the room, because this is what truly makes
11 this country great. It truly does.
12 Because the judge decides matters of law,
13 and that's part of the reason you are not here,
14 because during this trial we are working hard
15 to decide issues of law and rulings and things
16 of that nature. As you all probably know and
17 it's not because we are rude. And by the way,
18 that's another thing I think I ought to bring
19 up. I have been called many things in
20 courtrooms, you know, and I sometimes lose
21 what -- you might consider good decorum,
22 because I have a passion for all of my clients,
23 in particular in this case, but I want you to
24 know, and I talked about this before the jury
25 instructions and you are going to hear this

1 from the judge and this goes to everybody. The
2 fact that I am emotional and I'm high strung,
3 the fact that the evidence is difficult at
4 best, it's horrible the tragedy, but we are not
5 here for sympathy; and that goes to both sides.
6 You may feel, you know, Mr. Panter of --
7 you were too mean to those witnesses and we are
8 sympathetic to them. Or you may feel,
9 Mr. Alba, we are sympathetic to Clementina
10 Brown and her family. And the judge is going
11 to tell you: In reaching your verdict, you are
12 not to be swayed from the performance of your
13 duty by prejudice or sympathy or sentiment for
14 or against any party. Your verdict must be
15 based on the evidence that has been received
16 and the law on which I instruct you. You know
17 what, that's all that we want.
18 So even when I sit down at the conclusion
19 of my arguments, I plan on presenting just a
20 short version of the day in the life of how
21 Tina Brown's life ended and not to curry
22 sympathy. I want to say that now. It's
23 because it's the evidence. And when the Brown
24 family, Thelma Leon came in to see me with John
25 Perez and we decided to work on this case, we

1 took on an obligation to present all aspects of
2 it, not just to prove that Dr. Alba was
3 negligent; not just to prove that Dr. Alba had
4 an obligation to see this patient; not just to
5 prove that Dr. Alba ignored this patient; not
6 just to prove that Dr. Alba wasted an
7 opportunity and passed up a moment of opportune
8 time; not just to prove that Dr. Alba failed to
9 be safe; not just to prove that he needlessly
10 endangered his patients, but we also have to
11 prove that the injury and the consequences, as
12 I started off talking about, that this was a
13 horrific injury which could have been avoided
14 if this doctor would have attended to the
15 patient in a reasonably timely manner.
16 So, therefore, that evidence is not for
17 that reason. But with that said, I would not
18 be doing my job if we didn't talk about who
19 Clementina Brown was or Tina. Clementina Brown
20 wasn't -- Clementina Brown was first and
21 foremost, the number one thing she was a mom.
22 A single mom is tough. I mean there was a
23 father but, you know, his role was limited.
24 You didn't see him in this courtroom, you know,
25 but she was a mom. You heard how great of a

1 sibling she was. And not to leave out the
2 mommy of her that she was a great daughter.
3 But this Court only, and it's interesting
4 you heard a lot of evidence and when you
5 hear -- when I come to you at the end ask you
6 to render a verdict, the only people that are
7 compensated are her two children. You might
8 think, you know, Mr. Panter, why can't her mom
9 recover? Why can't her sisters recover? Why
10 can't the rest of her family who are marvelous
11 people; that's not what this trial is about.
12 We have to look and we have to confine
13 ourselves within the law.
14 The only two people who have a claim,
15 people, are the two boys, the estate, and I
16 will talk about that and the economic damages.
17 Do you remember when I got up at the beginning
18 of trial and I said let's talk about economic
19 damages versus noneconomic. That's kind of
20 what I am talking about now.
21 I want to, if I could, take you back to
22 Monday. I want to take you back to Monday,
23 which wasn't too long ago. Number one, we
24 talked about not to needlessly endanger
25 patients and, of course, better safe than

1 sorry. But more importantly right now, I want
2 to just talk about a mom who was Tina and
3 unfortunately you didn't get to meet her, but
4 we do our job in bringing her to life by
5 talking to her family.
6 There is not a single shred of evidence,
7 this is not an issue in the case, as to who
8 Tina Brown was, that she was not a terrific
9 person and a terrific sibling and a terrific
10 mom; you didn't hear anything to the contrary.
11 So let's be real clear about that.
12 And your mom, you can't replace a mom.
13 Those two boys when Bryan --excuse me, may I
14 have the pleasure, when Bryan sat, and he is
15 bigger than me, but his heart -- his heart is
16 broken. And, you know, he may not have cried
17 to you. Thelma is now Mommy, knows his tears.
18 She knows his tears. Clementina, the grandma,
19 knows his tears. But you can only see and hear
20 him for ten minutes or so. But there is no
21 question that that mom is irreplaceable. That
22 mom nurtured these two boys, which were the
23 light of her life.
24 Her marriage didn't work out, but she
25 never abandoned those guys. She was with them

1 and that was her life. That was her life. And
2 more importantly or equally important that was
3 their life, their mom.
4 Thank God for Thelma Leon. Thank you for
5 taking care of two boys who are not out in the
6 street. And they will never be out in the
7 street, because they have a good fortune to
8 have a great family. But does that mean that
9 their loss of a mom is any less? Does that
10 mean that that loss is replaceable by Thelma?
11 She is their aunt. She has her own child now,
12 but they are fortunate to have that, but you
13 don't replace it.
14 You know, someone said that a mom is 24/7,
15 24/7. So when those children, before this
16 happened, would sleep in the middle of the
17 night and wake up as children do. And we have
18 all been there, knock on the door or a pulling
19 of the sheets for their mom; they didn't have
20 that. They have Thelma. Thank God they are
21 not in a foster home. They have Thelma.
22 Twenty-four/seven all ages, all ages.
23 They don't have the ability to go off to
24 college and call their mom and say, hey, this
25 class stinks; I like this girl; I don't like

1 this girl. They won't have their mom, God
2 willing, at their weddings. They won't have
3 their mom, when it's time to have their own
4 children. They won't have the pleasure of
5 bringing their children to Clementina Brown,
6 the senior, the mom. They don't have that.
7 What is a mom? Caring. A mom sacrifices
8 everything. We knew this lady had two jobs,
9 two jobs; not one but two and took her boys to
10 work while she cleaned. You know that's
11 interesting, because when we look at the
12 economics Mr. Missun, my partner David put on
13 the stand, he didn't testify she had two jobs.
14 He didn't talk about the second job. He talked
15 about the job at Ford, right? We didn't factor
16 that in, but she had two jobs. So, you know,
17 that's just a fact; unconditional love.
18 Someone once said that moms are
19 overprotective; they don't have an
20 overprotective mom. And, I don't know, someone
21 talked about ambiguity in life and a great
22 cook. This was a young lady who took it upon
23 herself to have the two children. There is no
24 daddy there; that's even more important to
25 these children.

1 You know one of them couldn't make it
2 here, but we provided you with some information
3 about that. He is emotionally handicapped.
4 And ladies and gentlemen, don't hold that
5 against Anthony for not being here, please. We
6 are not required to bring him here to present
7 his case but his brother, his twin, born at the
8 same time, came and spoke for his brother as
9 best as a brother could. He wasn't perfect,
10 but no kids are. But that's the mom that they
11 are missing. That's the Thelma who had gastric
12 bypass surgery.
13 And you could see she is involved, not
14 with just her family, but if we look here you
15 can see that this young lady at age 33, and
16 these pictures are probably a little bit
17 before, didn't care about herself -- this is
18 Toys for Tots, Toys for Tots; she cared about
19 the community. And because of someone who
20 didn't want to be better safe than sorry, we
21 lost this lady. Our community lost this lady,
22 and those two children lost this lady and that
23 family lost this young lady. And if you ask
24 anyone she looked pretty good and pretty
25 healthy in a bathing suit at age 33, after

1 having two children.
2 That's young Tina, probably about the age
3 that Bryan and Anthony were, when they lost
4 their mommy, probably close, ladies and
5 gentlemen. If we could talk about what
6 happened. Horrible, horrible, abdominal pains
7 and Tina did everything right. What did Tina
8 do? She didn't wait until the next day to get
9 help, right? She called the emergency and they
10 took her right to the hospital where you should
11 be. And the hospital then puts together a
12 team. You know, little by little you go in
13 through the emergency room, and then you go the
14 floor and then you go to where you need to be.
15 Consults, every one came. Arguments about
16 stats and not stats. It's a good time to get
17 that one out of the way. Where is that board?
18 Where is that one, John? Policy. I have it.
19 Let's talk about policy. You know, I was
20 very clear with Dr. Alba and that he got his --
21 let's see, he is not his friend Comperatore.
22 He knows him for 20-plus years. He is the
23 chief of surgery at the same hospital where
24 Dr. Alba has privileges, but they are not
25 friends, they are competitors. That's fine,

1 but forget about what Comperatore said. What
2 about what Alba said? And we blew this up
3 because we think it's important. We had the
4 court reporter do that for us.
5 And I would just like to read it, so we
6 can put that out of the way. Basically, "the
7 Palmetto Hospital policy" -- this is a question
8 -- "that your lawyer has brought up today is
9 irrelevant to your decision as to whether you
10 saw the patient on 5/7 or waited until 5/8.
11 You made your own decision as a medical doctor
12 not to see her". His answer is "correct."
13 So they -- the lawyers want to hide behind
14 a policy and they want to use a witness,
15 Dr. Comperatore, to hide behind a policy, but
16 Dr. Alba, the defendant in this case, admits he
17 confesses that this -- that really shouldn't be
18 used.
19 The next question is "Okay. So can we put
20 that policy aside? Say, ladies and gentlemen
21 of the jury, ladies and gentlemen of the jury,
22 that has nothing to do with this doctor's
23 decision one way or another. They can weigh in
24 on your decision, but know that the policy
25 didn't influence you one way or another; am I

1 correct? That's correct. Yes."
2 That's not ambiguous. That's very clear
3 that that policy, which I think is in evidence,
4 that this policy is not the guiding decision.
5 This policy doesn't set the standard of care.
6 And even if you wanted to consider it, it says
7 consultation must be done within 24 hours. But
8 if I heard Dr. Comperatore, who I got angry
9 with. I got angry and I apologize. Dr.
10 Comperatore says that gives them 24 hours.
11 You all took notes. Maybe you took a note
12 on this, but my recollection is he tried to
13 allow this doctor to walk away from this family
14 without any responsibility at all. And he
15 simply, if we simply put it, they want to blame
16 the nurses. They want to blame the nurses and
17 Dr. Llanes. So let's take them down, but we
18 don't want to accept our responsibility for
19 this tragedy. We appreciate that he's sorry,
20 but that's not what this is about. So he hires
21 or he doesn't hire because he does it for free.
22 Dr. Comperatore does it as a public service or
23 a service to his colleague.
24 Interestingly, once again, Dr. Comperatore
25 was critical of Dr. Llanes and the nurses, if

1 you recall. But Dr. Alba himself, if we look
2 to his testimony and I had the -- Diana, our
3 court reporter, I had this typed up. And I am
4 sorry it got a little smashed up, but it says,
5 "Okay, and the doctors didn't know to call you
6 because they are not surgeons. I am talking
7 about Dr. Llanes. He didn't know. He thought
8 he was doing the right thing by calling
9 cardiology and pulmonology and you have no
10 criticism of him, correct? I think they were
11 doing the best that they could with that
12 information they had. And I don't know what
13 their thought process was at the time."
14 Aside from that, his testimony was very
15 clear, because we went on and on about this
16 that he has no criticism of Dr. Llanes or any
17 of the other doctors in this case. He has none
18 and he's a doctor. He is a surgeon. He has a
19 right to defend himself. We have no problem
20 with that. That's why we are here. He has no
21 criticism, but then they go out and get the
22 surgeon that works next to him that has the
23 office next door to him to come in and say it's
24 all Dr. Llanes' fault and it's all the nurses'
25 fault.

1 Stand up. Accept responsibility. The
2 buck stops here. Stand up. Accept
3 responsibility. That's -- that's why we are
4 here, because Dr. Alba refused to do that.
5 And one other issue we need to get out of
6 the way. This is not a case about Dr. Alba and
7 whether he's a good person or a good doctor in
8 general or about his license or anything like
9 that. And you hear Dr. Comperatore try to
10 prejudice you and say how good of a person he
11 was; that's appealing to your sympathy. That's
12 not what it's about. It's about what occurred
13 at Palmetto General Hospital on May 7th or what
14 probably better put is what should have
15 occurred on May 7th.
16 What should have occurred was simple. It
17 was simple. This surgeon was called and
18 Dr. Hickey testified he absolutely should have
19 seen this patient, and should have done the
20 exploratory laparotomy, which is a very safe
21 surgery, with a less than one percent chance of
22 mortality, and that's the only way to figure
23 out what the problem was, because everything
24 else was not getting there and these other
25 doctors are not surgeons. They are medicine

1 doctors, cardiology doctors, pulmonology
2 doctors, infectious disease doctors. The guy
3 that was needed most as part of the team didn't
4 show up until the following day, when it was
5 all too late.
6 And I want to refresh your recollection of
7 a little bit about what Dr. Hickey said. And
8 Dr. Hickey is a qualified board certified
9 trauma and general surgeon from Texas. You
10 know, before I do that -- I am sorry. I am
11 going to put this down one second. You know
12 what, we went to Texas, those two lawyers and
13 they brought their doctor. He came to Texas.
14 They had every opportunity to cross-examine
15 Dr. Hickey about every single issue in this
16 case. And for the most part Dr. Hickey's
17 testimony went unrebutted until now they want
18 to pick on it in the courtroom, but that was a
19 videotape done for the trial in this matter.
20 And I just have something from
21 Dr. Hickey's depo again, and I am going to read
22 here, ladies and gentlemen. I am sorry for all
23 my scratches and marks but again, "I think that
24 given the monitoring guidelines, if you are
25 tied up in surgery, did Dr. Alba ask you to

1 look at the evidence in this case?" Did Dr.
2 Alba give those nurses in that hospital
3 guidelines? How to handle this patient? Call
4 me if there is a problem. Call me if there is
5 a problem. By the way, he was consulted for
6 abdominal problems, so the abdomen remained the
7 same. The other doctors for cardiovascular
8 things, for pulmonology, but he was a consult
9 in the case. He's going to get called if there
10 is an abdominal problem, because that's what he
11 is consulted for, so they are very critical.
12 You know, if he was there none of this
13 would have been relevant, but what Dr. Hickey
14 says, "You can get there within three or four
15 hours. If you can't, you would get someone
16 else to cover for you and see the patient, but
17 you need to, as we say in surgery, lay your
18 hands on the abdomen and find out what's going
19 on". That's the bottom line and he chose not
20 to come in on May 7th at 4:00 in the afternoon
21 on Saturday as he chose.
22 He made that choice and the consequences
23 were that Tina suffered, and the boys suffered,
24 and their family suffered and he made that
25 choice. But you need to -- I am sorry. I

1 don't mean to read that again, "lay your hands
2 and find out what's going on". And you know
3 what? You can't do it over the phone. That's
4 taught starting as an intern. There is no
5 doubt that this doctor, in accordance with the
6 standard of care of reasonable medicine, should
7 have been to that hospital sometime in the
8 afternoon and this would have never, ever
9 happened, never, ladies and gentlemen, never.
10 And, you know, we know that Dr. Otero was
11 called in as a consult and Dr. Otero did his
12 job. He did a gastroscopy. And that's a
13 procedure where he ruled out certain things,
14 making it even more important, when Dr. Alba
15 got that information to get to the hospital,
16 because things are ruled out. We know that
17 this patient had gallbladder surgery and these
18 are reasons for him to come in, because that
19 ruled other things out.
20 Now, we also know that doctors, this is
21 not a one-way street. When a doctor talks to a
22 nurse, he has an obligation to ask you
23 questions. He doesn't rely on you. He is
24 trained. He knows exactly what he is looking
25 for or should know and it's a two-way street.

1 This is some questions and answers from
2 Dr. Alba's trial testimony. "Doctor, you claim
3 you didn't have all the information about this
4 patient, in terms of that timeline and some of
5 the history went over."
6 ANSWER: "Yes."
7 Now we have a doctor at home who admits to
8 you in trial, and we asked Diana to type this
9 up. He doesn't have all the information on a
10 surgical patient. And the question is "Okay,
11 well you are the specialist" -- we know he's
12 the only surgical specialist in this case --
13 "you are the surgeon. Don't you agree that
14 it's your responsibility to request from the
15 people that you are talking to all the
16 necessary information that you need to properly
17 make a decision whether you should come in and
18 see the patient now or later?" Answer, "yes."
19 Except now in trial he accepts that
20 responsibility. If he would have done that on
21 May 7th, 2005, we wouldn't be here today.
22 We have created a board, this helps
23 summarize the red lights or calls to Dr. Alba.
24 We have here a non-emergent case. And on the
25 right side we have an ischemic bowel and we

1 already know -- I can put this down again --
2 Tina Brown came into the hospital with an
3 ischemic problem, ischemic bowel. This was
4 very important. I read this to him, these
5 questions just most recently. I said, "I want
6 the record to be clear that her internal hernia
7 and ischemic bowel was the cause of her
8 internal respiratory arrest."
9 ANSWER: "The ischemic bowel is what
10 brought her into the hospital."
11 He acknowledges that her ischemic bowel
12 brought her into the hospital. "I believe the
13 herniation and the ischemia is what I believed
14 caused her to be very sick and have an acute
15 surgical abdomen."
16 And the ischemia in my next question is
17 caused by the internal hernia and his answer is
18 "correct. And the ischemia caused her to have
19 all the change in physiology that caused her to
20 arrest."
21 This is the defendant in this case
22 acknowledging when she came in she had an
23 ischemic bowel emergency. The next question:
24 QUESTION: ""Would you agree that ischemia
25 is what is causing abdominal pain as well?"

1 We know that now retrospectively, but I
2 know that now, but I didn't know that then. If
3 you would have got the history, he would have
4 come in and seen the patient, he wouldn't be
5 gambling with her very life. I would say,
6 sure, that was causing either the ischemia or
7 the fact that it was pre-ischemic or
8 herniating.
9 So he knew, he knew, he knew what a
10 Roux-en-Y surgery was all about. He even had
11 the audacity to come in front of you and show
12 you how smart he was and draw it for you, so he
13 could tell you how great of a job he did in a
14 surgery. There is no issue about the mechanics
15 of the surgery. It's all about the timing,
16 ladies and gentlemen. It's all about the
17 timing. "That caused her, when she presented
18 to the emergency room with pain ten out of ten,
19 that's how she presented originally. You know
20 that, right?"
21 ANSWER: "I don't recall that, but I
22 am -- if you are saying so, I believe you. You
23 are telling me."
24 You are telling me that. So going back to
25 this doctor knew or should have known number

1 one, red light better safe than sorry. Come
2 see me. She had three previous abdominal
3 surgeries, including gastric bypass. That's a
4 red light for any surgeon and that's what
5 Dr. Hickey told you and that required him to
6 get into the hospital on Saturday.
7 Severe pain for over 38 hours and they
8 quibbled and quibbled about that because she
9 was on morphine and Demerol and Dilaudid and
10 whatever else they could give her at the
11 hospital to relieve the horrible pain. The
12 pain that her brother witnessed in this lady's
13 eyes. The pain that that doctor never
14 witnessed, because he didn't go look at her.
15 He didn't go see her. He didn't go. He
16 didn't go except stay at home and make an
17 excuse that the nurses should have called me at
18 night; that's his excuse. Blame them. Blame
19 them. Halitosis and chills. Halitosis, no big
20 deal. It's just bad breath. Well, she's
21 vomiting. You heard from Bryan, her son,
22 saying she's vomiting blood. You know, and
23 it's not one of these. You have to look at all
24 of them together. So, yeah, if the lady had
25 halitosis, maybe she had bad breath and chills.

1 That's a general symptom.
2 We have to look at everything. No
3 gallbladder. That's important for a surgeon.
4 That rules out the probability of gallbladder
5 problems, but then somehow they made some
6 excuse, well, she could still have some kind of
7 gallbladder problems. I don't know what but
8 some excuse.
9 Then a CT scan. Dilated loops of bowel
10 fluid. They want to make it like it was a
11 normal CT. And the clinical where the report
12 says clinical correlation suggested that's just
13 because of the lawyers. That's because of the
14 lawyers. You know what, if it's because of the
15 lawyers I am proud of what I do to maybe save
16 some people. Save some people in this
17 community, if that's what it takes.
18 Gastroscopy was normal. That ruled out a
19 gastric pouch or an ulcer. So we know that one
20 doctor, who was consulted on a regular consult,
21 came in timely and did his job and we ruled out
22 the problems. He did his job. Elevated white
23 blood count, 13,000. It's just a little bit
24 elevated. Not a big deal. If she had nothing
25 else and she had white blood counts at 13,000

1 you wouldn't be too worried. You wouldn't.
2 Same ever signs of ischemic bowel. She had
3 escalated ischemic bowel on her presentation.
4 Elevated blood sugar, elevated hematocrit and
5 lowered CO consistent with acidosis. So that's
6 the picture. That's why we drew it like this.
7 By the way, if you remember, when I
8 started off in this case and I said to you this
9 is a civil case and the burden is just a little
10 bit of the tipping of the scale and we accept
11 that burden. Well, the evidence shows beyond
12 what we need to prove to have Dr. Alba be
13 responsible and held accountable for this
14 horrible loss for this family. Well and beyond
15 a civil burden in this case, well and beyond.
16 And what happens is this is how this
17 33-year-old lady ends up. And this is not for
18 sympathy. This is evidence in this case,
19 folks. This is what happens. This isn't one
20 day. This isn't one day. What this is and
21 I -- help me out over here.
22 MR PEREZ: Yes.
23 MR. PANTER: Take one box, one-third.
24 Bring them over here, please, please.
25 MR PEREZ: Where would you like it?

1 MR. PANTER: Right here (indicating). I
2 don't need them all. I don't need them all.
3 16,000 pages of medical records and, you know
4 what, every single page here reflects horrible
5 pain and suffering, a horrible existence.
6 Nothing can be imagined worse. I don't think
7 that I can put it into words, but 16,000 pages
8 of medical records. And the family came and
9 saw their love, Tina. It took about a month
10 for the boys to come to see their mom in a
11 deplorable condition with no dignity, suffering
12 until the very end, February 13th, 2007. And
13 then the funeral, and then life with their
14 aunt, which they have been doing for a long
15 time. What did that all cost to the estate?
16 $5,430,627.07. That's what the bill was at
17 Palmetto Hospital.
18 John, where are the nursing home bills?
19 And then for a short period of time the family
20 moved her to a nursing home, Hampton. You
21 haven't heard much evidence about that.
22 Because I think we presented enough damage
23 evidence to you, but we did present the bill.
24 That wasn't pleasant, the family having to see
25 their loved one at the nursing home. The bill

1 there before she died is $48,213.67, not --
2 this is not for those boys. This is to the
3 estate. These are liquidated certain -- this
4 is not speculative or a pie in the sky. This
5 is what it cost. This is what it was all
6 about. That's what happened.
7 Now the defense is going to argue Llanes
8 and the nurses -- Llanes and the nurses but
9 guess what, I talked to you about burden of
10 proof and we accept and embrace our burden of
11 proof, after we have proven to you that Dr.
12 Alba should have come to this hospital for
13 many, many reasons, but it's their burden of
14 proof to prove that Dr. Llanes and the nurses
15 actually did something wrong that contributed
16 to this tragedy.
17 They could have put Dr. Llanes on the
18 stand. They have subpoena power. If they
19 thought he was guilty they should have brought
20 him up on the subpoena. And if he doesn't show
21 up, the judge will order him to that chair.
22 And they could have put him on the stand right
23 in front of your eyes and your ears to hear
24 what he had to say.
25 The same thing with the nurses. It's a

1 lot easier to argue an empty chair and it
2 doesn't meet the burden of proof, because
3 that's their burden of proof. That's what
4 needs to be known. We accept ours. Do they
5 accept theirs? Did they bring the witness? Do
6 they have an expert witness? And they could
7 have done that, an expert nurse that said these
8 nurses fell below the standard of care.
9 You didn't hear that, because these nurses
10 were under the control of Dr. Llanes.
11 Dr. Llanes is the doctor in charge and they did
12 call him and even Dr. Llanes and Dr. Freeman,
13 they didn't comprehend the surgical aspects
14 here, but the one that did and should have is
15 sitting over there. Is sitting over there;
16 that's Dr. Martinez-Alba. He knew. He knew.
17 He didn't do anything about it. Doctors must
18 never needlessly endanger a patient. Doctors
19 must be safe. It's better to be safe than
20 sorry.
21 I will leave the mom's statement about, "I
22 am in the hospital. I will come to see you" to
23 your opinions. You heard it.
24 Now, you know, interesting and I want to
25 go back, because I would like to go back to the

1 beginning when the lawyer got up here. And I
2 brought this up a few times, because I think
3 it's important. Knowledge is a candle that
4 lights our way. Completely agree with that
5 statement by Mr. Alba. Completely. But who
6 had knowledge here? He would barely admit that
7 the surgeon had superior knowledge.
8 Both of them, him and Comperatore, I had
9 to struggle with them to get them to admit to
10 you that a surgeon is the one with the greatest
11 knowledge about the surgical abdomen, and a
12 laparotomy, and the surgery that's necessary
13 and all the events that led up to that. But I
14 think they finally agreed. And I think it's
15 clear that a surgeon is the one with the
16 knowledge. A surgeon is the one that needs to
17 put their hands on a patient. There is just no
18 getting around that. If this surgeon put his
19 hands on the patient, we wouldn't be here
20 today. There is absolutely no getting around
21 that.
22 And with respect to that one of the most
23 important things, and I am sorry that I don't
24 have it enlarged, but I asked Diana again, I am
25 keeping her working. Between how fast I talk

1 and how much we ask of her, I hope that she
2 will forgive us, but in any event this is what
3 the doctor said and this is what I asked him.
4 This is the key. This is the key, ladies
5 and gentlemen. "Would you agree that the
6 surgical procedure, if it had been performed
7 the day of the surgical consult was requested,
8 if it had been performed that day, May 7th,
9 more likely than not the cardiology pulmonary
10 arrest would not have occurred. It wouldn't
11 ever have occurred". He says along with other
12 things, yes. Then I say to him, "Would you
13 agree that cardiorespiratory arrest was the
14 cause of her anoxic encephalopathy? Yes.
15 Would you agree that the anoxic encephalopathy
16 contributed to her death? Yes."
17 These are the elements that we accept the
18 burden of proof that he was negligent. He
19 didn't timely operate on her and that failure
20 led and contributed to her death and the
21 evidence is clear in this case. "Doctor, you
22 claim that you didn't have all of the
23 information about this patient in terms of
24 timeline and some of the history we went over,
25 correct? Yes. Okay. Well, are you the

1 specialist? You are the surgeon. Don't you
2 agree that it's your responsibility to request
3 from the people that you are talking to all the
4 necessary information that you needed to
5 properly make a decision, whether you should
6 come in and see the patient now or later?
7 Yes."
8 He didn't come in. He knew it was his
9 responsibility. He knew it and he is sorry
10 now. That's not what this case is about. It's
11 not about being sorry.
12 I am going to have to take a few minutes,
13 if I can, to talk to you, ladies and gentlemen,
14 about a verdict form. This is how things end
15 up, because this is the closure and the end and
16 where you decide the case. And you will get a
17 verdict form. And the questions here, ladies
18 and gentlemen, are -- they are very simple.
19 The first one is was there negligence on
20 the part of Dr. Martinez? And, ladies and
21 gentlemen, there is no question that we accept
22 our burden and that this doctor should have
23 timely and appropriately seen this patient and
24 if he did the consequences would not have
25 occurred that occurred. He had all the

1 information or he should have had all the
2 information to know he needed to come in and
3 put his hands on this lady's abdomen and do the
4 exploratory laparotomy, which would have saved
5 her life. So the answer is yes.
6 The next page, was the negligence on the
7 part of Jesus Llanes? That's their defense.
8 Blame someone else. Despite the fact that
9 Dr. Comperatore came, his colleague, this
10 doctor, Dr. Alba, says I think they were doing
11 the best that they could with the information
12 that they had and I don't know what their
13 thought process was at the time. But more
14 importantly in trial, and I read to him
15 actually from his deposition. I said you have
16 no criticisms of the doctors in this case and
17 his answer was very clear. I do not have any
18 criticisms.
19 So if the main -- if the defendant admits
20 to you that Dr. Llanes didn't do anything
21 wrong, then they go out and get
22 Dr. Comperatore, who is less than credible, the
23 answer should be no with respect to Dr. Llanes.
24 If you feel differently on any of this. This
25 is in your hands. I will be done in a few

1 minutes.
2 Now the next thing is was there negligence
3 on the nurses? And, you know, I think they did
4 a less than adequate job proving the case
5 against the nurses. However, if there is any
6 scintilla of this, we can embrace that. We are
7 reasonable. I am not suggesting that you put
8 100 percent on Dr. Alba. So the answer to this
9 can be yes, I will tell you that right now.
10 Although the important part is how do we
11 evaluate and apportion this. By the way, if
12 you tell me you know what, Mr. Panter, I heard
13 the case and I don't think that the nurses did
14 anything wrong; that's up to you.
15 Don't get me wrong. When we go down the
16 percents here I don't give the nurses more than
17 10 percent. Because I think they did their
18 job. They were calling people. They were
19 calling doctors, but they are not surgical
20 nurses. They are not from the surgical ICU and
21 I don't put much fault on those nurses. They
22 were doing their job as best they could. And
23 for this guy to get up in front of you and try
24 to pass the buck to them is not fair and
25 doesn't meet the evidence in the case.

1 So Llanes is a zero and Dr. Alba is
2 90 percent. That's how the evidence played out
3 in this case. If he was there by his own
4 statement, by his own statement, this patient
5 wouldn't have ended up with cardiorespiratory
6 and pulmonary arrest and in that comatose state
7 in front of her own family.
8 Now this is called damages to the estate.
9 This is the econ part. Let's be clear. This
10 doesn't go to the children. Let's be very
11 clear about that. I had to take notes on this,
12 because you heard a lot of evidence in the
13 case. It says what's the amount of earnings
14 lost from the estate from the date of the
15 injury to the date of death? We have an
16 economist. By the way, they again can have an
17 economist, if they don't trust our numbers.
18 They have a right to bring in whoever they
19 want.
20 There was one economist in this case. He
21 said the earnings were 46,846 in net
22 accumulations. He had numbers or earnings were
23 about $1 million, but the money left was much
24 less, because he already accounted for her
25 personal consumption and he came -- I am using,

1 by the way, he had two set of numbers. Just so
2 it's clear I am using the lower set of numbers
3 to be conservative here.
4 The net accumulation numbers, and you may
5 have your own notes on this, were 231,557.
6 That's the numbers, folks. We had an
7 enlargement. This is the board that
8 Mr. Sampedro used with the economist and this
9 is where I got my information from and just
10 hold that there for a minute. So we have a --
11 I used the lower numbers on that accumulation
12 and the past loss and I haven't got to
13 household services yet, which I will.
14 Now the medical bills were $5,430,627.
15 That reflects 16,000 pages of pain and
16 suffering. Sixteen thousand pages of agony for
17 this family. Sixteen thousand entries of a
18 woman withering away in the hospital bed in
19 front of her eleven-year-old children, who
20 during that time went from eleven to twelve and
21 a half years old; that's what this is about
22 right here. There is no dispute about that.
23 Now, the next element is for what's called
24 support and services and that was, you heard
25 from the economist on that as well, what the

1 value, remember he went over it. It was
2 somewhat boring and it's our job to present
3 boring and sometimes gruesome and sometimes
4 difficult complex evidence. We had to do that.
5 The support and services that he had was
6 this number, but he separated out the past and
7 the future, okay. I have the math for you
8 here. And he said from the date of injury to
9 the present date was 27,829. And in the future
10 was 25,229 and then the part that I talked to
11 you all about at the beginning of the case. I
12 said, ladies and gentlemen, do you have any set
13 limits on what you think is appropriate in
14 cases of this nature? And each of you took an
15 oath and said no, I will start and listen to
16 the evidence. I will be fair and just. I will
17 try this case true, true, and I will listen to
18 you, Mr. Panter.
19 Someone talked about $100,000,000 for
20 tobacco. And I said to you, I promise you I
21 will not ask for $100,000,000, although I bet
22 you that -- I bet you that Tina, if she could
23 come back and the boys could get $100,000,000
24 right now and you could award it, and they
25 could get it, they would rather have their

1 mom's arms around them, and their mom hugging
2 them, and their mom with them when it's time to
3 graduate high school in two years, and their
4 mom with them when it's time to go to college,
5 and their mom with them on Mother's Day, and
6 their mom with them on Christmas and New Years,
7 and their mom with them when they get in
8 trouble, and their mom with them when they get
9 a problem with the girl, and their mom with
10 them with their kids crying out, and their mom
11 with them when they want to go with their
12 spouse to the movies and the mom can come and
13 watch those kids. I will bet you -- where is
14 she? Clementina does that for her other kids.
15 And I will bet you if she was alive, when
16 those boys have their children, she will be
17 there as a great grandma, but their mom won't
18 be there. And $100,000,000, I will bet you
19 they will tell you, forget it. I would rather
20 walk out of this courtroom with my mommy, but
21 that can't happen.
22 We are here to be fair and just. Each of
23 you promised that if someone talks about
24 that -- some limits back in the room you will
25 report it back to the bailiff and he will talk

1 to the judge, because that's not the law. The
2 law allows you to determine what is fair and
3 right and just. And it gives you the
4 obligation and the privilege. So all I can do
5 is put a number down. And if you think,
6 Mr. Panter, you are being not very generous for
7 those boys or you are asking for too much
8 money, you tell me by writing it in there. You
9 tell me, Mr. Panter, no, sir.
10 But I suggested, folks, in the past a
11 number of $1 million and that's not a big
12 number for these children going to the hospital
13 for almost two years seeing their mom whither.
14 This is not. Death is bad enough and untimely
15 death is bad enough. This is worse. This is
16 untimely. And why is it untimely? Because the
17 doctor wasn't on time. And it's untimely
18 because she's 33 years old. And it's untimely
19 because the boys are eleven years old. And
20 it's untimely and horrible because they had to
21 witness it for two years, almost two years of
22 seeing their mom.
23 So that $1 million, if you are telling me
24 you are crazy. You are crazy, Mr. Panter. You
25 put your own number there, folks. For the rest

1 of their life for all of the things that I told
2 you $2 million. The boys are now 15 years old.
3 You have to add all of that up, folks. I don't
4 know -- what is it? Three million this one
5 here, that's 53 or something like that. I am
6 not -- so it's 3,053,058. That's for a boy.
7 That is for him. That's not this. That is not
8 the medical bills. That's for Anthony. And
9 you didn't even see Anthony. You can imagine
10 what that young boy is going through.
11 We know that he is emotionally
12 handicapped. And if there is any question
13 about that, they can subpoena all the records
14 that they want. They have the power of this
15 court. So anything that is not presented is by
16 choice or it's not necessary or what have you.
17 Every lawyer has a right to present what they
18 want.
19 And then if we go here, I will just repeat
20 it and this is a -- this is the support and
21 services 27829, 25229 and his parental, same
22 thing: One million and two million and then
23 you come up to the total number the same number
24 which is 53 -- what is it? 503 -- 053?
25 053058. I think to go back here, I think I

1 made a mistake. I did. I didn't put the zero
2 here. Sorry. Sorry. This is the only form of
3 justice that we can do on behalf of our
4 clients.
5 You know, it says there, "We labor here to
6 seek only truth" and I believe that in the last
7 four days you heard the truth. You finally got
8 it. You had to kind of work through it. And
9 we were put to our burden and did a good job,
10 but good job, bad job not relevant. Lawyers,
11 not relevant. What is relevant is the evidence
12 and how it comes in and the truth of it. And
13 you have had that time.
14 Now what I would like to do as my job and
15 I told you at the beginning that I was going
16 to. We have the video assistance and I have no
17 better way to express -- one second -- to
18 express what this family went through. And I
19 would like to give them a tribute. And I will
20 not put them through the six minutes of
21 replaying this, but two minutes. Two minutes,
22 no sound. And as difficult as it is, I will
23 promise to the Court, the clerk, the court
24 reporter, counsel, my counsel, to sit down and
25 be quiet. I can do that. With that I thank

1 you for your time and attention. And I know
2 that either this afternoon or tomorrow your
3 verdict will be just. Thank you.
4 (Thereupon, a video was shown to the
5 jurors.)
6 MR. PANTER: Thank you.
7 * * * * *
8
9 * * * * *
10 MR. PANTER: Choices. The choices were
11 made and forever have altered the lives of
12 Anthony and Bryan. And I will not go down and
13 repeat the choices. The bottom line here is
14 that Dr. Alba made a choice. He had nothing
15 else going on in his life that Saturday
16 afternoon, and no reason not to see this
17 patient and every single medically reasonable
18 reason to go in and see her and lay his hands
19 upon her abdomen, because he had the knowledge
20 or he is supposed to have the knowledge.
21 And, you know, if he had any concern and
22 he picked up the medical cues that were all
23 there, as clear as day, as clear as day. All
24 the medical evidence was in front of him and he
25 kind of maybe wasn't sure if he should come in,

1 there is nothing stopping him from picking up
2 the phone and making a call at 5 o'clock, 6
3 o'clock, 7 o'clock, 8 o'clock, 9 o'clock,
4 10 o'clock. He could have done that as well.
5 But the point is this patient was consulted to
6 him for abdominal problems and her abdominal
7 problems were constant throughout. The nurses
8 did what those nurses were supposed to do.
9 They called the doctor.
10 It was interesting because it was either
11 Dr. Comperatore or Alba corrected me at one
12 point and on the chart it says who the
13 admitting doctor is for the patient. It's
14 Dr. Mygins (as spoken), who became Dr. Llanes
15 who was covering for him. So nurses had a
16 problem with blood pressure and cardio
17 vascularly. They called the right doctor. He
18 said call me if there are any changes.
19 She had an ischemic bowel the day she came
20 into the hospital and he knew it. And he
21 testified to it and he admitted to it. And,
22 therefore he needed to come and investigate
23 that bowel and put his hand on that lady's
24 abdomen and we wouldn't be here today, not at
25 all.

1 The lawyer got up here and said that he
2 didn't have to order more tests. You know
3 what, forget about small bowel series and
4 repeat CT scans, forget about all of that. Put
5 it off to the side. Simply march yourself down
6 to Eighth Street to the Palmetto to 122nd
7 Street. Get in the emergency room parking lot
8 and see this patient. If he can get there,
9 according to him, in 38 minutes, then that's
10 what you do. You are a doctor. You make
11 choices. You are not a plumber, you know, you
12 are not something else. You are a doctor. You
13 made a choice to care for people and meet the
14 standard of care and the judge will instruct
15 you on what negligence is.
16 Negligence is the requirement that
17 everyone use reasonable and due care, whether a
18 doctor or truck driver or airline pilot;
19 reasonable due care. This doctor didn't do
20 that. He gambled with a patient and the gamble
21 went south. It went terrible and this family
22 is the one that suffers from the consequences
23 of it.
24 Now they want to get up without proper
25 evidence and blame Dr. Llanes and the nurses,

1 without even proper evidence to do that.
2 And the CT scan, once again, I couldn't
3 believe I just heard a lawyer say no
4 obstruction. You have to pay attention to the
5 whole evidence. And if you are going to be
6 candid let's take the good and the bad. I
7 mean, it didn't say no obstruction, there was
8 no obstruction found. But more importantly to
9 correlate clinically, this doctor knew about
10 that and he knew that Dr. Franca, I probably
11 got the name wrong, but that radiologist
12 suggested that a doctor, and he is the one that
13 was requested to do it. Clinically means get
14 in there and put your hands on the abdomen,
15 just like Dr. Hickey said. Any reasonable
16 surgeon had a requirement to get to the
17 hospital. And you know what, the choice was if
18 he was busy doing something, which we didn't
19 hear that was the case.
20 If he was busy that Saturday afternoon
21 that's okay. Call Dr. Comperatore. He is the
22 chief. That's your competition. Well, give
23 him a little business, if you don't need it.
24 Let him come in and put his hands on the
25 patient and do a very safe surgical procedure

1 to save someone's life, so she doesn't end up
2 the way that she ended up.
3 All of the bells and whistles were blowing
4 and he chose to ignore them, and Tina suffered,
5 and Bryan and Anthony suffered and the whole
6 family suffered.
7 No evidence -- I wrote this down. There
8 was no evidence of a surgical abdomen. You
9 heard from Ralph right here, and he said how
10 much more evidence can there be from a
11 nonmedical doctor? I saw the agony in my
12 sister's eyes. I saw the agony in her eyes;
13 that's not evidence. But he couldn't see it,
14 because he didn't come in. But oh, no, one
15 call is not enough. One call was a life-saving
16 call that was made, should have been a
17 life-saving call. Put him on notice. He had
18 his obligation and his duty. He took a
19 Hippocratic oath and that didn't work. It
20 wasn't enough.
21 That life-saving call was made on May 7th
22 at 3:30 p.m. and it was ignored. It was
23 ignored. And Tina suffered the consequences.
24 I just don't feel that I would be doing my
25 job if I didn't read once more what I have

1 labeled causation. Because in a medical case
2 we have to prove that and I accept that burden.
3 They do too, as it relates to blaming someone
4 else, but we have it right here out of the
5 mouth of the defendant at trial and I am going
6 to read it one more time.
7 QUESTION: ""Would you agree that the
8 surgical procedure, if it had been performed
9 the day that the surgical consult was
10 requested, more likely than not that cardiology
11 pulmonary arrest would not have occurred?"
12 ANSWER: "Yes."
13 So he acknowledged that if he came in and
14 did the procedure that she wouldn't have
15 arrested. Well, then you can only believe that
16 it was absolutely necessary. She came into the
17 emergency room with an ischemic bowel and he
18 knew it two days before, two days before.
19 QUESTION: ""Would you agree that the
20 cardiorespiratory arrest was the cause of her
21 anoxic encephalopathy?"
22 It took me a while to say that word. It's
23 a horrible word.
24 ANSWER: "Yes."
25 QUESTION: ""Would you agree that her

1 anoxic encephalopathy contributed to her
2 death?"
3 ANSWER: "Yes."
4 So he says if he would have operated on
5 her the day before it would have saved her.
6 And because he didn't he caused her brain
7 damage and her brain damage caused the death.
8 QUESTION: ""Doctor, you claim you didn't
9 have all the information about the patient, in
10 terms of timeline and some of the history you
11 went over, correct?"
12 ANSWER: "Yes, I didn't have all the
13 information."
14 Well, you can't have it both ways. If you
15 don't have it then you get it. That's your job and
16 he admits that. He says okay.
17 QUESTION: ""Well, are you the specialist?
18 You are the surgeon, don't you agree? Don't
19 you agree that it's your responsibility to
20 request from the people that you are talking
21 to, the nurses?"
22 He wants to blame them. It's all their
23 fault. All the necessary information that you
24 need to properly make a decision, whether you
25 should come in and see the patient now or

1 later. He answered simply yes. Simply yes.
2 So if ever there was a case where there is
3 a confession, ladies and gentlemen, the doctor
4 confessed right in front of you, right in front
5 of you in this courtroom.
6 Once again, I thank you on behalf of every
7 one and I now, as I told you, if you recall in
8 voir dire, you know, my job is over. And I
9 would like to thank my partners and Thelma Leon
10 for asking us to help her sister and her
11 family.
12 * * * * *
13
14
15
16
17
18
19 CERTIFICATE
20
21 STATE OF FLORIDA:
SS:
22 COUNTY OF MIAMI-DADE:
23
24 I DIANA SANTOS, Shorthand Reporter, do hereby
25 certify that the case of THELMA LEON, as Personal