In The Matter Of:

Virginia DeJean, Etc. v. Praveen Giri, M.D., et al

James Toole, M.D. Vol. 1, October 18, 1999

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Praveen Giri, M.D., et al

	APPEARANCES	Page 2
IN THE COURT OF COMMON PLEAS		
MARION COUNTY, OHIO	For the Plaintiff Wean: Gary Cowan, Esquire	
Virginia DeJean, Etc.,	Garson & Associates Co.	
Plaintiff,) V.) Case No. 98 CV 0248	1600 Rockefeller Building	
	614 Superior Avenue NW	
Praveen Giri, M.D., et al,	Cleveland, Ohio 44113	
Defendants,) Deposition of JAMES TOOLE, M.D.	For the Defendants GM, M.D., et al:	
Heid at Wake Forest University School of Medicine	Mark D. Frasure, Esquire	
Winston-Salem, North Carolina	Buckingham, Dooliitle & Burroughs	
Monday, October 18, 1999	4518 Fulton Drive NW	
1:04 P.M.	Post Office Box 35548	
Volume 1 of 1	Canton, Ohio 44735-5548	
Pages 1 through 82		Page 3
	TABLE ÖFCOMENTS	rayes
	Witness Direct Cross Redirect Recross	
	James Toole, M.D.	
	by Mr. Cowan: 4-80	
	EXHIBITS	
	Number Description Marked	
	No exhibits	
		Page 4
	[1] PROCEEDINGS 1:04 P.M.	-9-1
	[2] (Whereupon,	
	[3] James Toole, M.D.	
	[4] was called as a witness, duly sworn, and testified as	
	[5] follows:)	
	[6] DIRECT EXAMINATION 1:04 P.M.	
	[7] By Mr. Cowan:	
	[8] Q: Let the record reflect that we're taking the	
	(9) deposition of Dr. James Toole per notice and agreement	
	10] of counsel. Dr. Toole is an expert for the defense in	
	11] the case captioned Virginia DeJean, Etc. versus Praveen	
	12] Giri, M.D., et al, case number 98 CV 0248 that is	
	13] presently pending in the Marion County Court of Common	
	14) Pleas Doctor, can I assume that you've had your	
	15] deposition taken before?	
	16] A: YOU may.	
	17] Q : Let me give you a couple of the ground rules	
	18] since you've probably done this many times. You're	
	¹⁹ under oath today and you must answer the questions	
	20] truthfully and to the <i>best</i> of your knowledge; is that	
	21] fair?	
	22] A: That's fair.	
	23] Q : If you don't understand a <i>question</i> , please	
	24] stop me and I can rephrase it. Is that fair?	
	25] A: Thank you.	

Page 5 (1) Q: In answering the question, I will presume		Page 8
[2] that you understood the question that I was asking; is		
[5] Q: If you could state your full name?	[4] a year.	
 [6] A: James Francis Toole. [7] Q: And, Doctor, where do you presently reside? 		
[8] A: In Winston-Salem, North Carolina at 1836	[9] practice?	

 [21] Ithaca, New York at Cornell? [22] A: No, that was in New York City on East 68th [23] A: No, that Was in New York City on East 68th 	[21] Q. Doctor, are you presently on the board of any [22] medical journals?
[23] Street, the New York Hospital. The medical school is[24] in the city.	[23] A: I'm on the board of Stroke and Cerebral [24] Vascular Disease.
[24] In the city. [25] Q: Oh, it is? Okay, is it still today?	Mr. Frasure: Is that one or two?
¢1 • •	De 6 Page 9
 (1) A: Yes, they don'thave patients — well, at (2) that time Ithaca if I understand this story was small (3) and New York City was big so if you wanted to see a lot (4) of sick people you would go to New York City. (5) Q: And you did your internship at — (6) A: The University of Pennsylvania. (7) Q: And your residency at the University of (8) Pennsylvania? (9) A: That's correct. (10) Q: And you received a Fulbright scholarship in (11) neurology in years 1955 through 1956? (12) A: That's true. (13) Q: So I gather you went to England then? (14) A: I did. (15) Q: Doctor, what specialties are you board (16) certified in? (17) A: Internal medicine and neurology. (18) Q: And can you recall what years you became (19) board certified? (20) A: 1958 in internal medicine, 1961 in neurology. (21) Q: Do you have to become recertified in those (22) areas? (23) A: In medicine at the time I took it, no; after (24) a certain year they changed the rules and the answer 	Mr. Co [8] nam [9] M [10] M [12] [13] could tell you. [14] By Mr. Cowan: [15] Q: Would they all be listed in the CV? [16] A: Everything is in my CV. [17] Q: Have you printed any textbooks in the last [18] ten years? [19] A: Of course; excuse me. Theoretically this is [20] a CV that is updated. Let me see the upper left-hand [21] corner, if it doesn't have a date on it — here, it was [22] revised October '99, within the past month. [23] Q: And which textbooks have you authored within [24] the last five years?
Page [1] grandfathered in both. [2] G: And, Doctor, are you presently on the staffs [3] of any hospitals? [4] A: I'm on the staff of the North Carolina [5] Baptist Hospital and the Forsyth Memorial Hospital. [6] Q: And, Doctor, what are your present [7] appointments at Wake Forest University? [8] A: I'm professor of neurology and director of [9] the stroke research center. [10] Q: And, Doctor, do you presently teach at the [11] medical school at Wake Forest? [12] A: Ido. [13] Q: And what subjects do you teach? [14] A: Neurology and most precisely stroke. [15] Q: And, Doctor, I see you're a professor also at [16] Wake Forest in Neurology, Epidemiology and Public [17] Health Sciences, is that fair? [18] A: I believe that's at the University of North [19] Q: Oh, and how often do you teach at that [21] A. They come here two or three times a year. I [22] A They come here two or three times a year. I [23] do a seminar now and then. [24] A: I also saw your CV that you're a visiting [25] lecturer in Law and Forensic Medicine since 1987.What	[25] A: Well, the fifth addition of my book Cerebral Page 10 [1] Vascular Disorder and Eve years would take us back to [2] '93or '94. [3] Q: What about the Handbook of Clinical — [4] A: That's '87. That's a three volume set. [5] Whether it's been republished, I don't know. It's part [6] of a major group of books. My editorship of that was [7] in the year of 1987, '88 and I don't think it's been [8] reprinted, but I won't swear to that. [9] Q: Now the Cerebral Vascular Disease, that's in [10] its fifth edition? [11] A: Right. [12] Q: Is that used at any medical schools? [13] A: I have no way to know that. It is not [14] specifically — I don't know the answer. [15] Q: Do they use it at Wake Forest at the medical [16] school? [17] A: I use it. I had my students use it. [18] Q: Doctor, have you written any articles on the [19] use of anticoagulants for the treatment of acute [20] osternic stroke? [21] A I have.

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ded me? A: Yes.	Page 11	Page 14
	-	Q: How many times a year on average are you
		[2] requested and or retained to be a medical expert in
: Have you written an article on the use of		[3] cases involving medical malpractice?
coagulants for the treatment of acute systemic		[4] A: Well, that's changing over time. There was a
ke within the last three or four years?		^[5] time when I never had any and in the early '70's some
A: Well, that would be my textbook which I've		[6] were sent up from Florida and mow in the mid '90's, it
lated to the year 1999.		[7] may be as many as one a month to review but not
2: That's the Cerebral Vascular Disease?		[8] specifically render an opinion. In other words, I'm
Yes.		[9] willing to look at people's summaries or brief
2: And, Doctor, in that textbook are there		ing summations of records to see if I have skills that
pters that deal with TIA's, the treatment and		in relate to the problem.
nagement of TIA's?		12] Q: So you may get requests once a month and how
A: Yes, there are.		13] often — let's say going into 1998 and 1999, how many
: Is there a chapter on cerebral infarctions?		 14] cases per year are you actually retained as an expert? 15] 8: I would think maybe six or seven.
A: Yes.		
2: Is there a chapter, also, on cardiac bolisms?		16] Q: Would it be fair to say that the majority of 17] the cases that you review are on behalf of physicians
A: There is.		(a) that are named as defendants?
a : Doctor, have you ever been named as a		A: No, <i>if</i> anything, I'm asked to review more of
endant in a medical malpractice lawsuit?		20) thereverse.
Ar. Frasure: Objection but you may answer.		(9) Do you know percentage-wisebased on looking
The Witness: Yes.		22] back over the fast five years?
By Mr. Cowan:		A: Within the past year — I had my secretary
2: How many times?		24] Look it up and she said it's sixty/forty, more for the
A: Once.		25] defendant physician group than for the plaintiff.
		Page 1
2: And how long ago was that?	Page 12	
A: Mid 1970's.		[1] Mr. Frasure: Sixty/forty for the defendant
a : And in a nutshell, what type of case was it?		
		[3] The Witness: The defendant, €or the doctor; [4] that's not a bias on my part. That's the way it
at were the plaintiffs claiming in that case?		[5] breaks.
A: They were claiming conspiracy. A group of		
visicians in this institution conspired not to tell		
the truth about a hairline fracture in her back		[7] IR. Mr. Ernourou In the last year he said
t another physician found and that we were doing		[8] Mr. Frasure: In the last year he said.
t in order to prevent her from collecting		[9] By Mr. Cowan:
ability.		10] Q: Doctor, have you reviewed cases on behalf of
2: Were you a consultant in that case?		11) doctors who have retained the law firm of Buckingham h_{p}
A: I was.		12] Doolittle?
2: I gather the case was probably thrown out		13] A: Do you mean this group?
on		 Q: Yes. A: Mr. Banas and I have worked together once,
A: It went all the way to the Court of Appeals		 [5] A. Mr. Ballas and I have worked together once, [6] twice, previously, yes.
I then North Carolina Supreme Court.		
2: And what was the outcome?		17] Q: How many times have you had cases where Mr. 18] Banas's law firm had retained you?
A: The young lady defended her own case and got		A last I generate in trying before this
If the way to the top and it was thrown out.		
2: Doctor —		(0) One.
A: She pled her own case.		21] Q: Can you recall what years?
2: Without a lawyer?		2] A: No, I can't.
A: Without a lawyer.		(3) Q: Would they have been in the last — in the
2: Did she win at the trial level?		34] 1990's? Would that be safe to say?
A: Yes, they split. It was a curious case if		A: Well, whether it's late '80's or early '90's,
	Page 13	Page 1
I'd like to hear it. The jury hung the Erst time.		[1] I can't split the difference, but that's what it was.
e - it was retried and didn't reach $-$ so she took		[2] Q: Can you recall what type of cases? Were they
the Court of Appeals. The Court of Appeals		[3] stroke cases?
t; therefore, it went to the Supreme Court and she		[4] A: No, I can't.
s getting her day in court more than she was getting		[5] Q: Have you ever been retained by Mr. Frasure to
nething else.		[6] be an expert on a case?
2 : She didn't have to pay an attorney either.		A: He suggested I have not. I don't remember.
4: I think so, maybe. I don't know.		[8] Q: You don't recall; any other attorney at
2 : Doctor, do you review medical negligence		[9] Buckingham Doolittle than Gary Banas?
es as an expert witness?		A: How many other names are on there! I don't
A: If they're within my area of expertise, yes.		1) how.
2: And do you advertise your service in any		^{2]} Mr. Frasure: Lee Bell, Jeff Schoburt
rnals?		3] The Witness: None of those names mean
A: No.		4 anything to me, so I don't know. Those people I can be
1: Have you ever been listed as a reviewer or		5) reasonably certain I've never been.
pert Grany expert service to review medical-legal		6] By Mr. Cowan:
es?		7 Q: How many times a year do you have you
		aj deposition taken as an expert?Im just asking ⊕r an
A: For about two years an outfit in		9] average.
A: For about two years an outfit in ladelphia, it was said to be jointly operated by		oj A: Six, seven.
	1	
ladelphia, it was said to be jointly operated by		11 Q : Have you ever testified live at a medical
ladelphia, it was said to be jointly operated by visicians and attorneys to settle malpractice cases of court but might have been a <i>sham</i> for all I know.		1] Q: Have you ever testified live at a medical 2] malpractice trial?
ladelphia, it was said to be jointly operated by sciences and attorneys to settle malpractice cases		2] malpractice trial? 3] A: Several times, yes.
ladelphia, it was said to be jointly operated by visicians and attorneys to settle malpractice cases of court but might have been a <i>sham</i> for all I know. I was listed for about two years and have never		2) malpractice trial?

	Page 17		The second s	Page 2
A: Yes.			the way you're doing it is better. What records did	
Q : The cases that actually go to trial, can you			you receive — I know there are some records you just	
recall if that was primarily for the defense of a			recently received which was the family doctor. When you did the drafting of your report, what records did	
doctor or for — as an expert for the plaintiff? Mr. Frasure: Those he's testified live at			you have at that time?	
trial?		[0] 101	A: At that time it came in piece mill, so it's	
Mr. Cowan: Yes, correct.			not all in a big bunch of records from the beginning.	
The Witness: The most recent one was for		181	Q: I thirk you list them in your report. Let me	
the plaintiff in Georgia.		[9]	just quickly go through them. You had the med center	
By Mr. Cowan:	r		hospital records for the three days?	
Q: And how long ago was that?		[11]	Â' Right.	
A: Better part of eight months.	1	[12]	Q: You had some records from Wyandot Memorial	
Q: And if you just briefly explain what the fact			Hospital; you had the Riverside Methodist Hospital	
pattern in that case was?			necropsy report; you had the CAT scans of the brain,	
A: Seemed to have been a lack of diagnosis of			the MRI of the brain and the carotid ultrasound, is	
systemic attacks and a diagnosis of seizure disorder		• •	that correct?	
was made and the doctor was being sued by his patient	1	[17]	A: Yes, and then down below I said I've had	
who then had a stroke.			letters.	
Q : And on that you were retained by the		[19]	Q: You received the letters — Mr. Frasure: He's just asking about	
plaintiffs law firm?		[20]		
A: I was.			records. The Witness: Oh, excuse me; oh, yes, sorry,	
Q: Do you recall the name of the law firm?		[22]		
A: Kellogg and something. Q: And where are they located?		[24]	yes. By Mr. Cowan:	
And where are they located? A: Atlanta, Georgia.		[25]	Q: Then you also received the two expert reports	
	Page 18	[∠ 3]	=. Then you also received the CHO expert reports	Page2
Q: Do you remember — do you actually — can you	l age 10	m	from Dr. Gelbloom and one from Dr. Gedousky and then	ruger
recall the name of the attorney from Kellogg's office?			you received the &position transcripts of the nurses?	
A: No.		[3]	A: Right.	
Q: Doctor, what is your rate for videotape		[4]	Q: Did you also receive the transcripts of Dr.	
testimony for trial?		[5]	Giri and Dr. Thompson?	
A: It doesn't change, the \$600 per hour during		[6]	A: Yes, and I neglected to include that in my	
the week and double that during the weekends.		[7]	letter, but I did see them.	
Q: And what is your rate if you have to fly into		[8]	Q: And then recently you received copies of Dr.	
a place for live testimony?		[9]	Thurton's records?	
A: Same rate, but I start the clock at the		{10}	A: Thornton, yes.	
moment I leave the town until I get back except for		[11]	Mr. Frasure: Yes, I showed them to you	
eight hours of sleep at night.			today.	
Q: A rough guess, if you have to fly into		[13]	The Witness: I don'thave them. I have nor	
Columbus, Ohio in the morning and back by the end of		[14]	received them. I read them, but I should have them, I	
the day, would that be around \$3,000 or \$4,000?			guess.	
A: Weil the day began at 6:00 in the morning		[16]	Mr. Cowan: And I guess in the package is also some of the Smith Clinic records which are related	
and ended at 6:00 at night that would be twelve hours			to the cardiology department is that safe to say?	
times \$600.		[10] [19]	Mr. Frasure: Sure.	
Q: Doctor, do you know any of the defendants;		[20]	The Witness: Smith Clinic — I don't	
this Dr. Giri or Dr. Thompson personally?			know -	
A: No, I don't. Q: Doctor, do you know Dr. Jeff Gelbloom who is		[22]	Mr. Fra sure: That's where Giri and Thompson	
Q: Doctor, do you know Dr. Jen Gelbloom who is the plaintiff's expert neurologist in this case?			practice.	
A: No, I don't.		[24]	The Witness: I see.	
Q: Doctor, what percentage of your income is		[25]	By Mr. Cowan:	
	Page 19	-		Page 2
derived from being an expert witness?		111	Q : Are there any records <i>that</i> you've received	r uge L
A: I'venever added it up, but if last year was		[1] [2]	that we haven't mentioned?	
		[3]	Mr. Frasure: I don't thirk so.	
ignear, it would be about one-status, someting like			The Witness: The stress test?	
		(**)	Mr. Cowan: I think that's also filed in	
typical, it would be about one-sixth, something like that, not as much as a quarter working backwards. Q : So you think about one-sixth of your income		[4] [5]		
that, not as much as a quarter working backwards. Q : So you think about one-sixth of your income		[5]	the cardiology stuff.	
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		Page 23		Page 26
(1) [2]	who made corrections and then you made corrections? A: No.		 Q: Doctor, is it safe to say that your opinions today will be limited to your areas of specialty? 	
[3]	Q : Doctor, how many hours have you spent on this		 [3] A: Yes. [4] Q: Doctor, after reading your expert report, 	
	case including reviewing the records, drafting of your report and the conferences with the defense counsel?		[5] would it be fair to say that one of your opinions in	
[6]	A: My secretary would have that precisely but -		[6] this case is that Dr. Giri and Dr. Thompson's diagnosis	
[7]	Mr. Frasure: Approximate, Doctor, as best		[7] of seizure disorder on October 29th, 1996 with Todd's	
[8]	you can.		[8] paralysis was a reasonable one?	
[9]	By Mr. Cowan:		[9] A: In my opinion it was reasonable to assume	
[10]	Q: Is it possible you could provide me with a		0] that.	
	breakdown?		11] Q: Doctor, <i>can</i> you tell me why, from your view 12] of the records, why you think that is a reasonable	
[12]	A: Well, I'm looking right now, Here's the only — I have two charges, one for five hours and one for		13] differential diagnosis to have the seizure disorder	
[13] [14]	twenty minutes.		14] with Todd's paralysis?	
[15]	Q: So as of today, prior to the conference you		A: When dealing with an emergency room patient,	
	had with Mr. Frasure, it's been five hours reviewing		16] who can't give you a history, who is found - one with	
	plus another twenty minutes?		[7] evidence of a bruise or something on the chest	
[18]	A: Unless I forgot to add it up which is		18] indicating injury, in someone who's taking an	
	conceivable; sometimes I simply tell my secretary —		19] anticonvulsive, a logical physician would think this	
	let's say this letter, if I dictated the letter and I		20] person had a seizure and he's on anticonvulsants for	
	said it took me forty-five minutes, I'd say charge		21] that reason. It is very common to have injury in a 22] convulsion, unusual to have it in a stroke . Most	
[22]	forty-five, so I wouldn't have it written. Anyway, the answer seems to be that it's five or six hours.		23] strokes don't begin as rapidly and instantaneous. They	
[24]	Q: And have you been paid by defense counsel?		24] evolve over time. Therefore, the person first gets	
[25]	A: To be quite honest, I don'tknow. I trust		25] weak, perhaps in a leg or arm and then over time	
<u> </u>		Page 24		Page 27
[1]	him so far.		[1] develops what we call evolving stroke. The only one	
[2]	Q: He's a trustworthy person. Doctor, have you		[2] that presents with a sudden instantaneous ictus from	
[3]	spoken with any of the defendants, Dr. Giri. or Dr.		[3] which you might fall and injure yourself is a	
	Thompson? A: No, I have not.		[4] hemorrhage. So within the differential diagnosis in [5] this patient would be a hemorrhage into the head with a	
[5] [6]	Q: Doctor, did you review any medical textbooks		[6] convulsion or some loss of consciousness or a	
	including your own prior to this deposition?		[7] convulsion with a sudden fall to the floor and self	
[8]	A: I did.		[8] injury and that the loss of consciousness with the	
[9]	Q: Okay, are there any articles or journals in		[9] gradual recovery is typical for the seizure, not	
[10]			in typical for a stroke; that if one is going to have a	
[11]	issues that are involved in this case?		In sudden massive cerebral infarction, one is going to	
[12]	A: I think what I'm — the literature there's a		12) have it. The chances are they would not specifically 13) lose consciousness from the beginning. The other	
	regard to the differential diagnosis of stroke so that I reviewed my own book to be sure that what I recollect		[4] compelling thing that I didn't see until today but	
	from having read and written is, in fact, what I		15] which is — adds substance to what I've been saying is	
	believe today.		16] this man was said by his parents to have episodes of	
[17]	Q: Is your textbook, Cerebral Vascular Diseases,		right-sided events, call it what you will, and that on	
	is that a fairly reliable text as it concerns the up-		18] a previous occasion he'd been walking out and he had a	
	to-date studies that have been going on in this area?	010	19] sudden loss of consciousness and confusion. This kind	
[20]	A: I'd like to believe that it is, but I have to	Knor	20] of recurrent loss of consciousnessis not vascular.	
	admit that a few cases have taken positions on topics that others don't agree with because I believe that	00	 21] It's seizures. 22] Q: Doctor, do you think that when he first came 	
	what I have to say is the correct way rather than	Norl	23] into the emergency room that a TIA should have been	
	simply say some do this and others do that and some		24] part of the differential diagnosis?	
	don't do either one. In other words, it's not a	OSW	A: I spent many years laking care of this	
<u> </u>		Page 25		Page 28
	summarization of everybody's literature. It's a	Mal	[1] particular thing. This is what I consider to be my own	
	summarization of my own personal experience and	Schul	[2] area of extra special skill, above which I was	
	beliefs.		[3] referring having written a chapter which deals with	
[4]	Q : So it would be fair to say that your textbook wouldn't be deemed to be as authoritative in the		[4] views which I think are as good as anyone's, if not [5] better, and I have yet to see a loss of consciousness	
[0] [6]	general field of neurology or cerebral vascular		61 of an abrupt nature with injury from what's called a	
[0]	disease?		[7] TIA. It just doesn'thappen.	D.L.L
[8]	A: No, I think it's more authoritative, because		[8] Q: Doctor, would you agree with me that Dilantin [9] can be used for treatment of other disorders and not	Dilart
[9]	I'vehad fifty years of experience in the field.		[9] can be used for treatment of other disorders and not \checkmark	
[10]	Q : Now there are other textbooks that are out		10] Just as anticonversion	
	there. Can you list one or two other ones that are		A: Rarely, yes; everything from cardiac	
[12]			 disrhythmia to peripheral neuropathy for pain. Q: Doctor, were you aware - I b o w you just got 	
[13]	A: Yes, there's one by Barnett, Stein, Yatsu and Moore. There's the one that I edited, the Handbook of		14] the records today that he was — that John Martin was	
	Clinical Neurology with chapters by people from all		(5) treated for a neuropathy —	
	over the world which would probably be the ultimate		A: I was just told that, but I don't see any	
[17]	reference source until recently. There's one by		17] evidence that he had one. It wasn't well documented.	
[18]	Kaplan, Louis Kaplan.		18] Neuropathy as a rule means lower extremities and lower	
[19]	Q: Is that with a K?		19] extremity means absence of ankle jerks.	
[20]	A: K-A-P-L-A-N.		20] Q: What about peripheral neuritis, what is	
[21]	Q : What about the Victor one?		21) peripheral neuritis? A^{*} It just means the peripheral nerve is	
[22]	A: Victor one is pretty good, but he and Adams are not — they are part of Harrison's textbook which		22 A: It just means the peripheral nerve is 23 inflamed.	
[23] [24]	is used mostly by generalists and neither one of them		Q: Were you aware -	
[25]			A: Any one, there are hundreds of nerves.	
• •	-		•	

Q: Were you aware that he was diagnosed by his	[1] get a CAT scanto see if I canfind a focal underlying
mily doctor with peripheral neuritis in his hand?	[2] legion, and with a little more leisure, I'd get an EEG.
A: I just was told that today and who would have	[3] Q: Now if the CAT scan comes back negative, what
uessed that? It is not usual and customary to treat	[4] does that tell you or rule out?
ne neuritis in the hand with an articonvulsive.	[5] A: Generally hemorrhage but it doesn'trule out
Q: Can Dilantin be used for people with pain $\sqrt{2}$, $\sqrt{2}$	[6] a scar or an AV malformation unless it's a big AV
sorders and migraine headaches?	[7] malformation.
A: Yes, it can. Does it work?	[8] Q: Now you mentioned that you would order an
Q: Does it work?	(9) EEG. And what are you looking for in the EEG?
A: Not well.	10] A: Well, you look for evidence of a — either a
Q: Can Dilantin be prescribed for patients with	11] hyper or hypo increased or decreased electrical
eripheral neuritis?	12] activity. Foilowing a seizure with using what I
A: Usually of the lower extremity and usually	13] mentioned earlier, it's called the exhaustion, the EEG
or pain; there are several forms of peripheral	[4] may be abnormal at flat or slow and around it. If the
euritis. One is a pain syndrome. Another one is a	15] person is still ictus or having more seizures it would 16] be spikes .
reakness syndrome and a third is an autonomic	
ympatheticparasympathetic fiber, vascular problem.	
lost neuritides are for the lower extremities and	is] basis, from your years of practice, what kind of time
hat's interesting to me having just read this is	[19] frame are we looking at from the time you order an EEG
omeone diagnosed him as having gout. I didn't see	30] stat? Is it two hours, four hours that you would
hat sustained anywhere. Gout is a syndrome which can	21] expect to get the results back?
e misdiagnosed and can be called neuropathy.	A: EEG depends. They are usually scheduled and
Q : Do physicians give Dilantin for gout or is	23] not everybody has the capacity to do portables. If
nat—	24] this person is still in dire straits, you defer the EEG
A: That would be news to me. I don't know.	251. until they stabilize their breathing, their level of
Page 3	
Q : Is hemiparesis a common symptom of a seizure	[1] consciousness, et cetera.
isorder with Todd's paralysis?	Q: Let's say that the patient is stable.
A: That definition would mean a focal motor	(3) A: Okay, and does the hospital have a portable
eizure in the motor strip of the opposite hemisphere	[4] EEG that they can take different places?
nd if one has a legion in the appropriate place	[5] G: Yes. [6] A. Then I'd say within two hours.
nearing anything from a neoplasm to an arterial venous	
alve formation or scar or head injury, whatever,	[7] G: Now going back to a diagnosis of the seizure
odd's paralysis is a common event for focal motor	[8] disorder with Todd'sparalysis, after doing the EEG and
eizure, but it is not a common event for convulsion	[9] let's say the EEG comes back normal, are there any
er se.	10] other tests that you would do to rule out the Todd's
Q: Is a left eye deviation a common symptom of a	11) paralysis or a seizure disorder?Let's say your
eizure disorder?	[2] diagnosis is turning out to be incorrect; is there some
A: In a postductal state, yes; in a focal	(3) test that will tell you that this person doesn'thave a
eizure; you keep having to say focal. Now what this	14] seizure disorder with Todd's paralysis?15] A: No.
heans is you begin with a focal abnormality due to one	
lace in the brain that starts firing off and once that	[6] Q: Doctor, is it fair to say that a seizure or [7] focal convulsion is accompanied by a short-lived focal
res often enough, it is called exhausts the opposite	18] neurological deficit which can simulate a TIA?
art of the body which is $-$ once that happens the	19] A: It can and within the subtlety of the
rain sometimes has what's called a generalized	3) difference, generally ninety percent probably of
onvulsion. In other words it spreads from focal to	1] patients who have a TIA simply have a loss of use, ten
eneralized which causes a convulsion and the person	2] percent have a focal convulsive sort of movement; limbs
wakens from that confused, unable to respond and	2] percent have a rocal conversive soft of movement, minos 23] shaking TIA's.
aralyzed in the area of the brain where the seizures	
egan. That becomes a localizing sign and symptom and	[24] Q: Now with the seizure disorder, isn't the [35] actual neurological deficit short-lived? There's a
hat's what is called a Todd's paralysis.	
Page 3	Page 3 [1] time where that deficit is going to end?
Q: Doctor, would it be important to you that	
ohn'sparents told the ER physician that they were	[2] A: Well, they usually say upwards of twenty-four [3] hours before Todd's — in the flagrant cases, you've, [4] get twenty four hours in which to wait before the
naware that their son had a seizure disorder?	
	M got twenty four hours in which to weit hefore the
A: No, the reason <i>is</i> most thirty year old people	[4] got twenty-four nours in which to wait before the
on't tell their parents anything, so it has nothing to	[5] Todd'sparalysis clears.
on't tell their parents anything , so it has nothing to o with anyone. It's just that adults take care of	 [5] Todd's paralysis clears. [6] Q: Would it be fair to say, then, if the
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		1		
[1]	A: I would eliminate it. I'd put it down at the	m	Mr. Cowan: In the case of John Martin. 🛛 🙀	Page 38
	five percent level.	[2]	The Witness: Yes.	
[3]	Q: What, at that point in time, in the case of	[3]	By Mr. Cowan:	
[4]	John Martin, what would be your number 1 on your	[4]	Q: And you realize that in this case they were	
[5]	differential diagnosis after the first twenty-four		not ordered until the third day which would have been	
	hours assuming the EEG came back normal, CAT scan		October 31st? A: All right.	
	negative? A: If he's not recovering, you mean?	[7] [8]	Q: Going back to the — you're aware that the	
[8] [9]	Q: Right, and the deficit continues.	[9]	1 a . 11 f	
[10]	A: I would say it's an established stroke		activated a partial thromboplastin?	
	infarction.	[11]	A: Yes.	
[12]	Q: Doctor, I'd like to ask you some questions	[12]	Q: Why would the emergency room doctor — or	
	about John Martin and in these questions I want you to	[13]		
	assume that a diagnosis for TIA or acute CVA is	[14]	show you the test results. The prothrombin is a 13 and	
	diagnosed on the morning and afternoon of October 29,	[15]	I gather beside it is the normal range?	
	1996. That's the first day. So I want you to exclude	[16]	A: Yes, that's normal.	
	the seizure disorder and this is just a hypothetical	[17]	Q : And the second line, is that the —	
	question. Assuming that you've diagnosed or your	[18]	A: Partial thromboplastin.	
	differential diagnosis is TIA, what would your initial evaluation consist of?What type of tests would you	[19]	Q: which falls within — A: The normal range right	OI
	order?	[20]	A: The normal range, right. Q: And the reason the emergency room physician $\sqrt{2}$	Hota
[22]	Mr. Frasure: You're not including seizure?	[21]		110 0
[23]	Mr. Cowan: This is a hypothetical, right.	[23]		
	Let's say you have a diagnosis of TIA versus possible	[24]		
	acute CVÁ.	[25]	Q: And would these results be in the range	
	Page 36			Page 39
[1]	The Witness: All right, by definition which	[1]	whereby one could use anticoagulants?	-
[2]	is somewhat obsolete but still commonly used, a TIA can	[2]	A: That's right. They could be.	
[3]	last for twenty-four hours, twenty-three hours and	[3]	Q: And these ranges would show at least from	l
[4]	fifty-nine minutes and fifty-nine seconds. If it goes	[4]		
[5]	one second beyond, it is now called a stroke. That's	[5]		
	artificial obsolete and useless, but let's just say	[6]	A: That's true.	
	this man was in the first four hours of his event.		Q: On the emergency room physician when you took	
[8]	It's very easy to call this — except for the loss of	[8]	the second se	
	consciousness and the self-injury and the extreme		99 with the range here being 70 to 110. Do you find that glucose level to be a little on the high side?	
	repetitive of its onset, it is more likely to have been	[11]	• T	
	a hemorrhage but he got a CT and it was negative. Now	[12]	Q: So that wouldn't concern you?	
	a man who is recovering some consciousness but not fully recovered, the next move would be to get an	[13]		
	ultrasound of the neck, to see if there's some legion	[14]		
	there that could have caused an unusual event, and an		let's say after the twenty-four hour time period, where	
	echocardiogram to see if, per chance, he had some		you've ruled out the Todd's paralysis, would you order	
[17]	legion that might have caused an embolus.	[17]	- you mentioned the ultrasound. Would you also order	
[18]	Q: What about the prothrombin times, would you		the MRI at that point in time or would you order an MRI	
[19]	have ordered that immediately?	1	within the first twenty-four hour time period?	
[20]	A: No, I think a pro time has to be predicated	[20]	A: MRI in the presence of a negative CT is an	
	on the fact that you want to use anticoagulants and I		elective procedure. I think that if that CT had been	
	still think it's — given as it was, finding him	1	showing something or read as being taps abnormal, you'd	
[23]	unconscious on the floor or seemingly unconscious, that is not the usual or customary for a stroke and pro time		get an MRI. I think that an MRI is an expensive test that you get in order to institute a therapy and you	
	wouldn't have been one of the high level things I would		don't get it simply for curiosity and I think that an	/
	Page 37		don't get it shipty for earrostly and i dhink that an	Page 40
m	have ordered. Ne was already on Persantine which if	[ft]	MRI while you're observing a patient because you think	ago to
	you're thinking of anticoagulant type things,		he has a Todd'sparalysis isn'tnecessary. If after	14
L1	Persantine is an appropriate medication for that. I		the twenty-four hours you think that something else is	/ ×
[4]	would say that he would have had a need for a		the etiology, certainly you should get an MRI.	J NR
	differential diagnosis. You still haven't proved he -	[5]	Q: And you'reaware in this case that the MRI	1110
	if you rule out a seizure, you haven't proved what it		was ordered on the third day and not on the second day?	
	is. You've ruled out one thing, but you haven'tsaid	[7]	A: Yes.	
	what it is. You said it isn't something, not what it	[8]	Q: I know in your report you discuss the	
	is and I stick to the idea that it's — no way in less		findings of the CAT scan report of October 29, 1996.	
[io]	than twenty-four hours could you have said it wasn't a	[10]		
	Todd's paraiysis. Now let's say the twenty-four hours	[11]	Q : And you state that the <i>CT</i> is of marginal	
[12]	has gone by and it's not a Todd's paralysis, what else		quality and suggests the possibility of edema of a	
14.45	is it? Knowing what the answer 15, it makes it easy.		diffuse nature. Is that — that's what you said in	
	He obviously threw a blood <i>clot</i> but at that time how would one have diagnosed that blood clot in his carotid	[14]	your report? A. That's what I said.	
	would one have diagnosed that blood clot in his carotid ultrasound would have been — what I always get now	[16]	Q: Okay, dc you disagree with the radiologist's	
	because it's a common problem and it's a major problem.	1	findings?	
	Echocardiogram carotid ultrasound is in the	[18]	A: No, I'm not a radiologist. I'd take it to a	
	differential diagnosis of any prolonged loss of use of		radiologist and say what do you think. I never put	
			myself up against a radiologist and say this is what it	
[21]			is and you're wrong. I believe it's often appropriate	
	ultrasound of the carotids and the echocardiogram after		to coder with the radiologist when you suspect	
	that twenty-four hour time period?	[23]	something, get them to give a final opinion.	
[24]	Mr. Frasure: Which case are we talking	[24]	Q: Can you state with a reasonable degree of	
[25]	about?We're jumping back and forth.	[25]	medical certainty that there was evidence of hemorrhage	

	Page 41	1-1		Page 44
(1)	or edema on that file of October 29, 1996?	(1)	Mr. Frasure: Let me just object. I'm not	
[2]	The Witness: No.		sure he said that but for clarification.	
[3]	Mr. Frasure: The test is reasonable medical	[3]	The Witness: The answer is no and the	
[4]	probability, not certainty, more likely than not, so I	[4]	reason it's no is that the horse is out of the barn.	
	object to the form of the question.	151	Heparin is used while it's evolving, not after it's	
[6]	The Witness: I cannot. I'm not an expert		fixed. And there's a big distinction that many people	
[7]	in that field.	Yn	have not yet made regarding the use of anticoagulants.	
[8]	By Mr. Cowan:	(18)	You can use TPA to dissolve a clot. That means a	
[9]	Q: Now, Doctor, assuming for this next set of	[9]	stroke is evolving. Heparin does not dissolve	
[10]	questions I'm going to ask you - on October 29, 1996,	[10]	anything. It doesn't restore anything. It simply	
	let's say you've got a diagnosis of an systemic stroke;	[11]	keeps more clots from forming.	
[12]	the CAT scan of the brain is negative; you have a	[12]	By Mr. Cowan:	
[13]	thirty-nine year old male, 315 pounds; he cannot speak;	[13]	Q: Now, Doctor, if you've — at a certain point	
	he obeys commands; he's got right hand-paresis; now		in time can't rule out the actual origination of the	
	let's say in this hypothetical, the emergency room		stroke and let's say at a point in time you think	
[16]	physician hands it over to you for neurological		there's a cardiac involvement that maybe this is a	
[17]	consult. What neuro — and this is ruling out the		cardiac embolism, would you at that point give a	
[18]	Todd's paralysis — a case with no Todd's paralysis,	1	patient Heparin to stop secondary emboli from —	
	what neuropharmacology therapies would you order, if	[19]	A: Well, I was under the impression that this	
	any?		man had had echocardiogramswhich never showed any	
[21]	Mr. Frasure: You're asking him to assume		source for an embolism. One doctor said he might have	
	there's no Todd's paralysis initially?		had mild mitro regurgitation, mitro insufficiency, so	
[23]	By Mr. Cowan:		to speak, but he d had a full work-up and he didn't	
[24]	Q: Correct, so your differential diagnosis in		have evidence of cardiac abnormalities.	
[25]	this hypothetical is one of a TIA then, or a stroke.	[25]	Q: Doctor, are you aware that — d the	De 40
	Page 42			Page 45
্যা	A: Another person, not this one?	SJ	suboptimal quality of the echocardiogram?	
[[2]	Q: Correct, right.	[2]	A: Yes, I think that a cardiologist or a person	
[3]	A: If all studies are negative, I'd personally	[3]	who is supposed to know the answers is willing to write	
[4]	use anticoagulants and Heparin. Now remember, this man		off someone and say they don't have cardiac disease,	
[5]	was found unconscious or lack of any — unable to		you take their word for it.	
[6]	express when it began. He was not observed so, of	[6]		
KИ	course, he cannot be eligible for TPA which one of the	1 2 7	bat please note the technical quality of the	
	physicians had suggested and I think that would have		echocardiogram is suboptimal because of the poor acoustic window —	
	been blatantly wrong, so then we get to the next level	18	Mr. Frasure: What is the date on that?	
	which is would Heparin been possibly used and the answer is yes.	[10]	Mr. Cowan: 10/30/96, the second day.	
	Q: Now why in this hypothetical you would use	/ [[11] [[12]	Mr. Frasure: Okay.	
[12]	anticoagulants versus the case with John Martin with	[13]	By Mr. Cowan:	
	the diagnosis of the seizure disorder? Is it because	[14]	Q: — and the fact that the patient is sub —	
	the anticoagulant could have a disastrous effect if	[15]	A: Well, the horse is out of the barn and I	
	somebody has a seizure?	1 .	don't think an echo done after he's had all these	
[17]	A: That's exactly-true.	1	things is useful. What is useful is before he had it	
[18]	Q: And what could that do if you give somebody		and he had a full cardiac work-up less than a month	
	who has a seizure disorder anticoagulants? What would	1	before the ictus and one would assume that if it was	
	happen?	1	negative, then it was negative then. I mean, if it was	
[21]	A: Well, first of all, Heparin without any		negative at the beginning, it would be negative - not	
	trauma or seizure or any other kind of event can cause		enough time had elapsed for there to have been a	
	bleeding of internal organs and even of the brain.		change.	
	When one has a seizure, not only does one thrash about	[24]	Q: Doctor, if you thought — if there was a	
	uncontrollably, but often they have to be restrained.		possibility that the origin of the thrombus was	
<u>`</u>	Page 43	-		Page 46
[1]	For example, you put something in their mouth so they	[1]	cardiac, would you have ordered a transesophageal	0
	won't bite their tongue, but if they bit their tongue		cardiogram versus a normal cardiogram?	
	and they're:on Heparin, they'll just bleed to death.	[3]	A: In a semi-comatose patient?	
[4]	Now during a convulsion, the blood pressure goes up	[4]	Q: Yes.	
[5]	dramatically sometimes of f the cuff. This man was	[5]	A: No; again, it would be useless. You don't	
[6]	normal tensive. It goes up to the 300 level in the	[6]	just do dangerous things. You do something to prove	
	middle of a convulsion. That would have popped his	[7]	you should do something in response. Now after this	
[8]	cerebral vessels and made him bleed to death in the	[8]	man has a fixed neurologic deficit of the kind he had,	
[9]	brain. One does not use an anticcagulant of any sort,		the use <i>d</i> anticoagulants to prevent further emboli was	
	Heparin or any other kind, unless one is morally	[10]	pretty useless. Ne was already — unless you want to	
	certain they will not have a complication of that by	[11]	preserve the opposite hemisphere, but once the	
	some underlying problem and the underlying problem in		hemisphere is gone, you don'trestore it by preventing	
[13]	this man was likely to be seizures. If one had another	[13]	another embolus.	
[14]	problem like bleeding ulcers or bleeding polyps of the,	[14]	Q: At what point or stage would you order a	
	colon, there's all kinds of reasons not to use	[15]	cerebral arteriography?	
	anticoagulants. The most important one being Heparin	[16]	A: Never.	
[17]	has never been proved to be effective by any trial and	[17]	Q: In a patient such as John Martin, would you	
[18]	so those of us who use it are duty bound not to use it	[is]	have ordered on that second day any antiphospholipid	
[19]	if there's a reason that it might cause trouble or a	[19]	antibody study?	
[20]	likelihood that it might cause trouble.	[20]	A: Designed to do what?	
[21]	Q: Now assuming in John Martin's case after she	[21]	Q: Find out if there was a presence of any	
	twenty-four hour time period where you've essentially	[22]	antiphospholipid antibody if it's a genetic disorder.	
[23]	ruled out the seizure disorder and Todd's paralysis, in	[23]	A: In order to have done what — in ocher words,	
[24]	your own practice, would you have given this patient		I'm thinking of treatment now. Sure, I would have	
[25]	Heparin at that time?	[25]	gotten those studies in a man of that age, but how	
		1		

		Page 47			Page 50
[1]	would I have changed the course of his events?		[1]	present before it'sclinically expressed.	
[2]	Q : You yourself would have ordered those		[2]	• Q: Would an MRI, if it had been taken on day	
[3]	studies, is that correct?		[3]	two, would that show the swelling?	
[4]	A: Academically I do a lot of things.		[4]	A: Yes.	
[5]	Practically it would not have changed anything for this		[5]	Q: But unfortunately we only have day three to	
[6]	man.			look at, so you can't say for sure on day two how bad	
[7]	Q: Do you h o w if the antiphospholipid antibody			the swelling was at that time?	
[8]	testing was ever performed at Med Center Hospital?		[8]	Mr. Frasure: I'll object to "for sure".	
[9]	A: No, I don't.			The test is reasonable medical —	
[10]	O: Have you ever seen anything to indicate that		[10]	Mr. Cowan: With a reasonable degree Of	
[11]	it was?			medical certainty or probability you can't say how much	
[12]	A: No.			swelling there was in John Martin's brain on the left-	
[13]	Q: Now, Doctor, I want to assume that you've		[13]	hand side that day.	
[14]	diagnosed - let's say you've done the MRI; it shows a		[14]	The Witness: No, I can't	
[15]	middle cerebral artery thelusion; you've done the		[15]	By Mr. Cowan:	
	Doppler ultrasound that shows an inclusion in the left		[16]	Q: Doctor, is the mortality rate for patients	1. AL
	internal carotid and assuming now that we're on day two			who have had infarctions involving the middle cerebral	Nr Worth
	which is October 30th of 1996, at that point in time			artery approximately twenty percent?Does that sound	\' \
	once your MRI studies come back and the ultrasound,			right?	C. Jones
[20]	what would be the standard of care of treatment of the		[20]	Mr. Frasure: Say that again, Gary I'm	21.
[21]	patienti			SOTTY.	و معو
[22]	Mr. Frasure: This is at day two now?		[22]	By Mr. Cowan:	
[23]	Mr. Cowan: On day two, so you'vefound —		[23]	Q: What is the mortality rate for patients who	
[24]	The Witness: There are a variety of			have had infarctions involving the middle cerebral	
[25]	experimental — and this is where the medical opinion		[25]	artery?	
		Page 48		A more than the state of the st	Page 51
[1]	begins to diverge. Some would say watchful waiting.	×	(1)	A: Thirty day mortality — I think you'reabout	
	Others would say a decompression surgery to rear	11-20	[2]	right.	1 4 .
	edema.A few would say hyperbaric oxygen plus		[3]	Q: And is survival significantly better after a $1/C$	Mral b
[4]	Dexamethasone plus agents to resolve edema.		[4]	cerebral infarction than after a major hemorrhagic	have
[5]	By Mr. Cowan:			stroke?	13630107
[6]	• Would Mannitol and Decadron r lay into that?		[6]	A: No.	
[7]	A. They'd be among them.		[7]	Q : I'm just talking about survival .	
[8]	Q: Would you at this point in time refer to a		[8]	A: Let me tell you something.	
191	neurosurgical consult, I guess, with the decompression?		[9]	Q : I'm <i>talking</i> about <i>survival</i> ; mortality versus	
[10]	A: It would have been what I would do if the			morbidity here. I don't want to trick you.	
	family wanted me to and, again , this now gets into the		[11]	A: No, you're not and I'm not being tricky, but	
	ethics and the right to life and a variety of areas			when you just generalize and say all hemorrhages and	
	that are personal and I don't know whether this man had			all infarcts, you can't do that. You're talking middle	
	a living will or not, for example, and I think when a			cerebral?	
	person is so badly disabled at that age, one sometimes		[15]	Q: Middle cerebral artery.	
[1	makes very difficult decisions. I don't think there		[16]	A: Versus <i>what</i> kind of a hemorrhage?	
	was any way to restore him to function, although there		[17]	Q: Just a hemorrhage in the cerebellum or	
	might have been capacity to keep him alive, but whether			something, in that area.	
	one wants to live a hemiplegic in aphasia for the next		[19]	A: And the question is again?	
	thirty years of one's life is a matter of different		[20]	Q: When has a better rate of survival if it's a	
[21]	choices than I'm prepared to discuss.			hemorrhagic stroke in that area or a systemic stroke?	
[22]	Q : Doctor, would you have intubated that		[22]	A: Depends on the size; I can'tanswer your	
	patient? Let's say on — this is hypothetical.			question. I'm sorry.	•
[24]	A: It depends on how he's breathing; not		[24]	Q: Can you tell me from your own experience, do	
[25]	everybody that is hemiplegic has trouble breathing but	_	[25]	younger patients do better surviving middle cerebral	and the second s
		Page 49			-"Page 52"
	at his weight, 315, if he had labored breathing and his			artery strokes than older patients?	
	tongue fell back, which I don't how, yes.		[2]	A: All things being equal they can tolerate bed	
[3]	Q: And would you order the Mannitol or —			rest longer but this particular man at 315 pounds is	
[4]	A: If the family — again, I had to step back			not a typical young man. He's an abnormal man who was	
	one step. I would discuss it with the family and let			evidently not normal all his life from what I understand He had from Perthes discuss and staved	
	them decide or help me decide.			understand. He had Legg-Perthes disease and stayed	æ
[7]	Q : And would you order the Mannitol or Decadron			home and who knows what. Was he — I don'th o w any o	Л
[8]	to reduce the brain swelling?	1		his social background or his mental background or intellectual background and so on his discose state or	
[9]	A: Again, it depends on — it might reduce			intellectual background and so on, his disease state or	
	swelling, but it would not restore function and then			excuse me, underlying diseases. It seems strange to me	
	one has massive edema. The only thing that truly	X		that a young man such as he was going to so many	
	restores anything is to decompress which means major	R		doctors getting so many treatments for so many problems	
	surgery on the skull to remove a great big window so			without some unifying underlying disease and I was	
	the brain <i>can</i> swell out of the brain — so the brain			quite surprised he didn't have diabetes.	
	can swell out of the head. And to do that in my	1	[15]	Q: Were you surprised that he didn't have	
	impression often preserves a — someone who stays in a —			coronary artery disease ?	
	rest home in an unresponsive state for years.		[17]	A: I was shocked and also extremely surprised	
[18]	O: Doctor, do we know from the records on day			that his blood pressure is normal, so here's this obese	
	two that there was massive edema? I think the record			person, worked up with reasonably normal results by	
	would suggest that on day three his pupil had blown			good doctors who ends up having this event, unheralded.	
	out.			A month earlier he'd had a passing out spell with	
[22]	A: That's me. (1) (1) (2) $(2$	1		confusion. Anyway, he had a lot of problems.	1
[23]	Q: On day three you'd agree that there was		[23]	Q: Doctor, from your review of all the medical	1
	A: Dight new massive adams may or may not be	X		records in this case, would you <i>classify</i> Mr. Martin's	
[25]	A: Right, now massive edema may or may not be	~ }	[∠ 5]	stroke as a progressive stroke, a partial non-	

Page 53		Page 56
Page 53 [1] progressive <i>stroke</i> , or a complete stroke or is it a [2] combination? [3] A : A completed. [4] G : So the moment that he got into the emergency [5] room, it's your testimony that it was a completed [6] stroke? [7] A : Yes; within the frame of reference of what we [8] define completed as, he had a stroke; he never [9] recovered, period. Now whether it propagated distally [10] from the place where it had been initially that made [11] himhemiplegic is a matter of debate. [12] Q : Is it possible that the clot in the internal [13] carotid could Rave gone up to the middle cerebral [14] artery sometime during that time period that he was - [15] A : Conceivable; it is my belief that [16] anticoagulants would not have prevented that. [17] Q : Had John Martin been diagnosed by the end of [18] day one, let' ssay; by the end of day one, October [19] 29th, or by the morning of day two with an acute [20] systemic CVA of the middle cerebral artery and [21] thiclusion of the left internal carotid and had proper [23] support measures and neuroprotective therapies been [24] degree of medical probability as to whether John Martin [25] would have had a greater than fifty percent chance of [26] survival? I'm saying if they diagnose it now, end of	 A: Well, I'm always willing to learn from somebody that knows more than I do. I think that they'd have to explain to me how it would go backward from the left subclavian artery to the left carotid which are not necessarily — they don't come off the same place in the aortic artery, Q: So would it make more sense that the thrombus there was a thrombus on the aortic arch that would have thrown the clot to the carotid — A: And to the subclavian. Q: And that's what you think the actual — that's how it happened; is that your view? A: No, if I would — I can review it if you want the me to. The McProxy report says the aortic arch is dean, does not have athero in it which makes it strange that there should have been a primary clot in n contrast to the one in the internal carotid which was soft and easily movable, then you have an answer that suggests that it is — just a minute, let me review this. The other consideration that I put out for you is that the man Rad a pulmonary venous occlusion and that the pulmonary venous and the heart full fungs. 	Page 57
 [2] day one October 29th or early morning of October 30th. [3] Mr. Frasure: Diagnosed the completed [4] stroke? [5] Mr. Cowan: Correct. [6] The Witness: By the end of day one, meaning [7] twenty-four hours; diagnosed his complete stroke, what? [8] By Mr. Cowan: [9] Q: And had proper support measures, the ones [10] that you said you would have done and if there had been [12] than fifty percent [13] A:	 (i) fungs. (2) Q: In this autopsy, I don't believe they looked (3) at the lungs. (4) A. I don't know. (5) Q: Do you have anything — mine doesn't have (6) anything. (7) A: Well, for example the dependent portions of (8) the lower Lobes and this is the thorax — the dependent (9) portions of the lower lobes are dark bluish red; no (10) dissection of the lung we performed and the lungs are (11) left — that means they didn't remove them. (12) Q: But in the necropsy report the — I don't (13) know what page, page 2 it says thrombus occupying (14) left internal carotid extending the left middle (15) cerebral artery halfway to the point of trepidation. (16) A: Yeah, and then it says above, in the middle (17) paragraph in the middle of the middle paragraph, the 	
[1]A: No, I can't.Page 55[2]Q: Doctor, upon your review of the records and[3]the necropsy report, would you agree that the middle[4]cerebral artery clot as well as the left internal[5]carotid artery dot had a cardiac origin?[6]A: Weil, I'm looking for origin and there are[7]some individuals who have paradoxical clots,[8]particularly people who have extreme obesity. I call[9]him extreme. They have pulmonary venous thrombosis. I[10]think it strange that the chambers of the heart and[11]valves showed no evidence of clot and it's common that[12]pulmonary AV shunts or pulmonary legions per se can[13]lead to clot, embolus and that's where I would be[14]looking if I were faced with the same problem. The[15]other is, that occurred to me, that this might have[16]been an origin from the aortic arch and not from the[17]heart itself.[18]Q: Okay, so aortic arch is outside of the heart,	 (1) there's no evidence of atherosclerosis whatsoever on (2) the smooth, shiny surface; however, block in the osteal (3) left is a dot, as if it came from somewhere else, of (4) course. (5) Ey Mr. Cowan: (6) Q: That's the clot that didn't cause the (7) internal carotid or the - (8) A: It says it has a tail like elongation of one (9) centimeter in length and two millimeter in diameter (10) extending to the interior aspect of the margin of the (11) osteal left carotid artery and they're suggesting that (12) this is one dot of which it was long and part of it (13) went ineo the subclavian. That's the front of it, and (14) the back of it went into the origin of the left (15) carotid. It says there's no thrombus or narrowing of (16) the osteal of the right - which is the one that goes (17) up to the right. Clot blocks the ostium of the left (18) subclavian extends into the left subclavian for a (19) distance of seven centimeters. Then he goes further (20) and says how patient of the left common carotid and (21) internal carotid artery reveals no thrombi or (22) occlusion. Then he goes further, under examination of (23) the brain its thrombus of the left middle cerebral artery (25) halfway to the point of trepidation meaning distal 	Page 58

Page 59	Page 62
[1] carotid, I guess.	[1] he cando it. All I know is it is suboptimal and the
[2] Q: Doctor, you're not a pathologist, is that	[2] cardiologist obviously would try his best and if I were
[3] correct?	[3] the neurologist or the physician in charge, I would say
[4] A: No, I'm not but I <i>can</i> read what they say.	[4] when can you do it and make it work?
[5] Q: So do you disagree with the findings that —	15 A So you would like to get one performed, is 16 that correct?
[6] which would be on page 2 saying autopsy revealed recent	
[7] thrombosis of the aortic arch and ostium of the left	[7] A Well, if I was — thought it might make a [8] difference in what I might do I would insist on keeping
[e] subclavian artery. This site, thrombi embolus reached	
[9] the —	[9] at it until it is right. But I think when you're
A: Show me where that is, please.	10] dealing with a person who's extremely disabled you're
\mathbf{Q} : Page 2; let's go back to page 2 of the	ii) trying to preserve life at that time. I don't know
[12] document, right over here. It says autopsy revealed	12] what his condition was. Was he stable enough to
(is) recent the office and in the abrie are and ostalin a the	tal transport would be the question in my mind. I don't
[14] left subclavian artery. From this site thrombi embolus	14] know.
[15] reached the intracranial part of the left internal	is] Q: Doctor, let's say in this hypothetical there
[16] carotid and continuous left middle cerebral artery.Do	16] is a cardiac source and let's say of an embolism.
[17] you disagree with that?	17] Would the use of anticoagulants at that time be
[18] A: No, I agree with that. By thrombosis I think	18] warranted for acute cerebral systemic infarct when a
[19] he's probably meaning — I won't say what somebody	19] cardiac source of embolism is demonstrated and your CAT
(20) means, but I think if you use the word thrombus in the	20] scan had come back negative?
[21] aortic — when you say thrombosis, that means a legion	21] Mr. Frasure: You're asking to assume
[22] in there which had a thrombus occur on it. Thrombus	22] prospectively that we know there is a cardiac source of
[23] means it could have come from anyplace. But there was,	23) theemboli?
[24] of course, a thrombus in the aortic arch or ostium and	^{24]} Mr. Cowan: Correct, for hypothetical; it
[25] left subclavian.	25 doesn'thave to be in this case.
Page 60	Page63 [1] Mr. Frasure: We how that ahead of time.
[1] Q: Doctor, from your review of the records in	
[2] the necropsy report, would you agree that John Martin	
[3] did not have atherosclerosis of his coronary arteries?	[3] Mr. Frasure: You're asking would he
[4] A: I do.	[4] prescribe anticoagulants?
[5] Q: Doctor, do blood clots — do blood clot	is] By Mr.Cowan:
[6] embolisms dissolve more faster than atherothrombotic	[6] Q: Correct, if you now have tests done, you find
[7] infarctions?	[7] those thrombus somewhere on the heart, would you use
[8] A: No, the athero doesn't lice. it's there but	[8] anticoagulants at that point in time?
[9] a thrombus on it would lice at the same rate as a	[9] A: In a man that has got evidence of changing
[10] thrombus anywhere else.	101 level of consciousness it is extremely dangerous to
[11] Q: Doctor, would it be fair to say that Dr.	11] give Heparin because you convert notoriously — you
[12] Thompson on October 30th which is day two contemplated	¹²] convert embolism to hemorrhage and most people will not 13] give anticoagulants to someone who is suspected of
[13] a cardiac source and ordered an echocardiogram?	14] having a cerebral embolism from the heart at the acute
[14] A: I don't know.	15] phase of the legion if they have a disability. The
[15] Q: Do you recall he ordered an echocardiogram on	¹⁶ reason is they very frequently recanalize and bleed so
[16] October 30th, 1996?	¹⁶ hardly anybody uses anticoagulants in the hyperacute
[17] Mr. Frasure: Look at the records, Doctor.	18] phase of cerebral embolism.
[18] Mr. Cowan: October 30th around 8:30 A.M.	
[19] at the — I believe Dr. Thompson requested a cardiac	19] Q: So it's your testimony that anticoagulants
[20] consult and ordered an echocardiogram.	20] given in an acute state may cause the infarct to become
[21] The Witness: Called consult about echo to [22] Peggy in heart, SA Ballis; is that what you're talking	
[23] about? [24] By Mr. Cowan:	23] Q: But wouldn't you agree that most clinicians 24] believe that the danger of reoccurrence outweighs the
	25] risk and provided that the CAT scanshows no bleeding,
[25] Q: Correct; he testified in his deposition that Page 61	Page 64
[1] he ordered an echocardiogram.	[1] anticoagulant therapy should be initiated immediately?
 [2] A Okay, and after that cardiology says hold off [3] on cardiac work up for reasons I can'tunderstand. 	[2] A: I do not believe that and I so state in my [3] textbook and I doubt if you could find most people who
	[4] would say that. Some might but most won't.
	[5] Q : You don't think that most clinicians believe
[5] cardiologist did do the echocardiogram, You don't [6] disagree with that?	[6] that the danger of the hemorrhagic occurrence outweighs
	[7] the risk?
$\sum_{i=1}^{n} \sum_{j=1}^{n} \sum_{i=1}^{n} \sum_{i$	[8] A: No, no, you had it reversed. You told me
[e] Q: And we stated earlier that the — it was a [9] suboptimal echocardiogram.	[9] that the risk of another embolism is greater than the
[10] A : Yes.	10] risk of the hemorrhage. If that's what you said, most
	11 doctors would not believe that.
[11] G: Now if you got a suboptimal echocardiogram [12] and were informed by the cardiologist, would you redo	12] Q: Would you agree that anticoagulants may
[13] the echocardiogram and that's if you're thinking	¹² reduce recurrent embolisms by as much as seventy
[14] there's a cardiac source of the blood cloti	14) percent?
[15] M. Frasure: When are we assuming the	A: Over how much time?
[16] cardiologist is recommending it?	16] Q: I guess, let's say over twenty-four hours .
[17] By Mr. Cowan	A: No, I would not. You'retalking about now is
[18] Q : I guess in my hypothetical is the	¹⁷ preventing them over time. The embolus that's happened
[19] cardiologist comes back to you telling you that the	19] already is like you said before; the horse is out of
[20] echocardiogram is a poor quality. My question is what	¹⁹ the barn; then you close the door. It's too late. You
[21] would you do as the -	mtght after that particular event to the brain or
[22] A: I would ask the cardiologistwhat he	2] wherever else it went is over and done with, then put
[23] recommends. If he would say hold off, you can only do	2] wherever else it went is over and done with, then put 3] the person on long-term anticoagulants as I do, but
[23] recommends. If he would say hold <i>aff</i> , you can only do [24] what you can do and if he says he can't do it, he can't	 wherever else it went is over and done with, then put the person on long-term anticoagulants as I do, but during that interim between the acute event and the
[23] recommends. If he would say hold off, you can only do	2] wherever else it went is over and done with, then put 3] the person on long-term anticoagulants as I do, but

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11 reason is that the hemorrhage is so likely to happen 10<	<i>Y</i> UL 1, UUUU 10, 1777		,
 a) The first a provide the second s	p	Page 65	Page 68
 gi in the a person who had an systemic infraction and twent in the approximation in this success of the synchronic of any physical in the basel of the other of a maximum infraction and the synchronic of any physical in the synchronic of any physical in the synchronic of any physical in the synchronic of any physical intervence of a neurophysical diagnosis, when we need to be synchronic of a maximum infraction and the synchronic of a maximum infraction and maximum infraction and the sy			
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git is no a massive head. Xee just don 'to hat, above git is no harm and his is when you get hat, above git is no harm and his is when you get hat, above git is no harm and his is when you get hat, above git is no harm and his is when you get hat, above git is no harm and his is when you get hat harm and git is not harm and his is when you get hat harm and git is not harm and his is when you get hat harm and git is not harm and his is when you get hat git is not harm and has and harm	[3] take a person who had an systemic infarction and invert	[3] Q: But I'm asking if you've actually seen	
 a) and and uses found unconversions. b) and cho arb arm, and this is where you get into the general and the fact of this is the sense of the fact of the fac	[4] it to a massive bleed. You just don't do that; above		
 p) problem of harm. C) Doctor goin back to the factor of his case. f) Control to a single standard of the sing	[5] all do no harm and this is where you get into the		
c) Decreasing point place to the facts of this case. c) Decreasing point place to the facts of this case. c) Decreasing place the minition. c) A: Incipient hermition. c) Case and the minition. c) Case and what would be the appropriate standard of the minition. c) Case and what would be the appropriate standard when you reach the maintion of the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the machine are surgical documents of an anomal to second the are surgical docum	[6] problem of harm.	A: I thought it was in his local doctor's	
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(1) Care and treatment for a neurologist? (1) A Again / to whole Counsel close it with the second close it with the problem beins are an accurated in the problem beins are and accurated in the acc			
ind A Again, it's where I would counsel with the personal beliefs are adding what the personal beliefs are adding and the problem beliefs were explored and the parents want their sen to going into the beat for malf rounds 21 ying on the going into the parents want their sen to going into the beat for malf rounds 21 ying on the going into the beat for malf rounds 21 ying on the going into the beat for malf rounds 21 ying on the going into the beat for malf rounds 21 ying on the going into the beat for malf rounds 21 ying about a going into the beat for malf rounds 21 ying about a going into the beat for adding about a going into the personal beliefs were explored over the going into the malf value the heart or walk to get the remain? if a sent is to beat to bernia which means the brain in the beat of shupe? Page 80 if a sent is to beat to bernia which means the brain in the beat of shupe? Page 80 if a sent is to beat to bernia which means the brain in the beat of shupe? Page 80 if a sent is to beat to be main sevel if the similar of the brain sevel if the similar on the proved from the sevel if the similar on the sevel if the similar on the sevel is the correct? if a set is the vereas as the similar sevel is the seve senth if the seve sevel is			
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	Page 71	-		Page 74
[1]	Mr. Cowan: You're correct.	[1]	don't take care of inpatients continue to see such	
[2]	The Witness: Oh.		patients even though they are not taking care of the	
[3]	By Mr. Cowan:	[3]	patient primarily. It's a shared responsibility and in	
[4]	Q: Dr. Toole, from the review of the records, do	[4]	this case I haven't been made aware of the differential	
[5]	you <i>think</i> that the conversion disorder should have been	-5]	responsibilities of physicians at that hospital. At	
	part of the differential diagnosis on October 30th and	5 [6]	this hospital there's one doctor in charge and	
[7]	October 31st; that's day two and day three?	[7]	everybody else is a consultant. So my answer is that	
[e]	A: No, it should not have been and I think the		if Dr. Giri specifically was just a consultant, nothing	
[9]	person who said it was putting down information beyond	[9]	more, then he did okay.	
[10]	the scope of his knowledge.	[10]	G: Now let's say if Dr. Giri is — the patient	
[11]	Q: Is that the cardiologist who brought it up	- 1	is equally shared, then you do have some criticisms?	
[12]	first?	[12]	A: Well, I	
[13]	A: Yes.	[13]	Mr. Frasure: Standard of care deviations,	
[14]	Q: And conversion disorder is not a life-	14]	is that What you mean?	
	A: Well, I don't thirk it entered into the	1.	By Mr. Cowan:	
[16]		[iq	Q: Yes, if he deviated from standards of care	A 1-
	differential diagnosis and I don't think he should have	[18]	assuming that this patient is shared equally by Dr. Thompson and Dr. –	Uz Viel'
	Q: Were you aware that Dr. Thompson on October	1 -	A: Yeah, I think he would have been — well, bad	7412
[19]	31st, the last day, had requested a psychiatric	[19]	he been more alert to the inapient possibility of	LEFL
[20]	consult?	- [21]		77
	A: No, I'm not.	[22]	prophylaxis.	Y
[22]	Q: Would that surprise you?	[23]	Q: And that was on the third day then?	
[23] [24]	A: Yes.	[24]	A: I can't precisely say that.	-mt ²
	Q: Doctor, do you have any criticisms of the	[25]	Q : I thirk you've already testified your belief	
[25]	Page 72		C I Chill four four our our of the second	Page 75
[1]	emergency room physician and his care on the morning of		that the MRI and the Doppler ultrasound should have	1490 / 5
	October 29th, 1996?	121	been ordered earlier than day three, is that fair to	
[3]	A: No, I do not.		say?	-
[4]	Q: Now my final few questions I want to talk	[4]		
	about Dr. Thompson and Dr. Giri. Do you have any		as where I work that I wouldn't say that in a community	1
[6]	criticisms — let's start with Dr. Thompson, the	[6]	hospital that a think I consider to be an academic	Scillere [®]
	attending, on his care on October 29th of 1996?		exercise to prove etiology which has no therapeutic	AN IST OF
[8]	Mr. Frasure: Standard of care deviations?		implication for diagnosis would be necessary. It would	
[9]	By Mr. Cowan:		be a nice thing to have but not an essential thing to	
[10]	Q: Right, do you think he deviated with		have.	
	acceptable standards of care? This is the attending on	11]	Q: If the middle cerebral artery clot as well as	
	October -		the left internal artery clot could have been	
[13]	A: In my opinion, no.	[13]	diagnosed, let's say within the first twenty-four	
[14]	Q: What about on the second day, October 30th?		hours, would John Martin have had, with a reasonable	
[15]	A: What happens when a — two physicians — one	[15]	degree of medical probability, a better chance of	
	is a general physician and the other is a neurologist	[16]	survival than having it diagnosed on the third day,	
[17]	interact is a question as to who is in charge sometimes		October 31st?	
[18]	and I believe, if I'm correct, that the physician in	[18]	Mr. Frasure: Objection.	
	charge was Dr. Thompson and that the other doctors were	[19]	The Witness: Well, on the first day there's	
	consultants. And in that frame of reference, as	[20]	no evidence clinically or by CT of swelling of the	
	advised by others, Dr. Thompson did correctly. I find $\int_{\Omega} W(0, 1)$	[21]		
[22]	no fault.	[22]	swelling is the recanalization. In other words, if	
[23]	Q: Should Dr. Thompson have ordered the MRI on		there's no blood flowing into that part of the brain,	
	October 30th, 1996, the second day and the Doppler		it can't swell. So therefore, that's evidence that	
[25]	ultrasound?	- I	what had been blocked dff opened up and when it opens	
	Page 73			Page 76
[1]	A: In an academic medical center, I would have		up the swelling which is and/or hemorrhage. Now the	
	done that. In the practice of medicine where each test		swelling is a precursor to hemorrhage because the	
	needs to be done in order to institute a therapy for		arteries are open; the capillaries are open and they	
[4]	it, in order to get a diagnosis and start a treatment,		just allow fluid to out where they're not supposed to	
[5]	I do not believe having done those tests earlier as I	[5]	go out. The next thing that happens after that is	
	would have done would lead to a change in the treatment	[6]	hemorrhage, so that the arteries bad become	
	of the patient. Q: Would that be the same —		recanalized, the clot had dissolved or gone distally.	
[8]			At that moment in time is when the brain began to swell and the pupil began to blow and when that began to the	
[9]	A Therefore it would be an academic exercise.		and the pupil began to blow and when that happens, that	
[10]	Q: What about Dr. Giri , the neurologist, on the		becomes a medical emergency if you chose to treat the	
	second day? ^{1/4} A: Same kame.		person to whom that's happened and I don't have the answer to that part of the equation. That's up to the	
[12]			family to decide one way or the other. That's judgment	
[13]	Q: Would you have liked him to order the MRI —		calls.	
[14]	A: I would have enjoyed that, yes. I would have thought it would be a nice thing to have but it would		Q: Now let's say if on — within the first	
	thought it would be a nice thing to have, but it would not have changed the management of the patient.	15]	twenty-four hours you ordered a Doppler ultrasound of	
	Q : Do you have a criticism of Dr. Giri or the		the carctids and you found the occlusion of the left	
[17]	fact that he did not see the patient on October 30th,		internal carotid, what can be done at that time to	
	1996, the second day?	19	enhance or increase John Martin's survival?	
[20]	A: It depends on what the physician in charge	201	A: First of all, the Doppler of the neck would	
	wants. A consultant, as a rule, is not a continued		not have shown the legion of the brain and the carotid	
	second physician. Consultants are usually brought in	221	that was occluded was distal to the neck, so	
	to see the patient once and unless invited back, are	231	theoretically the ultrasound, duplex as we call it, not	
	released from obligation. Now in some places and some		Doppler would have show either an abnormality of	
[25]	times physicians who don'thave admitting privileges or		pulsation perhaps or flow. In other words, I think in	
()	k (- · · I	A A A A A A A A A A	

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 [1] this man happened is his distal carotid and the [2] siphon occluded and the neck arteries were open and [3] that seems to be the case. Now when that happened and [4] how it progressed up that artery and where it was at [5] any moment in time, nobody knows. Q: Let's say you can diagnose the clot, at [7] least, in the left internal carotid, if you can get to [9] that pretty quick, do you stop that embolism from going [9] up the middle cerebra artery? [10] A You're thinking of emergency surgery? [11] Q: I'm just saying is that a possibility? Let's [12] say within that first twenty-four hours you do a [13] Doppler or a duplex and Let's say they find the dot in [14] that carotid. [15] A: The answer is you have about three hours to [16] do that. It's just like TPA. Instead of giving TPA, [17] you take out the clot. That's very rare. It's very [18] sophisticated and never once have I done one. [19] <i>Q</i>: A neurosurgeon would do that. [20] <i>A</i> No, I mean diagnose and Rave it done. It [21] doesn' thappen. That's a theoretical, once in a [22] lifetime. [23] Q: Two more questions, is it your testimony that [24] the — do you think that the middle cerebral artery 	Page 77	Page 80 [1] <i>cf</i> Thursday, the morning of Friday, December the 3rd. [2] <i>Mr.</i> Frasure: So make room for him. That's [3] what he's saying. Get your experts off before then. [4] <i>Mr.</i> Cowan: I'll try my best; thank you, [5] Doctor, for your time here today. [6] (The proceedings were concluded.) [7] [8] [9] [10] [11] [12] [13] [14] [15] [16] [17] [18] [19] [20] [21] [22] [23] [24] [25]
 11 31st, 1996 or did the middle cerebral artery occlusion 12 happen prior to admission to the ER? 32 A: That happened when he fell out, when he lost 14 consciousness. It might have been an embolus that made 15 him have the convulsion and also produced the stroke, 16 but in thisparticular kind of event, an embolism is 17 notorious for causing a convulsion and it also 18 strengthens the Todd's paralysis, the most likely 19 etiology for the Todd's paralysis, but, again, in this 10 poor man, the event that signaled that he was sick is 11 the one that killed him. It's not the things you could 12 have done. This man had an embolism go to his brain 13 and too bad. He did what he should have done. He went 14 around to see the doctors, He was hurting in the 15 chest. He did all these different things, but it 16 didn't work and I Carnot blame the doctors at the end 17 of the train of sequences who happen to be the last 18 one of the doctors who had seen him earlier might well have been able to diagnose but didn't.Not that they 19 were below the standard, this man had a rare and 20 unusual sequence of events. I happen to think 21 unusual sequence of events. I happen to think 22 personally, nor as a testifying physician, that his 315 23 pounds of obesity and he can't breathe right, that he's 10 dotting up his lungs with clot. They're going through 21 his haert, out there and going up to his brain and you 23 weren 't going to stop this. 24 they don't have the autopsy has fully explained 25 what happened to the man. Where did the dot come 26 form? 27 G. We don' thave the autopsy of the lung. 29 A: Cowan: 20 guest, Doctor, my last question is, are you 21 guest, Doctor, my last question is, are you 23 going to testify live at	Page 78	Page 81 [1] SIGNATURE [3] I have reviewedthe precedingelighty pages, [4] which contain an accurate transcript of <i>the answers</i> [5] given by me to the questionshere in recorded. My [6] signature is subject to the corrections. [7] [8] [9] [10] James Toole, M.D. [11] [12] [13] [14] Sate of

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Pa [1] [2] NORTHCAROLINA 131 FORSYTH COUNTY [4] CERTIFICATE [5] I, David L Overby, Notary/Reporter, do [6] hereby certify that dames Toole, M.D. was duly sworn by	ge 82
[2] NORTHCAROLINA 131 FORSYTH COUNTY [4] CERTIFICATE [5] I, David L Overby, Notary/Reporter, do	
131 FORSYTH COUNTY [4] CERTIFICATE [5] I, David L Overby, Notary/Reporter, do	
[4] CERTIFICATE [5] I, David L Overby, Notary/Reporter, do	
[5] I, David L Overby, Notary/Reporter, do	
[7] Pamela S, Faucette, Notary/Reporter, prior to the	
[8] taking of the foregoing deposition; and that this	
191 deposition was taken by Pamela S. Faucette and	
[10] transcribed under my direction and that the eighty-two	
[11] pages which constitute this deposition are a true and	
[12] accurate transcript of the witness's testimony.	
131 I certify that I am not counsel for, or	
[14] employed by either party in this action, nor am	
[15] Interested in the outcome of this action.	
[16] I further certify that the stipulations	
[17] contained In this transcript were entered into by	
[18] Counsel, In my presence, before the laking of this	
[19] deposition.	
1201 IN WITNESS THEREOF, I have hereunto set my	
harm this 29th day of October, 1999.	
[22]	
[23]	
[24] DavM L Overby	
[25] Notary Public tor the	
[26] Sate of North Carolina	
[27]	
My commission expires: January 14,2003	

Num.

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