

**In The Matter Of:**

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

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

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IN THE COURT OF COMMON PLEAS  
MARION COUNTY, OHIOVirginia DeJean, Etc., )  
Plaintiff, )

V. ) Case No. 98 CV 0248

Praveen Giri, M.D., et al, )  
Defendants, )

Deposition of JAMES TOOLE, M.D.

Held at Wake Forest University School of Medicine

Winston-Salem, North Carolina

Monday, October 18, 1999

1:04 P.M.

Volume 1 of 1

Pages 1 through 82

## APPEARANCES

For the Plaintiff Wean:

Gary Cowan, Esquire

Garson &amp; Associates Co.

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Cleveland, Ohio 44113

For the Defendants GM, M.D., et al:

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## TABLE OF COMMENTS

Witness Direct Cross Redirect Recross

James Toole, M.D.

by Mr. Cowan: 4-80

EXHIBITS

Number Description Marked

No exhibits

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[1] PROCEEDINGS 1:04 P.M.

[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 best of your knowledge; is that  
[21] fair?

[22] A: That's fair.

[23] Q: If you don't understand a question, please

[24] stop me and I can rephrase it. Is that fair?

[25] A: Thank you.

<p>(1) Q: In answering the question, I will presume (2) that you understood the question that I was asking; is</p> <p>(5) Q: If you could state your full name? (6) A: James Francis Toole. (7) Q: And, Doctor, where do you presently reside? (8) A: In Winston-Salem, North Carolina at 1836</p>	<p>Page 5</p> <p>Page 8</p> <p>(4) a year.</p> <p>(9) practice?</p>
<p>(21) Ithaca, New York at Cornell? (22) A: No, that was in New York City on East 68th (23) Street, the New York Hospital. The medical school is (24) in the city. (25) Q: Oh, it is? Okay, is it still today?</p>	<p>(21) Q: Doctor, are you presently on the board of any (22) medical journals? (23) A: I'm on the board of Stroke and Cerebral (24) Vascular Disease. (25) Mr. Frasure: Is that one or two?</p>
<p>(1) A: Yes, they don't have 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 (25) would be yes, but the answer for me is no. I was</p>	<p>Page 6</p> <p>Page 9</p> <p>Mr. Co</p> <p>(8) nam (9) M (10) M</p> <p>(12) could tell you.</p> <p>(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? (25) A: Well, the fifth addition of my book Cerebral</p>
<p>(1) grandfathered in both. (2) Q: 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: I do. (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) Carolina in Chapel Hill. (20) Q: Oh, and how often do you teach at that (21) school? (22) A: They come here two or three times a year. I (23) do a seminar now and then. (24) Q: I also saw your CV that you're a visiting (25) lecturer in Law and Forensic Medicine since 1987. What</p>	<p>Page 7</p> <p>Page 10</p> <p>(1) Vascular Disorder and Eve years would take us back to (2) '93 or '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) osteemic stroke? (21) A: I have. (22) Q: And I know you've written a lot of articles. (23) How many articles have you written just on that topic? (24) A: I have no way to count. (25)</p>

<p>Page 11</p> <p>[1] handed me?</p> <p>[2] A: Yes.</p> <p>[3] Q: Have you written an article on the use of</p> <p>[4] anticoagulants for the treatment of acute systemic</p> <p>[5] stroke within the last three or four years?</p> <p>[6] A: Well, that would be my textbook which I've</p> <p>[7] updated to the year 1999.</p> <p>[8] Q: That's the Cerebral Vascular Disease?</p> <p>[9] A: Yes.</p> <p>[10] Q: And, Doctor, in that textbook are there</p> <p>[11] chapters that deal with TIA's, the treatment and</p> <p>[12] management of TIA's?</p> <p>[13] A: Yes, there are.</p> <p>[14] Q: Is there a chapter on cerebral infarctions?</p> <p>[15] A: Yes.</p> <p>[16] Q: Is there a chapter, also, on cardiac</p> <p>[17] embolisms?</p> <p>[18] A: There is.</p> <p>[19] Q: Doctor, have you ever been named as a</p> <p>[20] defendant in a medical malpractice lawsuit?</p> <p>[21] Mr. Frasure: Objection but you may answer.</p> <p>[22] The Witness: Yes.</p> <p>[23] By Mr. Cowan:</p> <p>[24] Q: How many times?</p> <p>[25] A: Once.</p>	<p>Page 14</p> <p>[1] Q: How many times a year on average are you</p> <p>[2] requested and or retained to be a medical expert in</p> <p>[3] cases involving medical malpractice?</p> <p>[4] A: Well, that's changing over time. There was a</p> <p>[5] time when I never had any and in the early '70's some</p> <p>[6] were sent up from Florida and now in the mid '90's, it</p> <p>[7] may be as many as one a month to review but not</p> <p>[8] specifically render an opinion. In other words, I'm</p> <p>[9] willing to look at people's summaries or brief</p> <p>[10] summations of records to see if I have skills that</p> <p>[11] relate to the problem.</p> <p>[12] Q: So you may get requests once a month and how</p> <p>[13] often — let's say going into 1998 and 1999, how many</p> <p>[14] cases per year are you actually retained as an expert?</p> <p>[15] S: I would think maybe six or seven.</p> <p>[16] Q: Would it be fair to say that the majority of</p> <p>[17] the cases that you review are on behalf of physicians</p> <p>[18] that are named as defendants?</p> <p>[19] A: No, if anything, I'm asked to review more of</p> <p>[20] therese.</p> <p>[21] Q: Do you know percentage-wise based on looking</p> <p>[22] back over the fast five years?</p> <p>[23] A: Within the past year — I had my secretary</p> <p>[24] look it up and she said it's sixty/fifty, more for the</p> <p>[25] defendant physician group than for the plaintiff.</p>
<p>Page 12</p> <p>[1] Q: And how long ago was that?</p> <p>[2] A: Mid 1970's.</p> <p>[3] Q: And in a nutshell, what type of case was it?</p> <p>[4] What were the plaintiffs claiming in that case?</p> <p>[5] A: They were claiming conspiracy. A group of</p> <p>[6] physicians in this institution conspired not to tell</p> <p>[7] her the truth about a hairline fracture in her back</p> <p>[8] that another physician found and that we were doing</p> <p>[9] that in order to prevent her from collecting</p> <p>[10] disability.</p> <p>[11] Q: Were you a consultant in that case?</p> <p>[12] A: I was.</p> <p>[13] Q: I gather the case was probably thrown out</p> <p>[14] on —</p> <p>[15] A: It went all the way to the Court of Appeals</p> <p>[16] and then North Carolina Supreme Court.</p> <p>[17] Q: And what was the outcome?</p> <p>[18] A: The young lady defended her own case and got</p> <p>[19] it all the way to the top and it was thrown out.</p> <p>[20] Q: Doctor —</p> <p>[21] A: She pled her own case.</p> <p>[22] Q: Without a lawyer?</p> <p>[23] A: Without a lawyer.</p> <p>[24] Q: Did she win at the trial level?</p> <p>[25] A: Yes, they split. It was a curious case if</p>	<p>Page 15</p> <p>[1] Mr. Frasure: Sixty/fifty for the defendant</p> <p>[2] or the plaintiff?</p> <p>[3] The Witness: The defendant, or the doctor;</p> <p>[4] that's not a bias on my part. That's the way it</p> <p>[5] breaks.</p> <p>[6] Mr. Cowan: That's the way the cases came</p> <p>[7] in.</p> <p>[8] Mr. Frasure: In the last year he said.</p> <p>[9] By Mr. Cowan:</p> <p>[10] Q: Doctor, have you reviewed cases on behalf of</p> <p>[11] doctors who have retained the law firm of Buckingham</p> <p>[12] Doolittle?</p> <p>[13] A: Do you mean this group?</p> <p>[14] Q: Yes.</p> <p>[15] A: Mr. Banas and I have worked together once,</p> <p>[16] twice, previously, yes.</p> <p>[17] Q: How many times have you had cases where Mr.</p> <p>[18] Banas's law firm had retained you?</p> <p>[19] A: As best I can recall is twice before this</p> <p>[20] one.</p> <p>[21] Q: Can you recall what years?</p> <p>[22] A: No, I can't.</p> <p>[23] Q: Would they have been in the last — in the</p> <p>[24] 1990's? Would that be safe to say?</p> <p>[25] A: Well, whether it's late '80's or early '90's,</p>
<p>Page 13</p> <p>[1] you'd like to hear it. The jury hung the first time.</p> <p>[2] The — it was retried and didn't reach — so she took</p> <p>[3] it to the Court of Appeals. The Court of Appeals</p> <p>[4] split; therefore, it went to the Supreme Court and she</p> <p>[5] was getting her day in court more than she was getting</p> <p>[6] something else.</p> <p>[7] Q: She didn't have to pay an attorney either.</p> <p>[8] A: I think so, maybe. I don't know.</p> <p>[9] Q: Doctor, do you review medical negligence</p> <p>[10] cases as an expert witness?</p> <p>[11] A: If they're within my area of expertise, yes.</p> <p>[12] Q: And do you advertise your service in any</p> <p>[13] journals?</p> <p>[14] A: No.</p> <p>[15] Q: Have you ever been listed as a reviewer or</p> <p>[16] expert or any expert service to review medical-legal</p> <p>[17] cases?</p> <p>[18] A: For about two years an outfit in</p> <p>[19] Philadelphia, it was said to be jointly operated by</p> <p>[20] physicians and attorneys to settle malpractice cases</p> <p>[21] out of court but might have been a sham for all I know.</p> <p>[22] But I was listed for about two years and have never</p> <p>[23] been since.</p> <p>[24] Q: What years would that have been?</p> <p>[25] A: I'd say early '80's.</p>	<p>Page 16</p> <p>[1] I can't split the difference, but that's what it was.</p> <p>[2] Q: Can you recall what type of cases? Were they</p> <p>[3] stroke cases?</p> <p>[4] A: No, I can't.</p> <p>[5] Q: Have you ever been retained by Mr. Frasure to</p> <p>[6] be an expert on a case?</p> <p>[7] A: He suggested I have not. I don't remember.</p> <p>[8] Q: You don't recall; any other attorney at</p> <p>[9] Buckingham Doolittle than Gary Banas?</p> <p>[10] A: How many other names are on there! I don't</p> <p>[11] know.</p> <p>[12] Mr. Frasure: Lee Bell, Jeff Schobert —</p> <p>[13] The Witness: None of those names mean</p> <p>[14] anything to me, so I don't know. Those people I can be</p> <p>[15] reasonably certain I've never been.</p> <p>[16] By Mr. Cowan:</p> <p>[17] Q: How many times a year do you have your</p> <p>[18] deposition taken as an expert? I'm just asking for an</p> <p>[19] average.</p> <p>[20] A: Six, seven.</p> <p>[21] Q: Have you ever testified live at a medical</p> <p>[22] malpractice trial?</p> <p>[23] A: Several times, yes.</p> <p>[24] Q: Have you also testified by a videotaped</p> <p>[25] deposition?</p>

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[1] A: Yes.

[2] Q: The cases that actually go to *trial*, can you

[3] recall if that was primarily for the defense of a

[4] doctor or for — as an expert for the plaintiff?

[5] Mr. Frasure: Those he's testified live at

[6] trial?

[7] Mr. Cowan: Yes, correct.

[8] The Witness: The most recent one was for

[9] the plaintiff in Georgia.

[10] By Mr. Cowan:

[11] Q: And how long ago was that?

[12] A: Better part of eight months.

[13] Q: And if you just briefly explain what the fact

[14] pattern in that case was?

[15] A: Seemed to have been a lack of diagnosis of

[16] systemic attacks and a diagnosis of seizure disorder

[17] was made and the doctor was being sued by his patient

[18] who then had a stroke.

[19] Q: And on that you were retained by the

[20] plaintiffs law firm?

[21] A: I was.

[22] Q: Do you recall the name of the law firm?

[23] A: Kellogg and something.

[24] Q: And where are they located?

[25] A: Atlanta, Georgia.

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[1] Q: Do you remember — do you actually — can you

[2] recall the name of the attorney from Kellogg's office?

[3] A: No.

[4] Q: Doctor, what is your *rate* for videotape

[5] testimony for *trial*?

[6] A: It doesn't change, the \$600 per hour during

[7] the week and double that during the weekends.

[8] Q: And what is your rate if you have to fly into

[9] a place for live testimony?

[10] A: Same *rate*, but I start the clock at the

[11] moment I leave the town until I get back except for

[12] eight hours of sleep at night.

[13] Q: A rough guess, if you have to fly into

[14] Columbus, Ohio in the morning and back by the end of

[15] the day, would that be around \$3,000 or \$4,000?

[16] A: Well the day began at 6:00 in the morning

[17] and ended at 6:00 at night that would be twelve hours

[18] times \$600.

[19] Q: Doctor, do you know any of the defendants;

[20] this Dr. Giri or Dr. Thompson personally?

[21] A: No, I don't.

[22] Q: Doctor, do you know Dr. Jeff Gelbloom who is

[23] the plaintiff's expert neurologist in this case?

[24] A: No, I don't.

[25] Q: Doctor, what percentage of your income is

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[1] derived from being an expert witness?

[2] A: I've never added it up, but if last year was

[3] typical, it would be about one-sixth, something like

[4] that, not as much as a quarter working backwards.

[5] Q: So you think about one-sixth of your income

[6] may be derived from being an expert witness?

[7] A: Possibly.

[8] Q: Let's go on to — moving along to this

[9] particular case; how were you first contacted in this

[10] case about being an expert witness?

[11] A: I received — my kind of guess is I received

[12] a call from Mr. Banas who I have not heard of in many

[13] years — heard from, that is, and said would I be

[14] willing to review records, I said — please send me a

[15] summary and I'll tell you if it falls within the scope

[16] of what I think I know about.

[17] Q: So he sent you a summary and the records that

[18] he had at that time?

[19] A: No, just the summary.

[20] Q: Okay, and after reading the summary, he would

[21] have to enter into some sort of retainer agreement with

[22] you?

[23] A: I don't have retainers. We charge by the

[24] hour, should I have retainers?

[25] Q: I don't know. I've seen them, but I think

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[1] the way you're doing it is better. What records did

[2] you receive — I know there are some records you just

[3] recently received which was the family doctor. When

[4] you did the drafting of your report, what records did

[5] you have at that time?

[6] A: At that time it came in piece mill, so it's

[7] not all in a big bunch of records from the beginning.

[8] Q: I think you list them in your report. Let me

[9] just quickly go through them. You had the med center

[10] hospital records for the three days?

[11] A: Right.

[12] Q: You had some records from Wyandot Memorial

[13] Hospital; you had the Riverside Methodist Hospital

[14] necropsy report; you had the CAT scans of the brain,

[15] the MRI of the brain and the carotid ultrasound, is

[16] that correct?

[17] A: Yes, and then down below I said I've had

[18] letters.

[19] Q: You received the letters —

[20] Mr. Frasure: He's just asking about

[21] records.

[22] The Witness: Oh, excuse me; oh, yes, sorry,

[23] yes.

[24] By Mr. Cowan:

[25] Q: Then you also received the two expert reports

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[1] from Dr. Gelbloom and one from Dr. Gedousky and then

[2] you received the &position transcripts of the nurses?

[3] A: Right.

[4] Q: Did you also receive the transcripts of Dr.

[5] Giri and Dr. Thompson?

[6] A: Yes, and I neglected to include that in my

[7] letter, but I did see them.

[8] Q: And then recently you received copies of Dr.

[9] Thurton's records?

[10] A: Thornton, yes.

[11] Mr. Frasure: Yes, I showed them to you

[12] today.

[13] The Witness: I don't have them. I have nor

[14] received them. I read them, but I should have them, I

[15] guess.

[16] Mr. Cowan: And I guess in the package is

[17] also some of the Smith Clinic records which are related

[18] to the cardiology department is that safe to say?

[19] Mr. Frasure: Sure.

[20] The Witness: Smith Clinic — I don't

[21] know —

[22] Mr. Frasure: That's where Giri and Thompson

[23] practice.

[24] The Witness: I see.

[25] By Mr. Cowan:

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[1] Q: Are there any records that you've received

[2] that we haven't mentioned?

[3] Mr. Frasure: I don't think so.

[4] The Witness: The stress test?

[5] Mr. Cowan: I think that's also filed in

[6] the cardiology stuff.

[7] Mr. Frasure: Yes, that's the Wyandot

[8] Memorial Hospital.

[9] The Witness: Got all that; no, there are no

[10] other records.

[11] By Mr. Cowan:

[12] Q: Doctor, did you draft a preliminary expert

[13] report prior to your expert report of September 21st,

[14] 1999?

[15] A: No; what do you mean by preliminary?

[16] Q: Like a preliminary draft, you may have sent

[17] to defense counsel and then an actual final draft?

[18] A: No.

[19] Q: So this is —

[20] A: I always draft my letter — in other words, I

[21] can't just OUE of my head write a letter this precise,

[22] but the answer is I got it from my secretary and then I

[23] corrected it for whatever I might have done wrong, but

[24] that's the end of that.

[25] O: But you didn't send it out to defense counsel

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[1] who made corrections and then you made corrections?  
 [2] A: No.  
 [3] Q: Doctor, how many hours have you spent on this  
 [4] case including reviewing the records, drafting of your  
 [5] report and the conferences with the defense counsel?  
 [6] A: My secretary would have that precisely but —  
 [7] Mr. Frasure: Approximate, Doctor, as best  
 [8] you can.

By Mr. Cowan:

[10] Q: Is it possible you could provide me with a  
 [11] breakdown?  
 [12] A: Well, I'm looking right now, Here's the only  
 [13] — I have two charges, one for five hours and one for  
 [14] twenty minutes.  
 [15] Q: So as of today, prior to the conference you  
 [16] had with Mr. Frasure, it's been five hours reviewing  
 [17] plus another twenty minutes?  
 [18] A: Unless I forgot to add it up which is  
 [19] conceivable; sometimes I simply tell my secretary —  
 [20] let's say this letter, if I dictated the letter and I  
 [21] said it took me forty-five minutes, I'd say charge  
 [22] forty-five, so I wouldn't have it written. Anyway, the  
 [23] answer seems to be that it's five or six hours.  
 [24] Q: And have you been paid by defense counsel?  
 [25] A: To be quite honest, I don't know. I trust

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[1] him so far.  
 [2] Q: He's a trustworthy person. Doctor, have you  
 [3] spoken with any of the defendants, Dr. Giri or Dr.  
 [4] Thompson?  
 [5] A: No, I have not.  
 [6] Q: Doctor, did you review any medical textbooks  
 [7] including your own prior to this deposition?  
 [8] A: I did.  
 [9] Q: Okay, are there any articles or journals in  
 [10] those textbooks that you believe are germane to the  
 [11] issues that are involved in this case?  
 [12] A: I think what I'm — the literature there's a  
 [13] regard to the differential diagnosis of stroke so that  
 [14] I reviewed my own book to be sure that what I recollect  
 [15] from having read and written is, in fact, what I  
 [16] believe today.  
 [17] Q: Is your textbook, Cerebral Vascular Diseases,  
 [18] is that a fairly reliable text as it concerns the up-  
 [19] to-date studies that have been going on in this area?  
 [20] A: I'd like to believe that it is, but I have to  
 [21] admit that a few cases have taken positions on topics  
 [22] that others don't agree with because I believe that  
 [23] what I have to say is the correct way rather than  
 [24] simply say some do this and others do that and some  
 [25] don't do either one. In other words, it's not a

Book  
used  
my  
Schm

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[1] summarization of everybody's literature. It's a  
 [2] summarization of my own personal experience and  
 [3] beliefs.  
 [4] Q: So it would be fair to say that your textbook  
 [5] wouldn't be deemed to be as authoritative in the  
 [6] general field of neurology or cerebral vascular  
 [7] disease?  
 [8] A: No, I think it's more authoritative, because  
 [9] I've had fifty years of experience in the field.  
 [10] Q: Now there are other textbooks that are out  
 [11] there. Can you list one or two other ones that are  
 [12] popular amongst neurologists?  
 [13] A: Yes, there's one by Barnett, Stein, Yatsu and  
 [14] Moore. There's the one that I edited, the Handbook of  
 [15] Clinical Neurology with chapters by people from all  
 [16] over the world which would probably be the ultimate  
 [17] reference source until recently. There's one by  
 [18] Kaplan, Louis Kaplan.  
 [19] Q: Is that with a K?  
 [20] A: K-A-P-L-A-N.  
 [21] Q: What about the Victor one?  
 [22] A: Victor one is pretty good, but he and Adams  
 [23] are not — they are part of Harrison's textbook which  
 [24] is used mostly by generalists and neither one of them  
 [25] is — they are both older than me and out of practice.

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[1] Q: Doctor, is it safe to say that your opinions  
 [2] today will be limited to your areas of specialty?  
 [3] A: Yes.  
 [4] Q: Doctor, after reading your expert report,  
 [5] would it be fair to say that one of your opinions in  
 [6] this case is that Dr. Giri and Dr. Thompson's diagnosis  
 [7] of seizure disorder on October 29th, 1996 with Todd's  
 [8] paralysis was a reasonable one?  
 [9] A: In my opinion it was reasonable to assume  
 [10] that.  
 [11] Q: Doctor, can you tell me why, from your view  
 [12] of the records, why you think that is a reasonable  
 [13] differential diagnosis to have the seizure disorder  
 [14] with Todd's paralysis?  
 [15] A: When dealing with an emergency room patient,  
 [16] who can't give you a history, who is found — one with  
 [17] evidence of a bruise or something on the chest  
 [18] indicating injury, in someone who's taking an  
 [19] anticonvulsive, a logical physician would think this  
 [20] person had a seizure and he's on anticonvulsants for  
 [21] that reason. It is very common to have injury in a  
 [22] convulsion, unusual to have it in a stroke. Most  
 [23] strokes don't begin as rapidly and instantaneous. They  
 [24] evolve over time. Therefore, the person first gets  
 [25] weak, perhaps in a leg or arm and then over time

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[1] develops what we call evolving stroke. The only one  
 [2] that presents with a sudden instantaneous ictus from  
 [3] which you might fall and injure yourself is a  
 [4] hemorrhage. So within the differential diagnosis in  
 [5] this patient would be a hemorrhage into the head with a  
 [6] convulsion or some loss of consciousness or a  
 [7] convulsion with a sudden fall to the floor and self  
 [8] injury and that the loss of consciousness with the  
 [9] gradual recovery is typical for the seizure, not  
 [10] typical for a stroke; that if one is going to have a  
 [11] sudden massive cerebral infarction, one is going to  
 [12] have it. The chances are they would not specifically  
 [13] lose consciousness from the beginning. The other  
 [14] compelling thing that I didn't see until today but  
 [15] which is — adds substance to what I've been saying is  
 [16] this man was said by his parents to have episodes of  
 [17] right-sided events, call it what you will, and that on  
 [18] a previous occasion he'd been walking out and he had a  
 [19] sudden loss of consciousness and confusion. This kind  
 [20] of recurrent loss of consciousness is not vascular.  
 [21] It's seizures.  
 [22] Q: Doctor, do you think that when he first came  
 [23] into the emergency room that a TIA should have been  
 [24] part of the differential diagnosis?  
 [25] A: I spent many years taking care of this

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[1] particular thing. This is what I consider to be my own  
 [2] area of extra special skill, above which I was  
 [3] referring having written a chapter which deals with  
 [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  
 [6] of an abrupt nature with injury from what's called a  
 [7] TIA. It just doesn't happen.  
 [8] Q: Doctor, would you agree with me that Dilantin  
 [9] can be used for treatment of other disorders and not  
 [10] just as anticonvulsives?  
 [11] A: Rarely, yes; everything from cardiac  
 [12] dysrhythmia to peripheral neuropathy for pain.  
 [13] Q: Doctor, were you aware — I know you just got  
 [14] the records today that he was — that John Martin was  
 [15] treated for a neuropathy —  
 [16] A: I was just told that, but I don't see any  
 [17] evidence that he had one. It wasn't well documented.  
 [18] Neuropathy as a rule means lower extremities and lower  
 [19] extremity means absence of ankle jerks.  
 [20] Q: What about peripheral neuritis, what is  
 [21] peripheral neuritis?  
 [22] A: It just means the peripheral nerve is  
 [23] inflamed.  
 [24] Q: Were you aware —  
 [25] A: Any one, there are hundreds of nerves.

\* D. Lark

- [1] Q: Were you aware that he was diagnosed by his  
 [2] family doctor with peripheral neuritis in his hand?  
 [3] A: I just was told that today and who would have  
 [4] guessed that? It is not usual and customary to treat  
 [5] the neuritis in the hand with an anticonvulsive.  
 [6] Q: Can Dilantin be used for people with pain  
 [7] disorders and migraine headaches?  
 [8] A: Yes, it can. Does it work?  
 [9] Q: Does it work?  
 [10] A: Not well.  
 [11] Q: Can Dilantin be prescribed for patients with  
 [12] peripheral neuritis?  
 [13] A: Usually of the lower extremity and usually  
 [14] for pain; there are several forms of peripheral  
 [15] neuritis. One is a pain syndrome. Another one is a  
 [16] weakness syndrome and a third is an autonomic  
 [17] sympathetic/parasympathetic fiber, vascular problem.  
 [18] Most neuritides are for the lower extremities and  
 [19] what's interesting to me having just read this is  
 [20] someone diagnosed him as having gout. I didn't see  
 [21] that sustained anywhere. Gout is a syndrome which can  
 [22] be misdiagnosed and can be called neuropathy.  
 [23] Q: Do physicians give Dilantin for gout or is  
 [24] that—  
 [25] A: That would be news to me. I don't know.

- [1] Q: Is hemiparesis a common symptom of a seizure  
 [2] disorder with Todd's paralysis?  
 [3] A: That definition would mean a focal motor  
 [4] seizure in the motor strip of the opposite hemisphere  
 [5] and if one has a legion in the appropriate place  
 [6] meaning anything from a neoplasm to an arterial venous  
 [7] valve formation or scar or head injury, whatever,  
 [8] Todd's paralysis is a common event for focal motor  
 [9] seizure, but it is not a common event for convulsion  
 [10] per se.  
 [11] Q: Is a left eye deviation a common symptom of a  
 [12] seizure disorder?  
 [13] A: In a postictal state, yes; in a focal  
 [14] seizure; you keep having to say focal. Now what this  
 [15] means is you begin with a focal abnormality due to one  
 [16] place in the brain that starts firing off and once that  
 [17] fires often enough, it is called exhausts the opposite  
 [18] part of the body which is — once that happens the  
 [19] brain sometimes has what's called a generalized  
 [20] convulsion. In other words it spreads from focal to  
 [21] generalized which causes a convulsion and the person  
 [22] awakens from that confused, unable to respond and  
 [23] paralyzed in the area of the brain where the seizures  
 [24] began. That becomes a localizing sign and symptom and  
 [25] that's what is called a Todd's paralysis.

- [1] Q: Doctor, would it be important to you that  
 [2] John's parents told the ER physician that they were  
 [3] unaware that their son had a seizure disorder?  
 [4] A: No, the reason is most thirty year old people  
 [5] don't tell their parents anything, so it has nothing to  
 [6] do with anyone. It's just that adults take care of  
 [7] their illnesses. They don't always tell anybody  
 [8] particularly about seizures, because if you are told  
 [9] you have a seizure, you lose your drivers license in  
 [10] many states, so it's kept quiet.  
 [11] Q: Now what if, in this case, the decedent lived  
 [12] at home with his parents?  
 [13] A: I wouldn't opine — I don't know. I just  
 [14] know it is very common to have people deny seizures  
 [15] when they have them, including certain pilots for the  
 [16] airlines that I happen to take care of.  
 [17] Q: Doctor, what would be the appropriate  
 [18] standard of care if you suspected a seizure disorder in  
 [19] an obese thirty-nine year old male with right hand  
 [20] paresis who has a history of taking Dilantin? I guess  
 [21] my question is, what would you have done when presented  
 [22] with that situation assuming your diagnosis is a  
 [23] seizure disorder with Todd's paralysis?  
 [24] A: I would get a stat Dilantin level. I'd put  
 [25] him on seizure precautions and careful observations and

- [1] get a CAT scan to see if I can find a focal underlying  
 [2] legion, and with a little more leisure, I'd get an EEG.  
 [3] Q: Now if the CAT scan comes back negative, what  
 [4] does that tell you or rule out?  
 [5] A: Generally hemorrhage but it doesn't rule out  
 [6] a scar or an AV malformation unless it's a big AV  
 [7] malformation.  
 [8] Q: Now you mentioned that you would order an  
 [9] EEG. And what are you looking for in the EEG?  
 [10] A: Well, you look for evidence of a — either a  
 [11] hyper or hypo increased or decreased electrical  
 [12] activity. Following a seizure with using what I  
 [13] mentioned earlier, it's called the exhaustion, the EEG  
 [14] may be abnormal at flat or slow and around it. If the  
 [15] person is still ictus or having more seizures, it would  
 [16] be spikes.  
 [17] Q: And if one was to order an EEG on a stat  
 [18] basis, from your years of practice, what kind of time  
 [19] frame are we looking at from the time you order an EEG  
 [20] stat? Is it two hours, four hours that you would  
 [21] expect to get the results back?  
 [22] A: EEG depends. They are usually scheduled and  
 [23] not everybody has the capacity to do portables. If  
 [24] this person is still in dire straits, you defer the EEG  
 [25] until they stabilize their breathing, their level of

- [1] consciousness, et cetera.  
 [2] Q: Let's say that the patient is stable.  
 [3] A: Okay, and does the hospital have a portable  
 [4] EEG that they can take different places?  
 [5] Q: Yes.  
 [6] A: Then I'd say within two hours.  
 [7] Q: Now going back to a diagnosis of the seizure  
 [8] disorder with Todd's paralysis, after doing the EEG and  
 [9] let's say the EEG comes back normal, are there any  
 [10] other tests that you would do to rule out the Todd's  
 [11] paralysis or a seizure disorder? Let's say your  
 [12] diagnosis is turning out to be incorrect; is there some  
 [13] test that will tell you that this person doesn't have a  
 [14] seizure disorder with Todd's paralysis?  
 [15] A: No.  
 [16] Q: Doctor, is it fair to say that a seizure or  
 [17] focal convulsion is accompanied by a short-lived focal  
 [18] neurological deficit which can simulate a TIA?  
 [19] A: It can and within the subtlety of the  
 [20] difference, generally ninety percent probably of  
 [21] patients who have a TIA simply have a loss of use, ten  
 [22] percent have a focal convulsive sort of movement; limbs  
 [23] shaking TIA's.  
 [24] Q: Now with the seizure disorder, isn't the  
 [25] actual neurological deficit short-lived? There's a

- [1] time where that deficit is going to end?  
 [2] A: Well, they usually say upwards of twenty-four  
 [3] hours before Todd's — in the flagrant cases, you've  
 [4] got twenty-four hours in which to wait before the  
 [5] Todd's paralysis clears.  
 [6] Q: Would it be fair to say, then, if the  
 [7] neurological deficit remains after the twenty-four hour  
 [8] time period, you can rule out the Todd's paralysis  
 [9] seizure disorder from a differential diagnosis?  
 [10] Mr. Frasure: In this case or —  
 [11] Mr. Cowan: In general.  
 [12] The Witness: The longer it goes, the less  
 [13] likely it is, but I do believe I would have to search  
 [14] the literature, because I don't carry it in my head  
 [15] that in the EEG or epilepsy literature cases forty-  
 [16] eight hours would not be absolutely unheard of, just be  
 [17] less likely.  
 [18] By Mr. Cowan:  
 [19] Q: Assuming in the case of John Martin that they  
 [20] — assuming negative CAT scan per the radiologist  
 [21] report and the fact that the neurological deficit  
 [22] continued past twenty-four hours, would it be your  
 [23] opinion that at that point in time you could rule out  
 [24] Todd's paralysis seizure disorder from your  
 [25] differential diagnosis?



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[1] A: I would eliminate it. I'd put it down at the  
 [2] five percent level.  
 [3] Q: What, at that point in time, in the case of  
 [4] John Martin, what would be your number 1 on your  
 [5] differential diagnosis after the first twenty-four  
 [6] hours assuming the EEG came back normal, CAT scan  
 [7] negative?  
 [8] A: If he's not recovering, you mean?  
 [9] Q: Right, and the deficit continues.  
 [10] A: I would say it's an established stroke  
 [11] infarction.  
 [12] Q: Doctor, I'd like to ask you some questions  
 [13] about John Martin and in these questions I want you to  
 [14] assume that a diagnosis for TIA or acute CVA is  
 [15] diagnosed on the morning and afternoon of October 29,  
 [16] 1996. That's the first day. So I want you to exclude  
 [17] the seizure disorder and this is just a hypothetical  
 [18] question. Assuming that you've diagnosed or your  
 [19] differential diagnosis is TIA, what would your initial  
 [20] evaluation consist of? What type of tests would you  
 [21] order?  
 [22] Mr. Frasure: You're not including seizure?  
 [23] Mr. Cowan: This is a hypothetical, right.  
 [24] Let's say you have a diagnosis of TIA versus possible  
 [25] acute CVA.

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[1] The Witness: All right, by definition which  
 [2] is somewhat obsolete but still commonly used, a TIA can  
 [3] last for twenty-four hours, twenty-three hours and  
 [4] fifty-nine minutes and fifty-nine seconds. If it goes  
 [5] one second beyond, it is now called a stroke. That's  
 [6] artificial obsolete and useless, but let's just say  
 [7] this man was in the first four hours of his event.  
 [8] It's very easy to call this — except for the loss of  
 [9] consciousness and the self-injury and the extreme  
 [10] repetitive of its onset, it is more likely to have been  
 [11] a hemorrhage but he got a CT and it was negative. Now  
 [12] a man who is recovering some consciousness but not  
 [13] fully recovered, the next move would be to get an  
 [14] ultrasound of the neck, to see if there's some lesion  
 [15] there that could have caused an unusual event, and an  
 [16] echocardiogram to see if, per chance, he had some  
 [17] lesion that might have caused an embolus.  
 [18] Q: What about the prothrombin times, would you  
 [19] have ordered that immediately?  
 [20] A: No, I think a pro time has to be predicated  
 [21] on the fact that you want to use anticoagulants and I  
 [22] still think it's — given as it was, finding him  
 [23] unconscious on the floor or seemingly unconscious, that  
 [24] is not the usual or customary for a stroke and pro time  
 [25] wouldn't have been one of the high level things I would

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[1] have ordered. Ne was already on Persantine which if  
 [2] you're thinking of anticoagulant type things,  
 [3] Persantine is an appropriate medication for that. I  
 [4] would say that he would have had a need for a  
 [5] differential diagnosis. You still haven't proved he —  
 [6] if you rule out a seizure, you haven't proved what it  
 [7] is. You've ruled out one thing, but you haven't said  
 [8] what it is. You said it isn't something, not what it  
 [9] is and I stick to the idea that it's — no way in less  
 [10] than twenty-four hours could you have said it wasn't a  
 [11] Todd's paralysis. Now let's say the twenty-four hours  
 [12] has gone by and it's not a Todd's paralysis, what else  
 [13] is it? Knowing what the answer is, it makes it easy.  
 [14] He obviously threw a blood clot but at that time how  
 [15] would one have diagnosed that blood clot in his carotid  
 [16] ultrasound would have been — what I always get now  
 [17] because it's a common problem and it's a major problem.  
 [18] Echocardiogram carotid ultrasound is in the  
 [19] differential diagnosis of any prolonged loss of use of  
 [20] heavy —  
 [21] Q: Excuse me. Would you have ordered the  
 [22] ultrasound of the carotids and the echocardiogram after  
 [23] that twenty-four hour time period?  
 [24] Mr. Frasure: Which case are we talking  
 [25] about? We're jumping back and forth.

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[1] Mr. Cowan: In the case of John Martin.  
 [2] The Witness: Yes.  
 [3] By Mr. Cowan:  
 [4] Q: And you realize that in this case they were  
 [5] not ordered until the third day which would have been  
 [6] October 31st?  
 [7] A: All right.  
 [8] Q: Going back to the — you're aware that the  
 [9] emergency room doctor did a prothrombin time and they  
 [10] activated a partial thromboplastin?  
 [11] A: Yes.  
 [12] Q: Why would the emergency room doctor — or  
 [13] what is the significance of the values — I can just  
 [14] show you the test results. The prothrombin is a 13 and  
 [15] I gather beside it is the normal range?  
 [16] A: Yes, that's normal.  
 [17] Q: And the second line, is that the —  
 [18] A: Partial thromboplastin.  
 [19] Q: which falls within —  
 [20] A: The normal range, right.  
 [21] Q: And the reason the emergency room physician  
 [22] wanted those results, is that in case he wanted to use  
 [23] something like an anticoagulant?  
 [24] A: Might have been.  
 [25] Q: And would these results be in the range

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[1] whereby one could use anticoagulants?  
 [2] A: That's right. They could be.  
 [3] Q: And these ranges would show at least from  
 [4] this test that there doesn't appear to be any abnormal  
 [5] clotting problems, is that correct?  
 [6] A: That's true.  
 [7] Q: On the emergency room physician when you took  
 [8] the blood work on October 29th, the glucose level was  
 [9] 99 with the range here being 70 to 110. Do you find  
 [10] that glucose level to be a little on the high side?  
 [11] A: No.  
 [12] Q: So that wouldn't concern you?  
 [13] A: No.  
 [14] Q: Doctor, in your practice with a patient —  
 [15] let's say after the twenty-four hour time period, where  
 [16] you've ruled out the Todd's paralysis, would you order  
 [17] — you mentioned the ultrasound. Would you also order  
 [18] the MRI at that point in time or would you order an MRI  
 [19] within the first twenty-four hour time period?  
 [20] A: MRI in the presence of a negative CT is an  
 [21] elective procedure. I think that if that CT had been  
 [22] showing something or read as being taps abnormal, you'd  
 [23] get an MRI. I think that an MRI is an expensive test  
 [24] that you get in order to institute a therapy and you  
 [25] don't get it simply for curiosity and I think that an

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[1] MRI while you're observing a patient because you think  
 [2] he has a Todd's paralysis isn't necessary. If after  
 [3] the twenty-four hours you think that something else is  
 [4] the etiology, certainly you should get an MRI.  
 [5] Q: And you're aware in this case that the MRI  
 [6] was ordered on the third day and not on the second day?  
 [7] A: Yes.  
 [8] Q: I know in your report you discuss the  
 [9] findings of the CAT scan report of October 29, 1996.  
 [10] A: Yes.  
 [11] Q: And you state that the CT is of marginal  
 [12] quality and suggests the possibility of edema of a  
 [13] diffuse nature. Is that — that's what you said in  
 [14] your report?  
 [15] A: That's what I said.  
 [16] Q: Okay, do you disagree with the radiologist's  
 [17] findings?  
 [18] A: No, I'm not a radiologist. I'd take it to a  
 [19] radiologist and say what do you think. I never put  
 [20] myself up against a radiologist and say this is what it  
 [21] is and you're wrong. I believe it's often appropriate  
 [22] to coder with the radiologist when you suspect  
 [23] something, get them to give a final opinion.  
 [24] Q: Can you state with a reasonable degree of  
 [25] medical certainty that there was evidence of hemorrhage

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[1] or edema on that file of October 29, 1996?

[2] **The Witness:** No.

[3] **Mr. Frasure:** The test is reasonable medical  
[4] probability, not certainty, more likely than not, so I  
[5] object to the form of the question.

[6] **The Witness:** I cannot. I'm not an expert  
[7] in that field.

[8] **By Mr. Cowan:**

[9] **Q:** Now, Doctor, assuming for this next set of  
[10] questions I'm going to ask you — on October 29, 1996,  
[11] let's say you've got a diagnosis of an systemic stroke;  
[12] the CAT scan of the brain is negative; you have a  
[13] thirty-nine year old male, 315 pounds; he cannot speak;  
[14] he obeys commands; he's got right hand paresis; now  
[15] let's say in this hypothetical, the emergency room  
[16] physician hands it over to you for neurological  
[17] consult. What neuro — and this is ruling out the  
[18] Todd's paralysis — a case with no Todd's paralysis,  
[19] what neuropharmacology therapies would you order, if  
[20] any?

[21] **Mr. Frasure:** You're asking him to assume  
[22] there's no Todd's paralysis initially?

[23] **By Mr. Cowan:**

[24] **Q:** Correct, so your differential diagnosis in  
[25] this hypothetical is one of a TIA then, or a stroke.

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[1] **A:** Another person, not this one?

[2] **Q:** Correct, right.

[3] **A:** If all studies are negative, I'd personally  
[4] use anticoagulants and Heparin. Now remember, this man  
[5] was found unconscious or lack of any — unable to  
[6] express when it began. He was not observed so, of  
[7] course, he cannot be eligible for TPA which one of the  
[8] physicians had suggested and I think that would have  
[9] been blatantly wrong, so then we get to the next level  
[10] which is would Heparin been possibly used and the  
[11] answer is yes.

[12] **Q:** Now why in this hypothetical you would use  
[13] anticoagulants versus the case with John Martin with  
[14] the diagnosis of the seizure disorder? Is it because  
[15] the anticoagulant could have a disastrous effect if  
[16] somebody has a seizure?

[17] **A:** That's exactly true.

[18] **Q:** And what could that do if you give somebody  
[19] who has a seizure disorder anticoagulants? What would  
[20] happen?

[21] **A:** Well, first of all, Heparin without any  
[22] trauma or seizure or any other kind of event can cause  
[23] bleeding of internal organs and even of the brain.  
[24] When one has a seizure, not only does one thrash about  
[25] uncontrollably, but often they have to be restrained.

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[1] For example, you put something in their mouth so they  
[2] won't bite their tongue, but if they bit their tongue  
[3] and they're on Heparin, they'll just bleed to death.  
[4] Now during a convulsion, the blood pressure goes up  
[5] dramatically sometimes off the cuff. This man was  
[6] normal tensive. It goes up to the 300 level in the  
[7] middle of a convulsion. That would have popped his  
[8] cerebral vessels and made him bleed to death in the  
[9] brain. One does not use an anticoagulant of any sort,  
[10] Heparin or any other kind, unless one is morally  
[11] certain they will not have a complication of that by  
[12] some underlying problem and the underlying problem in  
[13] this man was likely to be seizures. If one had another  
[14] problem like bleeding ulcers or bleeding polyps of the  
[15] colon, there's all kinds of reasons not to use  
[16] anticoagulants. The most important one being Heparin  
[17] has never been proved to be effective by any trial and  
[18] so those of us who use it are duty bound not to use it  
[19] if there's a reason that it might cause trouble or a  
[20] likelihood that it might cause trouble.

[21] **Q:** Now assuming in John Martin's case after she  
[22] twenty-four hour time period where you've essentially  
[23] ruled out the seizure disorder and Todd's paralysis, in  
[24] your own practice, would you have given this patient  
[25] Heparin at that time?

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[1] **Mr. Frasure:** Let me just object. I'm not  
[2] sure he said that but for clarification.

[3] **The Witness:** The answer is no and the  
[4] reason it's no is that the horse is out of the barn.  
[5] Heparin is used while it's evolving, not after it's  
[6] fixed. And there's a big distinction that many people  
[7] have not yet made regarding the use of anticoagulants.

[8] You can use TPA to dissolve a clot. That means a  
[9] stroke is evolving. Heparin does not dissolve  
[10] anything. It doesn't restore anything. It simply  
[11] keeps more clots from forming.

[12] **By Mr. Cowan:**

[13] **Q:** Now, Doctor, if you've — at a certain point  
[14] in time can't rule out the actual origination of the  
[15] stroke and let's say at a point in time you think  
[16] there's a cardiac involvement that maybe this is a  
[17] cardiac embolism, would you at that point give a  
[18] patient Heparin to stop secondary emboli from —

[19] **A:** Well, I was under the impression that this  
[20] man had had echocardiograms which never showed any  
[21] source for an embolism. One doctor said he might have  
[22] had mild mitro regurgitation, mitro insufficiency, so  
[23] to speak, but he'd had a full work-up and he didn't  
[24] have evidence of cardiac abnormalities.

[25] **Q:** Doctor, are you aware that — of the

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[1] suboptimal quality of the echocardiogram?

[2] **A:** Yes, I think that a cardiologist or a person  
[3] who is supposed to know the answers is willing to write  
[4] off someone and say they don't have cardiac disease,  
[5] you take their word for it.

[6] **Q:** In the echocardiogram it says right off the  
[7] bat please note the technical quality of the  
[8] echocardiogram is suboptimal because of the poor  
[9] acoustic window —

[10] **Mr. Frasure:** What is the date on that?

[11] **Mr. Cowan:** 10/30/96, the second day.

[12] **Mr. Frasure:** Okay.

[13] **By Mr. Cowan:**

[14] **Q:** — and the fact that the patient is sub —

[15] **A:** Well, the horse is out of the barn and I  
[16] don't think an echo done after he's had all these  
[17] things is useful. What is useful is before he had it  
[18] and he had a full cardiac work-up less than a month  
[19] before the ictus and one would assume that if it was  
[20] negative, then it was negative then. I mean, if it was  
[21] negative at the beginning, it would be negative — not  
[22] enough time had elapsed for there to have been a  
[23] change.

[24] **Q:** Doctor, if you thought — if there was a  
[25] possibility that the origin of the thrombus was

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[1] cardiac, would you have ordered a transesophageal  
[2] cardiogram versus a normal cardiogram?

[3] **A:** In a semi-comatose patient?

[4] **Q:** Yes.

[5] **A:** No; again, it would be useless. You don't  
[6] just do dangerous things. You do something to prove  
[7] you should do something in response. Now after this  
[8] man has a fixed neurologic deficit of the kind he had,  
[9] the use of anticoagulants to prevent further emboli was  
[10] pretty useless. He was already — unless you want to  
[11] preserve the opposite hemisphere, but once the  
[12] hemisphere is gone, you don't restore it by preventing  
[13] another embolus.

[14] **Q:** At what point or stage would you order a  
[15] cerebral arteriography?

[16] **A:** Never.

[17] **Q:** In a patient such as John Martin, would you  
[18] have ordered on that second day any antiphospholipid  
[19] antibody study?

[20] **A:** Designed to do what?

[21] **Q:** Find out if there was a presence of any  
[22] antiphospholipid antibody if it's a genetic disorder.

[23] **A:** In order to have done what — in other words,  
[24] I'm thinking of treatment now. Sure, I would have  
[25] gotten those studies in a man of that age, but how

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[1] would I have **changed** the course of his events?  
 [2] **Q:** You yourself would have ordered those  
 [3] studies, is that correct?  
 [4] **A:** Academically I do a lot of things.  
 [5] Practically it would not have changed anything for this  
 [6] man.  
 [7] **Q:** Do you h o w if the antiphospholipid antibody  
 [8] testing was ever performed at Med Center Hospital?  
 [9] **A:** No, I don't.  
 [10] **Q:** Have you ever seen anything to indicate that  
 [11] it was?  
 [12] **A:** No.  
 [13] **Q:** Now, Doctor, I want to assume that you've  
 [14] diagnosed — let's say you've done the MRI; it shows a  
 [15] middle cerebral artery ~~inclusion~~; you've done the  
 [16] Doppler ultrasound that shows an inclusion in the left  
 [17] internal carotid and assuming now that we're on day two  
 [18] which is October 30th of 1996, at that point in time  
 [19] once your MRI studies come back and the ultrasound,  
 [20] what would be the standard of care of treatment of the  
 [21] patient?  
 [22] **Mr. Frasure:** This is at day two now?  
 [23] **Mr. Cowan:** On day two, so you've found —  
 [24] **The Witness:** There are a variety of  
 [25] experimental — and this is where the medical opinion

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[1] begins to diverge. Some would say watchful waiting.  
 [2] Others would say a decompression surgery to treat  
 [3] edema. A few would say hyperbaric oxygen plus  
 [4] Dexamethasone plus agents to resolve edema.  
 [5] **By Mr. Cowan:**  
 [6] **Q:** Would Mannitol and Decadron play into that?  
 [7] **A:** They'd be among them.  
 [8] **Q:** Would you at this point in time refer to a  
 [9] neurosurgical consult, I guess, with the decompression?  
 [10] **A:** It would have been what I would do if the  
 [11] family wanted me to and, again, this now gets into the  
 [12] ethics and the right to life and a variety of areas  
 [13] that are personal and I don't know whether this man had  
 [14] a living will or not, for example, and I think when a  
 [15] person is so badly disabled at that age, one sometimes  
 [16] makes very difficult decisions. I don't think there  
 [17] was any way to restore him to function, although there  
 [18] might have been capacity to keep him alive, but whether  
 [19] one wants to live a hemiplegic in aphasia for the next  
 [20] thirty years of one's life is a matter of different  
 [21] choices than I'm prepared to discuss.  
 [22] **Q:** Doctor, would you have intubated that  
 [23] patient? Let's say on — this is hypothetical.  
 [24] **A:** It depends on how he's breathing; not  
 [25] everybody that is hemiplegic has trouble breathing but

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[1] at his weight, 315, if he had labored breathing and his  
 [2] tongue fell back, which I don't h o w, yes.  
 [3] **Q:** And would you order the Mannitol or —  
 [4] **A:** If the family — again, I had to step back  
 [5] one step. I would discuss it with the family and let  
 [6] them decide or help me decide.  
 [7] **Q:** And would you order the Mannitol or Decadron  
 [8] to reduce the brain swelling?  
 [9] **A:** Again, it depends on — it might reduce  
 [10] swelling, but it would not restore function and then  
 [11] one has massive edema. The only thing that truly  
 [12] restores anything is to decompress which means major  
 [13] surgery on the skull to remove a great big window so  
 [14] the brain can swell out of the brain — so the brain  
 [15] can swell out of the head. And to do that in my  
 [16] impression often preserves a — someone who stays in a  
 [17] rest home in an unresponsive state for years.  
 [18] **Q:** Doctor, do we know from the records on day  
 [19] two that there was massive edema? I think the record  
 [20] would suggest that on day three his pupil had blown  
 [21] out.  
 [22] **A:** That's me.  
 [23] **Q:** On day three you'd agree that there was  
 [24] massive edema?  
 [25] **A:** Right, now massive edema may or may not be

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[1] present before it's clinically expressed.  
 [2] **Q:** Would an MRI, if it had been taken on day  
 [3] two, would that show the swelling?  
 [4] **A:** Yes.  
 [5] **Q:** But unfortunately we only have day three to  
 [6] look at, so you can't say for sure on day two how bad  
 [7] the swelling was at that time?  
 [8] **Mr. Frasure:** I'll object to "for sure".  
 [9] The test is reasonable medical —  
 [10] **Mr. Cowan:** With a reasonable degree of  
 [11] medical certainty or probability you can't say how much  
 [12] swelling there was in John Martin's strain on the left-  
 [13] hand side that day.  
 [14] **The Witness:** No, I can't  
 [15] **By Mr. Cowan:**  
 [16] **Q:** Doctor, is the mortality rate for patients  
 [17] who have had infarctions involving the middle cerebral  
 [18] artery approximately twenty percent? Does that sound  
 [19] right?  
 [20] **Mr. Frasure:** Say that again, Gary. I'm  
 [21] sorry.  
 [22] **By Mr. Cowan:**  
 [23] **Q:** What is the mortality rate for patients who  
 [24] have had infarctions involving the middle cerebral  
 [25] artery?

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[1] **A:** Thirty day mortality — I think you're about  
 [2] right.  
 [3] **Q:** And is survival significantly better after a  
 [4] cerebral infarction than after a major hemorrhagic  
 [5] stroke?  
 [6] **A:** No.  
 [7] **Q:** I'm just talking about survival.  
 [8] **A:** Let me tell you something.  
 [9] **Q:** I'm talking about survival; mortality versus  
 [10] morbidity here. I don't want to trick you.  
 [11] **A:** No, you're not and I'm not being tricky, but  
 [12] when you just generalize and say all hemorrhages and  
 [13] all infarcts, you can't do that. You're talking middle  
 [14] cerebral?  
 [15] **Q:** Middle cerebral artery.  
 [16] **A:** Versus what kind of a hemorrhage?  
 [17] **Q:** Just a hemorrhage in the cerebellum or  
 [18] something, in that area.  
 [19] **A:** And the question is again?  
 [20] **Q:** When has a better rate of survival if it's a  
 [21] hemorrhagic stroke in that area or a systemic stroke?  
 [22] **A:** Depends on the size; I can't answer your  
 [23] question. I'm sorry.  
 [24] **Q:** Can you tell me from your own experience, do  
 [25] younger patients do better surviving middle cerebral

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[1] artery strokes than older patients?  
 [2] **A:** All things being equal they can tolerate bed  
 [3] rest longer but this particular man at 315 pounds is  
 [4] not a typical young man. He's an abnormal man who was  
 [5] evidently not normal all his life from what I  
 [6] understand. He had Legg-Perthes disease and stayed  
 [7] home and who knows what. Was he — I don't h o w any of  
 [8] his social background or his mental background or  
 [9] intellectual background and so on, his disease state or  
 [10] excuse me, underlying diseases. It seems strange to me  
 [11] that a young man such as he was going to so many  
 [12] doctors getting so many treatments or so many problems  
 [13] without some unifying underlying disease and I was  
 [14] quite surprised he didn't have diabetes.  
 [15] **Q:** Were you surprised that he didn't have  
 [16] coronary artery disease?  
 [17] **A:** I was shocked and also extremely surprised  
 [18] that his blood pressure is normal, so here's this obese  
 [19] person, worked up with reasonably normal results by  
 [20] good doctors who ends up having this event, unheralded.  
 [21] A month earlier he'd had a passing out spell with  
 [22] confusion. Anyway, he had a lot of problems.  
 [23] **Q:** Doctor, from your review of all the medical  
 [24] records in this case, would you classify Mr. Martin's  
 [25] stroke as a progressive stroke, a partial non-

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[1] progressive stroke, or a complete stroke or is it a  
[2] combination?

[3] A: A completed. \*

[4] Q: 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] him hemiplegic is a matter of debate.

[12] Q: Is it possible that the clot in the internal  
[13] carotid could have 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's say, 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] inclusion of the left internal carotid and had proper  
[22] support measures and neuroprotective therapies been  
[23] used, do you have an opinion based on a reasonable  
[24] degree of medical probability as to whether John Martin  
[25] would have had a greater than fifty percent chance of

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[1] survival? I'm saying if they diagnose it now, end of  
[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: ~~.....~~  
[14] decompression?

[15] Q: Let's say w

[17] Q: On both accounts?

[18] A: If he had a surgical decompression, it would  
[19] increase his likelihood of survival, but the quality of  
[20] life might have been intolerable.

[21] Q: But he would have had a greater than fifty  
[22] percent chance of living?

[23] A: I didn't say greater than fifty. I just said  
[24] increase.

[25] Q: You cannot give a specific —

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[1] A: No, I can't.

[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: Well, 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,  
[19] then?

[20] A: Yes.

[21] Q: I think the necropsy report states the  
[22] belief, I guess, of the neurologist there was that the  
[23] origin of the thrombus is the aortic arch or possibly  
[24] the left subclavian artery. Do you go along with that  
[25] neurologist's findings?

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[1] A: Well, I'm always willing to learn from  
[2] somebody that knows more than I do. I think that  
[3] they'd have to explain to me how it would go backward  
[4] from the left subclavian artery to the left carotid  
[5] which are not necessarily — they don't come off the  
[6] same place in the aortic artery,

[7] Q: So would it make more sense that the thrombus  
[8] — there was a thrombus on the aortic arch that would  
[9] have thrown the clot to the carotid —

[10] A: And to the subclavian.

[11] Q: And that's what you think the actual —  
[12] that's how it happened; is that your view?

[13] A: No, if I would — I can review it if you want  
[14] me to. The McProxy report says the aortic arch is  
[15] dean, does not have athero in it which makes it  
[16] strange that there should have been a primary clot in  
[17] that location. Now if the dot is adherent and solid  
[18] in contrast to the one in the internal carotid which  
[19] was soft and easily movable, then you have an answer  
[20] that suggests that it is — just a minute, let me  
[21] review this. The other consideration that I put out  
[22] for you is that the man had a pulmonary venous  
[23] occlusion and that the pulmonary veins feed into the  
[24] left atrium and it's common that you take out the heart  
[25] and look at everything, but you don't look at the

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[1] lungs.

[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 was 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

e that, examination of  
fixation is already —

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[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.

By 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 into 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 is the left internal carotid  
[24] artery and extended to the left middle cerebral artery  
[25] halfway to the point of trepidation meaning distal

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[1] carotid, I guess.  
 [2] Q: Doctor, you're not a pathologist, is that  
 [3] correct?  
 [4] A: No, I'm not but I can read what they say.  
 [5] Q: So do you disagree with the findings that —  
 [6] which would be on page 2 saying autopsy revealed recent  
 [7] thrombosis of the aortic arch and ostium of the left  
 [8] subclavian artery. This site, thrombi embolus reached  
 [9] the —  
 [10] A: Show me where that is, please.  
 [11] Q: Page 2, let's go back to page 2 of the  
 [12] document, right over here. It says autopsy revealed  
 [13] recent thrombosis in the aortic arch and ostium of the  
 [14] left subclavian artery. From this site thrombi embolus  
 [15] reached the intracranial part of the left internal  
 [16] carotid and continuous left middle cerebral artery. Do  
 [17] you disagree with that?  
 [18] A: No, I agree with that. By thrombosis I think  
 [19] he's probably meaning — I won't say what somebody  
 [20] means, but I think if you use the word thrombus in the  
 [21] aortic — when you say thrombosis, that means a legion  
 [22] in there which had a thrombus occur on it. Thrombus  
 [23] means it could have come from anyplace. But there was,  
 [24] of course, a thrombus in the aortic arch or ostium and  
 [25] left subclavian.

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[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?  
 [4] A: I do.  
 [5] Q: Doctor, do blood clots — do blood clot  
 [6] embolisms dissolve more faster than atherothrombotic  
 [7] infarctions?  
 [8] A: No, the athero doesn't lice, it's there but  
 [9] a thrombus on it would lice at the same rate as a  
 [10] thrombus anywhere else.  
 [11] Q: Doctor, would it be fair to say that Dr.  
 [12] Thompson on October 30th which is day two contemplated  
 [13] a cardiac source and ordered an echocardiogram?  
 [14] A: I don't know.  
 [15] Q: Do you recall he ordered an echocardiogram on  
 [16] October 30th, 1996?  
 [17] Mr. Frasure: Look at the records, Doctor.  
 [18] Mr. Cowan: October 30th around 8:30 A.M.  
 [19] at the — I believe Dr. Thompson requested a cardiac  
 [20] consult and ordered an echocardiogram.  
 [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:  
 [25] Q: Correct; he testified in his deposition that

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[1] he ordered an echocardiogram.  
 [2] A: Okay, and after that cardiology says hold off  
 [3] on cardiac work up for reasons I can't understand.  
 [4] Q: But we do how Later on October 30th, the  
 [5] cardiologist did do the echocardiogram, You don't  
 [6] disagree with that?  
 [7] A: No.  
 [8] Q: And we stated earlier that the — it was a  
 [9] suboptimal echocardiogram.  
 [10] A: Yes.  
 [11] Q: Now if you got a suboptimal echocardiogram  
 [12] and were informed by the cardiologist, would you redo  
 [13] the echocardiogram and that's if you're thinking  
 [14] there's a cardiac source of the blood clot?  
 [15] Mr. Frasure: When are we assuming the  
 [16] cardiologist is recommending it?  
 [17] By Mr. Cowan:  
 [18] Q: I guess in my hypothetical is the  
 [19] cardiologist comes back to you telling you that the  
 [20] echocardiogram is a poor quality. My question is what  
 [21] would you do as the —  
 [22] A: I would ask the cardiologist what he  
 [23] recommends. If he would say hold off, you can only do  
 [24] what you can do and if he says he can't do it, he can't  
 [25] do it and if you order it again, it still doesn't mean

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[1] he can do it. All I know is it is suboptimal and the  
 [2] cardiologist obviously would try his best and if I were  
 [3] the neurologist or the physician in charge, I would say  
 [4] when can you do it and make it work?  
 [5] A: So you would like to get one performed, is  
 [6] that correct?  
 [7] A: Well, if I was — thought it might make a  
 [8] difference in what I might do I would insist on keeping  
 [9] at it until it is right. But I think when you're  
 [10] dealing with a person who's extremely disabled you're  
 [11] trying to preserve life at that time. I don't know  
 [12] what his condition was. Was he stable enough to  
 [13] transport would be the question in my mind. I don't  
 [14] know.  
 [15] Q: Doctor, let's say in this hypothetical there  
 [16] is a cardiac source and let's say of an embolism.  
 [17] Would the use of anticoagulants at that time be  
 [18] warranted for acute cerebral systemic infarct when a  
 [19] cardiac source of embolism is demonstrated and your CAT  
 [20] scan had come back negative?  
 [21] Mr. Frasure: You're asking to assume  
 [22] prospectively that we know there is a cardiac source of  
 [23] the emboli?  
 [24] Mr. Cowan: Correct, for hypothetical; it  
 [25] doesn't have to be in this case.

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[1] Mr. Frasure: We know that ahead of time.  
 [2] Mr. Cowan: Correct.  
 [3] Mr. Frasure: You're asking would he  
 [4] prescribe anticoagulants?  
 [5] By Mr. Cowan:  
 [6] Q: Correct, if you now have tests done, you find  
 [7] those thrombus somewhere on the heart, would you use  
 [8] anticoagulants at that point in time?  
 [9] A: In a man that has got evidence of changing  
 [10] level of consciousness it is extremely dangerous to  
 [11] give Heparin because you convert notoriously — you  
 [12] convert embolism to hemorrhage and most people will not  
 [13] give anticoagulants to someone who is suspected of  
 [14] having a cerebral embolism from the heart at the acute  
 [15] phase of the legion if they have a disability. The  
 [16] reason is they very frequently recanalize and bleed so  
 [17] hardly anybody uses anticoagulants in the hyperacute  
 [18] phase of cerebral embolism.  
 [19] Q: So it's your testimony that anticoagulants  
 [20] given in an acute state may cause the infarct to become  
 [21] hemorrhagic?  
 [22] A: That's correct.  
 [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 scan shows no bleeding,

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[1] anticoagulant therapy should be initiated immediately?  
 [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  
 [6] that the danger of the hemorrhagic occurrence outweighs  
 [7] the risk?  
 [8] A: No, no, you had it reversed. You told me  
 [9] that the risk of another embolism is greater than the  
 [10] risk of the hemorrhage. If that's what you said, most  
 [11] doctors would not believe that.  
 [12] Q: Would you agree that anticoagulants may  
 [13] reduce recurrent embolisms by as much as seventy  
 [14] percent?  
 [15] A: Over how much time?  
 [16] Q: I guess, let's say over twenty-four hours.  
 [17] A: No, I would not. You're talking about now is  
 [18] preventing them over time. The embolus that's happened  
 [19] already is like you said before; the horse is out of  
 [20] the barn; then you close the door. It's too late. You  
 [21] might after that particular event to the brain or  
 [22] wherever else it went is over and done with, then put  
 [23] the person on long-term anticoagulants as I do, but  
 [24] during that interim between the acute event and the  
 [25] recovery from it, the person is on his own and the

Cat  
del

!!

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[1] reason is that the hemorrhage is so likely to happen  
[2] that it is one of the worst things you can do is to  
[3] take a person who had an systemic infarction and invert  
[4] it to a massive bleed. You just don't do that; above  
[5] all do no harm and this is where you get into the  
[6] problem of harm.

[7] Q: Doctor, going back to the facts of this case,  
[8] on October 31st, 1996 at around 11:15 A.M., Dr. Giri  
[9] noted the enlarged pupil. What is the significance of  
[10] that finding?

[11] A: Incipient herniation.

[12] Q: And what would be the appropriate standard of  
[13] care and treatment for a neurologist?

[14] A: Again, it's where I would counsel with the  
[15] family to find out what the personal beliefs are and  
[16] what the person who had the problem beliefs were.  
[17] There isn't one single standard when you reach that  
[18] phase.

[19] Q: Assuming the parents want their son to  
[20] survive or at least have the attempt at it

[21] A: Then a surgical decompression.

[22] Q: Would you intubate the patient at that point  
[23] in time?

[24] A: Depends on the breathing; when the pupil is  
[25] blown there about to herniate which means the brain

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[1] stem is to be affected, that's a warning sign. It's a  
[2] sign to decompress from above and assign that breathing  
[3] may be impaired over time.

[4] Q: Would you order Decadron or Mannitol or  
[5] things that might reduce the brain swell?

[6] A: If the family wanted it, I'd do it.

[7] Q: And would that be done immediately if the  
[8] family wanted that?

[9] A: Yes.

[10] Q: Do you think a four or five hour — let's say  
[11] the family wanted those measures. Would a four or five  
[12] hour delay in receiving Decadron or Mannitol, could  
[13] that — how would that affect the situation?

[14] A: The longer it lasts the worst — the less  
[15] likely it is to work

[16] Q: Doctor, are you aware from the review of the  
[17] records that John Martin's condition had improved from  
[18] the emergency room to the ICU on October 29th, 1996?

[19] A: That's what they say.

[20] Q: Is that a good sign if you're going to try  
[21] and diagnose a stroke or treat a stroke?

[22] A: Yes, that's a good sign. It's always a good  
[23] sign when a person gets better.

[24] Q: Doctor, based upon your review of all the  
[25] medical records and the necropsy report, did John

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[1] Martin have epilepsy or a seizure disorder?

[2] A: From the records I think he did. From the  
[3] autopsy there's no way to tell. Autopsies don't show  
[4] anything often in people with epilepsy.

[5] Q: So it's your opinion that you believe that  
[6] John Martin did have a seizure disorder?

[7] A: In my opinion it's as likely as anything else  
[8] and from the history as given of limbs shaking on  
[9] repeated occasions, of an episode of loss of  
[10] consciousness for no apparent reason, with confusion  
[11] thereafter which is typical of a seizure plus self  
[12] injury when he was found unconscious, those are  
[13] seizures. Now whether or not the doctor gave him  
[14] Dilantin for neuritis or for seizures, I'll never know,  
[15] nor will you. It seems to me that he might have been  
[16] playing both ends against the middle, I don't know.

[17] Q: In any of the records that you've seen, has  
[18] John Martin ever been diagnosed with a seizure  
[19] disorder?

[20] Mr. Frasure: Prior to this —

[21] Mr. Cowan: Prior to coming to Med Center  
[22] Hospital.

[23] Mr. Frasure: Yes.

[24] By Mr. Cowan:

[25] Q: Have you ever seen a diagnosis of seizure

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[1] disorder by any physicians?

[2] A: It said questionable.

[3] Q: But I'm asking if you've actually seen  
[4] anything in his medical records or any physician in his  
[5] medical records diagnose seizure disorder?

[6] A: I thought it was in his local doctor's  
[7] differential diagnosis, when he went out to get the  
[8] mail and was found unconscious.

[9] Mr. Frasure: That was the syncopated  
[10] episode.

[11] The Witness: The syncopated seizures is a  
[12] tough differential diagnosis and many people call —  
[13] let me see that.

[14] By Mr. Cowan:

[15] Q: I guess my question is, is there an actual  
[16] diagnosis of seizure disorder or epilepsy anywhere in  
[17] the medical records that you've reviewed?

[18] A: Well, again, I go to 8/6/96, passed out after  
[19] going into the heat for mail; found self lying on the  
[20] right side, confused briefly.

[21] Q: Could that have been exhaustion or heat  
[22] exhaustion or sun stroke or — we're talking about a  
[23] man who's 320 pounds.

[24] A: How far did he have to walk to get the mail?

[25] Q: Can we assume he's not in the best of shape?

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[1] A: If he lived on a country lane and walks three  
[2] miles, yes, but if he lives as the average person does  
[3] and he walks out to the mail box, there's no excuse for  
[4] fainting. He had a seizure.

[5] Q: But does his physician ever have that  
[6] diagnosis anywhere?

[7] A: No, that's what I say.

[8] Q: That's your opinion, correct?

[9] A: Correct.

[10] Q: And you've never examined John Martin?

[11] A: That's true.

[12] Q: Doctor, you're not an expert in hematology or  
[13] genetics, is that correct?

[14] A: No, I'm not.

[15] Q: Doctor, from your review of all the records  
[16] in this case are you aware of any positive blood lab  
[17] findings or tests that demonstrate or conclude that  
[18] John Martin had a protein C or protein S deficiency in  
[19] his blood?

[20] A: I don't see any evidence that it was tested  
[21] for.

[22] Q: Doctor, are you aware of any positive lab  
[23] findings that conclude or demonstrate that John Martin  
[24] had antiphospholipid antibody in his blood?

[25] A: I don't see the evidence or test run.

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[1] Q: Therefore, Doctor, is it fair to say that you  
[2] cannot state with a reasonable degree of medical  
[3] probability that John Martin had a genetic  
[4] hypercoagulable disorder?

[5] A: No, I cannot but I also find other reasons  
[6] and explanations for formation of blood clot including  
[7] obesity, lack of —

[8] Q: I'm talking about the genetic things like  
[9] protein C or protein S.

[10] A: I agree. I do not have that evidence.

[11] Q: If he had one of these disorders, would that  
[12] be found in his mother or his siblings? Would they  
[13] have the disorder?

[14] A: I don't know. It is a genetic abnormality.  
[15] Whether it would be specifically be found in what  
[16] member of the family and the genetics of it, I don't  
[17] know.

[18] Q: In fact, I believe the neurologist at  
[19] Riverside Methodist Hospital requested the family  
[20] members get tested for some genetic factors. Are you  
[21] aware of that?

[22] A: No, I'm not. What did they find?

[23] Q: Fortunately I have to ask the questions.

[24] I'll tell you afterwards.

[25] Mr. Frasure: It was negative.



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[1] **Mr. Cowan:** You're correct.  
 [2] **The Witness:** Oh.  
 [3] **By Mr. Cowan:**  
 [4] **Q:** Dr. Toole, from the review of the records, do  
 [5] you think that the conversion disorder should have been  
 [6] part of the differential diagnosis on October 30th and  
 [7] October 31st; that's day two and day three?  
 [8] **A:** No, it should not have been and I think the  
 [9] person who said it was putting down information beyond  
 [10] the scope of his knowledge.  
 [11] **Q:** Is that the cardiologist who brought it up  
 [12] first?  
 [13] **A:** Yes.  
 [14] **Q:** And conversion disorder is not a life-  
 [15] threatening event?  
 [16] **A:** Well, I don't think it entered into the  
 [17] differential diagnosis and I don't think he should have  
 [18] written it down.  
 [19] **Q:** Were you aware that Dr. Thompson on October  
 [20] 31st, the last day, had requested a psychiatric  
 [21] consult?  
 [22] **A:** No, I'm not.  
 [23] **Q:** Would that surprise you?  
 [24] **A:** Yes.  
 [25] **Q:** Doctor, do you have any criticisms of the

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[1] emergency room physician and his care on the morning of  
 [2] October 29th, 1996?  
 [3] **A:** No, I do not.  
 [4] **Q:** Now my final few questions I want to talk  
 [5] about Dr. Thompson and Dr. Giri. Do you have any  
 [6] criticisms — let's start with Dr. Thompson, the  
 [7] attending, on his care on October 29th of 1996?  
 [8] **Mr. Frasure:** Standard of care deviations?  
 [9] **By Mr. Cowan:**  
 [10] **Q:** Right, do you think he deviated with  
 [11] acceptable standards of care? This is the attending on  
 [12] October —  
 [13] **A:** In my opinion, no.  
 [14] **Q:** What about on the second day, October 30th?  
 [15] **A:** What happens when a — two physicians — one  
 [16] is a general physician and the other is a neurologist  
 [17] interact is a question as to who is in charge sometimes  
 [18] and I believe, if I'm correct, that the physician in  
 [19] charge was Dr. Thompson and that the other doctors were  
 [20] consultants. And in that frame of reference, as  
 [21] advised by others, Dr. Thompson did correctly. I find  
 [22] no fault.  
 [23] **Q:** Should Dr. Thompson have ordered the MRI on  
 [24] October 30th, 1996, the second day and the Doppler  
 [25] ultrasound?

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[1] **A:** In an academic medical center, I would have  
 [2] done that. In the practice of medicine where each test  
 [3] needs to be done in order to institute a therapy for  
 [4] it, in order to get a diagnosis and start a treatment,  
 [5] I do not believe having done those tests earlier as I  
 [6] would have done would lead to a change in the treatment  
 [7] of the patient.  
 [8] **Q:** Would that be the same —  
 [9] **A:** Therefore it would be an academic exercise.  
 [10] **Q:** What about Dr. Giri, the neurologist, on the  
 [11] second day?  
 [12] **A:** Same name.  
 [13] **Q:** Would you have liked him to order the MRI —  
 [14] **A:** I would have enjoyed that, yes. I would have  
 [15] thought it would be a nice thing to have, but it would  
 [16] not have changed the management of the patient.  
 [17] **Q:** Do you have a criticism of Dr. Giri or the  
 [18] fact that he did not see the patient on October 30th,  
 [19] 1996, the second day?  
 [20] **A:** It depends on what the physician in charge  
 [21] wants. A consultant, as a rule, is not a continued  
 [22] second physician. Consultants are usually brought in  
 [23] to see the patient once and unless invited back, are  
 [24] released from obligation. Now in some places and some  
 [25] times physicians who don't have admitting privileges or

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[1] don't take care of inpatients continue to see such  
 [2] patients even though they are not taking care of the  
 [3] patient primarily. It's a shared responsibility and in  
 [4] this case I haven't been made aware of the differential  
 [5] responsibilities of physicians at that hospital. At  
 [6] this hospital there's one doctor in charge and  
 [7] everybody else is a consultant. So my answer is that  
 [8] if Dr. Giri specifically was just a consultant, nothing  
 [9] more, then he did okay.  
 [10] **Q:** Now let's say if Dr. Giri is — the patient  
 [11] is equally shared, then you do have some criticisms?  
 [12] **A:** Well, I —  
 [13] **Mr. Frasure:** Standard of care deviations,  
 [14] is that what you mean?  
 [15] **By Mr. Cowan:**  
 [16] **Q:** Yes, if he deviated from standards of care  
 [17] assuming that this patient is shared equally by Dr.  
 [18] Thompson and Dr. —  
 [19] **A:** Yeah, I think he would have been — well, bad  
 [20] he been more alert to the inpatient possibility of  
 [21] cerebral edema and for the treatment of cerebral edema,  
 [22] prophylaxis.  
 [23] **Q:** And that was on the third day then?  
 [24] **A:** I can't precisely say that.  
 [25] **Q:** I think you've already testified your belief

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[1] that the MRI and the Doppler ultrasound should have  
 [2] been ordered earlier than day three, is that fair to  
 [3] say?  
 [4] **A:** I'm saying in an academic medical center such  
 [5] as where I work that I wouldn't say that in a community  
 [6] hospital that a think I consider to be an academic  
 [7] exercise to prove etiology which has no therapeutic  
 [8] implication for diagnosis would be necessary. It would  
 [9] be a nice thing to have but not an essential thing to  
 [10] have.  
 [11] **Q:** If the middle cerebral artery clot as well as  
 [12] the left internal artery clot could have been  
 [13] diagnosed, let's say within the first twenty-four  
 [14] hours, would John Martin have had, with a reasonable  
 [15] degree of medical probability, a better chance of  
 [16] survival than having it diagnosed on the third day,  
 [17] October 31st?  
 [18] **Mr. Frasure:** Objection.  
 [19] **The Witness:** Well, on the first day there's  
 [20] no evidence clinically or by CT of swelling of the  
 [21] brain so the swelling occurred thereafter. Part of the  
 [22] swelling is the recanalization. In other words, if  
 [23] there's no blood flowing into that part of the brain,  
 [24] it can't swell. So therefore, that's evidence that  
 [25] what had been blocked off opened up and when it opens

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[1] up the swelling which is and/or hemorrhage. Now the  
 [2] swelling is a precursor to hemorrhage because the  
 [3] arteries are open; the capillaries are open and they  
 [4] just allow fluid to out where they're not supposed to  
 [5] go out. The next thing that happens after that is  
 [6] hemorrhage, so that the arteries had become  
 [7] recanalized, the clot had dissolved or gone distally.  
 [8] At that moment in time is when the brain began to swell  
 [9] and the pupil began to blow and when that happens, that  
 [10] becomes a medical emergency if you chose to treat the  
 [11] person to whom that's happened and I don't have the  
 [12] answer to that part of the equation. That's up to the  
 [13] family to decide one way or the other. That's judgment  
 [14] calls.  
 [15] **Q:** Now let's say if on — within the first  
 [16] twenty-four hours you ordered a Doppler ultrasound of  
 [17] the carotids and you found the occlusion of the left  
 [18] internal carotid, what can be done at that time to  
 [19] enhance or increase John Martin's survival?  
 [20] **A:** First of all, the Doppler of the neck would  
 [21] not have shown the lesion of the brain and the carotid  
 [22] that was occluded was distal to the neck, so  
 [23] theoretically the ultrasound, duplex as we call it, not  
 [24] Doppler would have show either an abnormality of  
 [25] pulsation perhaps or flow. In other words, I think in

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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  
 [8] 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] Q: A neurosurgeon would do that.

[20] A: No, I mean diagnose and Rave it done. It  
 [21] doesn't happen. 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  
 [25] clot happened sometime between admission and October

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[1] 31st, 1996 or did the middle cerebral artery occlusion  
 [2] happen prior to admission to the ER?

[3] A: That happened when he fell out, when he lost  
 [4] consciousness. It might have been an embolus that made  
 [5] him have the convulsion and also produced the stroke,  
 [6] but in this particular kind of event, an embolism is  
 [7] notorious for causing a convulsion and it also  
 [8] strengthens the Todd's paralysis, the most likely  
 [9] 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 cannot blame the doctors at the end  
 [17] of the train of sequences who happen to be the last  
 [18] ones who got him when he's almost dead for doing what  
 [19] some of the doctors who had seen him earlier might well  
 [20] have been able to diagnose but didn't. Not that they  
 [21] were below the standard, this man had a rare and  
 [22] unusual sequence of events. I happen to think  
 [23] personally, nor as a testifying physician, that his  
 [24] trouble was coming out of his lungs and that his 315  
 [25] pounds of obesity and he can't breathe right, that he's

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[1] dotting up his lungs with clot. They're going through  
 [2] his heart, out there and going up to his brain and you  
 [3] weren't going to stop this.

[4] Q: This is your personal belief, not your  
 [5] testifying belief?

[6] A: Well, I might have to say that sometime  
 [7] because I don't believe the autopsy has fully explained  
 [8] what happened to the man. Where did the dot come  
 [9] from?

[10] Q: We don't have the autopsy of the lung.

[11] A: That's true.

[12] Q: I guess, Doctor, my last question is, are you  
 [13] going to testify live at the trial or by videotape on  
 [14] November 30th of 1999?

[15] Mr. Frasure: Videotape, do we have him  
 [16] scheduled for videotape?

By Mr. Cowan:

[18] Q: That's my question. Are you going to testify  
 [19] live or by videotape?

[20] A: I will do whatever I'm asked by my —

[21] Q: Are you going to be in the country?

[22] A: Oh, yeah.

[23] Mr. Frasure: Yes, he's planning on coming

[24] in  
 [25] The Witness: Yeah, I'll be there the night

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[1] of Thursday, the morning of Friday, December the 3rd.

[2] Mr. Frasure: So make room for him. That's

[3] what he's saying. Get your experts off before then.

[4] Mr. Cowan: I'll try my best; thank you,  
 [5] Doctor, for your time here today.

[6] (The proceedings were concluded.)

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## SIGNATURE

[3] I have reviewed the preceding eighty pages,  
 [4] which contain an accurate transcript of the answers  
 [5] given by me to the questions herein recorded. My  
 [6] signature is subject to the corrections.

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James Toole, M.D.

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[1]  
[2] NORTH CAROLINA  
[3] FORSYTH COUNTY  
[4] CERTIFICATE  
[5] I, David L. Overby, Notary/Reporter, do  
[6] hereby certify that James Toole, M.D. was duly sworn by  
[7] Pamela S. Faucette, Notary/Reporter, prior to the  
[8] taking of the foregoing deposition; and that this  
[9] 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.  
[13] I certify that I am not counsel for, or  
[14] employed by either party in this action, nor am I  
[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 taking of this  
[19] deposition.  
[20] IN WITNESS THEREOF, I have hereunto set my  
[21] hand this 29th day of October, 1999.  
[22]  
[23] David L. Overby  
[24] Notary Public for the  
[25] State of North Carolina  
[26]  
[27] My commission expires: January 14, 2003  
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