IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MARYLAND

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Plaintiffs, :
v. : Civil No.
., :
Defendant :
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TESTIMONY OF

Rockville, Maryland

DEPOSITION SERVICES, INC.
12321 Middlebrook Road, Suite 210
Germantown, MD 20874
(301) 881-3344

ORIGINAL

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MARYLAND

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Plaintiffs,

v. Civil No.

,

Defendant

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Rockville, Maryland

WHEREUPON, the proceedings in the above-entitled matter commenced

BEFORE: THE HONORABLE , JUDGE

APPEARANCES:

FOR THE PLAINTIFFS:

RODNEY M. GASTON, Esq.
Miller & Zois, LLC
Empire Towers
7310 Ritchie Highway
Suite 1001
Glen Burnie, MD 21061

FOR THE DEFENDANT:

1 P R O C E E D I N G S

2

3 called as a witness on behalf of the plaintiff, having been

4 first duly sworn, was examined and testified as follows:

5 THE COURT: You may be seated.

6 DIRECT EXAMINATION

7 BY MR. GASTON:

8 Q Good afternoon, doctor.

9 A Hello.

10 Q Could you please state your name and your business

11 address for the members of the jury?

12 A

13

14 Q Okay. Doctor, I show you what's been marked as

15 Plaintiff's No. 56 for identification, and I will ask if you

16 can identify this document.

17 A Sure. That's my resume.

18 Q Okay. Does that contain your educational experience,

19 your work experience as a physician?

20 A Yes.

21 Q Okay. If we can review with the members of the jury,

22 where did you attend medical school?

23 A School of Medicine.

24 Q What year did you graduate?

25 A '83.

1 Q And, after graduating from medical school, did you
2 attend an internship and residency program?
3 A Yes.
4 Q And where were they, doctor?
5 A That was at Hospital in .
6 Q And what was the nature of your residency and
7 internship?
8 A It was a three-year combined internship and residency
9 in family medicine.
10 Q Okay. After you completed your internship and
11 residency, did you become licensed to practice medicine?
12 A Yeah, actually during my, right after my internship,
13 I was licensed.
14 Q Okay. And what state are you licensed to practice
15 medicine in, doctor?
16 A Maryland.
17 Q Okay. And do you know how long you've been licensed
18 to practice medicine in the State of Maryland?
19 A Since '86.
20 Q Okay. Are you board certified in any recognized
21 specialty field of medicine?
22 A Family medicine.
23 Q Okay. And do you know when you became board
24 certified?
25 A 1986.

1 Q Okay. And, doctor, after finishing your residency at
2 University in family medicine, can you give the
3 members of the jury an understanding of where you worked as a
4 doctor and what you did?
5 A Yeah. For 11 years, I was on the eastern shore of
6 Maryland. We had a main office in . I was there, as I
7 said, for 11 years. I became the medical director of a small
8 group. There were four of us in the group, and, but most of my
9 work was clinical; 80 percent clinical work. It was office and
10 hospital-based, the full range of family medicine children all
11 the way on up to end of life care.
12 Q Okay. And then where did you go from there?
13 A Then I went to Baltimore to a similar community
14 health center, , doing very much the
15 same kind of thing, inpatient and outpatient family medicine,
16 also with administrative responsibilities.
17 Q Okay. Then when's your next employment, doctor?
18 A Okay. So, that, it got a little, a little sticky in
19 there, because I, I took a little time off to get into
20 electoral politics, and, so that I stopped working there, but
21 worked part-time in an urgent care center at Hospital,
22 at .
23 And, after I lost the election, I began working,
24 well, I wanted to work full-time for , but there wasn't
25 an opening, so I got three months worth of the family practice

1 in , Maryland. And, then, when the opening came at
2 , and they offered me the job, I went over there. So,
3 that's what I was doing. I've been at since 2007,
4 April of 2007.
5 Q Okay. And what is your primary responsibility as a
6 doctor for Hospital?
7 A Currently, I'm a hospitalist, so I spend 100 percent
8 of my clinical time in the hospital at ,
9 in .
10 Q Do you still hold any positions at
11 ?
12 A And, and a part-time clinical faculty, part-time
13 clinical.
14 Q Okay.
15 A Well, actually, I'm still on staff. I'm still, I
16 still have privileges at Hospital and at .
17 Q And you were also one of the chairman of
18
19 A I was, I was the director of that division. Yeah,
20 so, most of the time I've held some various administrative
21 positions, so I wasn't always 100 percent clinical. And, and
22 that's what I was doing for about four years at the main
23 hospital at . The division, the was in the
24 department of emergency medicine.
25 Q Okay. And what type of patients did you see while

1 you were employed at --

2 A ?

3 Q -- Emergency Medicine?

4 A Yeah, that's, yeah, it's a section of the emergency

5 department where we would see the more minor illnesses, not,

6 most of the time. I mean they, they, sometimes people would

7 come in with what seemed like a minor illness, but it was

8 obvious it was more serious, and they would either get admitted

9 or moved to another part of the emergency department.

10 I also worked in, in an observation unit in, in the

11 emergency department too. That was a smaller part of my

12 responsibilities, and that's like a mini-hospital environment,

13 a short stay kind of unit.

14 Q And, doctor, in your years of experience as a

15 physician, can you tell the members of the jury what family

16 practice medicine entails, the type of patients you see, and

17 the type of care that you give your patients?

18 A Well, the general concept of family, family medicine

19 is it's comprehensive. It's a continuous care over periods of

20 time. There's emphasis on, on, you know, treating the whole

21 family. There's no distinction made between different

22 diseases, or genders, or ages. So, we pretty much see all, all

23 patients, take all comers.

24 Q Do you treat patients for diabetes?

25 A Yes.

1 Q Do you treat patients for hypertension?
2 A Yes.
3 Q How about kidney failure?
4 A Yes.
5 Q Kidney disease?
6 A Yes. Yes.
7 Q Do you have sometimes patients that come in with hip
8 fractures, you have to follow them?
9 A Absolutely.
10 Q Okay. During the course of your treatment with
11 patients, have you ever treated patients who have had shock?
12 A Oh, yes.
13 Q And, as part of your job, as a physician in treating
14 all these patients, have you also had to treat patients who
15 suffered -- to watch for and treat patients who suffered from
16 internal bleeding?
17 A Oh, yes.
18 Q Okay. And, doctor, have you ever had to testify in a
19 court like this in a case like this?
20 A No.
21 Q And I believe we did ask you to come and testify as
22 an expert in this case, is that correct?
23 A Yes.
24 Q Okay.
25 MR. GASTON: Your witness on voir dire.

1 VOIR DIRE

2 BY MR. :

3 Q Good afternoon, sir.

4 A Good afternoon.

5 Q I'll let you pour that water first.

6 A Yeah. (Unintelligible.)

7 MR. GASTON: Oh, I'm sorry. I will have to qualify
8 the doctor with respect to standard of care, unless -- I don't
9 know if that should be appropriate at this time, but I guess I
10 need to do that.

11 DIRECT EXAMINATION (Resumed)

12 BY MR. GASTON:

13 Q Doctor, we've asked you to come and testify in this
14 case regarding the standard of care that Dr. gave to
15 Mr. while he was at Hospital.

16 In your practice as a physician in Maryland, are you
17 familiar with the standard of care that's required of doctors
18 with similar skills as Dr. teaching similar -- treating
19 similar patients, such as Mr. , in the Maryland medical
20 community?

21 A Yes.

22 Q Are you also aware, and can you testify to any
23 breaches of the standard of care that was occasioned by Dr.
24 treating Mr. in the Maryland medical community?

25 A Yes.

1 Q Thank you very much.
2 MR. GASTON: Sorry, counsel.
3 MR. : Thank you.
4 VOIR DIRE
5 BY MR. :
6 Q Good afternoon, again, sir.
7 A All right.
8 Q You say that you're a hospitalist, is that correct?
9 A Yes.
10 Q So, you spend your entire professional time in a
11 hospital, is that correct?
12 A Yes.
13 Q You don't see patients outside of a hospital, is that
14 correct?
15 A That's correct, yeah.
16 Q And, prior to being a hospitalist, you were employed
17 in the emergency medicine department starting in April of
18 2007 --
19 A Yes.
20 Q -- is that correct?
21 A Uh-huh. Yes.
22 Q Is that right?
23 A Yes.
24 Q Before 2007, you decided that you wanted to become a
25 member of the , is that right,

1 sir?

2 A Yes.

3 Q And you ran an election in the First Congressional

4 District --

5 A That's right.

6 Q -- is that correct?

7 A That's right.

8 Q Big venture, wasn't it?

9 A Oh, yeah. Eye-opening experience.

10 Q You actually wrote about that, didn't you, sir, about

11 your --

12 A I believe I did.

13 Q -- reasons for becoming a member of the

14 , didn't you?

15 A I, I think I, it was published in our family practice

16 journal, if I remember correctly.

17 Q The " ," is that right?

18 A Yes.

19 Q And, in there, you stated that you have been

20 providing -- and I'll show this to you -- public service for

21 almost 20 years. Is that right, sir?

22 A At that time, it would have been like 19, almost 20

23 years. That's right.

24 Q I'll show you Exhibit 25.

25 A Say that again. Oh, Exhibit 25.

1 Q You wrote that because you were -- I mean it's one
2 effort to try to encourage people to vote for you, is that
3 right, sir?
4 A Can, can, can I clarify, because you didn't read the
5 whole sentence? I said I have been providing public service
6 from the private sector for almost 20 years.
7 Q So, do you consider that you, in trying to become
8 elected, were telling everyone that you were providing a pubic
9 service to the citizens of the State of Maryland, is that
10 right?
11 A That's correct.
12 Q How many years did you work where you didn't provide
13 any medical care, and you just adjusted claims for the
14 Insurance Company?
15 A I was with for about seven months, seven and a
16 half months.
17 Q And you were providing a public service when you were
18 denying claims on behalf of for some of their members, is
19 that what you're trying to tell everyone in the "
20 ," when you were trying to be elected to the
21 ?
22 MR. GASTON: Objection. Argumentative.
23 THE COURT: Sustained.
24 BY MR.
25 Q Can we agree that you weren't providing a pubic

1 service when you were adjusting claims for , is that
2 right, sir?
3 A No, not a public service, no.
4 Q So, what you told in that statement in 2006 to become
5 elected, was not true, is that right, sir?
6 A No, it was true.
7 Q It was true. You believe that, when you were
8 adjusting claims for --
9 A No.
10 Q -- that was a public service --
11 A No.
12 Q -- you were performing?
13 A No, I didn't say that I was doing that continuously
14 for almost 20 years. I said I was doing that for almost 20
15 years. Yes, there was a seven and a half month hiatus when I
16 learned about the insurance industry from the inside. And you
17 should ask me why I only stayed for seven and a half months,
18 but --
19 Q And the rest of the time when you were getting paid,
20 and seeing patients down in and in Baltimore, you think
21 that's a public service, is that right?
22 A Would you like to know why I think that?
23 Q I'm asking you. You believe it's a public service,
24 is that right?
25 A Yes.

1 Q Because that's what you told people when you were
2 trying to solicit votes to become elected to the
3 , is that right?
4 A I had been saying that long before I decided to
5 solicit votes.
6 Q Now, you were listed also as a quote "fast track
7 position" unquote when you were taking care of medical problems
8 in the emergency department, is that right?
9 A Say it one more time.
10 Q You were listed as a quote "fast track position" when
11 you were taking care of minor medical problems in the emergency
12 department, is that right?
13 A Listed as one. I'm not sure what you mean by listed
14 as one.
15 Q Well, that's what you were characterized, and you
16 told us in your deposition that, is that right?
17 A Yes.
18 Q So, you would see a level 3, 4, or 5. You would see
19 the patients who had minor problems in the emergency
20 department, is that correct?
21 A That's right.
22 Q And they were triage. If they had a minor, they
23 would come to you. If they had a major problem they'd go
24 elsewhere, is that right?
25 A When I was working as fast track, yes.

1 Q How much are you charging Mr. Gaston, in this
2 particular case?
3 A Total?
4 Q Well, that's a good start.
5 A I don't know.
6 MR. GASTON: Objection. Doesn't go to his
7 qualifications, Judge.
8 THE COURT: I will permit it.
9 THE WITNESS: I don't have the total.
10 MR. GASTON: Okay.
11 THE WITNESS: I could tell you what I would charge
12 per hour.
13 BY MR. :
14 Q What are you charging per hour?
15 A $275.
16 Q Okay. And do you know how many hours you put in this
17 case?
18 A More than I charged for, that's for sure, but if I
19 had to guess I'd probably say somewhere around 20 hours total
20 that I billed, perhaps, more.
21 Q And you have furnished a bill recently, haven't you?
22 A Yes.
23 Q Well, have you been here since 9 o'clock yesterday?
24 A Been in the courtroom since 9 o'clock? No.
25 Q What time did you get here yesterday?

1 A 11:15 or so.

2 Q And you stayed here the rest of the day, is that

3 right?

4 A Yes.

5 Q You sat back there and listened to the testimony of

6 the fact witnesses in this case, is that right, sir?

7 A Yes.

8 Q And you've been here all morning, and you sat here

9 and listened to testimony from Dr. , is that correct?

10 A Yes.

11 Q So, you've been billing all that time too, is that

12 right?

13 A Well, my, I have a flat fee for a trial day.

14 Q You have a flat fee for a trial day?

15 A For one day, yeah, because I have to block this out

16 of my, this whole week out of my schedule, so I can't work, I

17 can't be earning, so I figured I would charge for the day.

18 Q Okay. And what's the flat fee for the day?

19 A $3,000 a day.

20 Q So, you're charging $6,000 just for the past two

21 days, plus the time per hour that you spent in reviewing

22 medical records and all in this case, is that right?

23 A That's what I billed for, right.

24 Q You don't have any formal training in pathology, do

25 you, sir?

1 A Other than what I got in four years of medical
2 school, and an elective in medical school, and what I learned
3 in residency, and everything I've picked up in the 25 some odd
4 years since then.
5 Q Did you take the occasion to look at any slides in
6 this case, sir?
7 A Slides? No.
8 Q And you don't have any formal, specialized training,
9 residency or otherwise, in hematology, is that right?
10 A That's right.
11 Q No formal, specialized training in the area of
12 pulmonology, is that correct?
13 A That's right.
14 Q No formal, specialized training in the area of
15 nephrology, is that correct?
16 A That's right.
17 Q And no formal, specialized training in the area of
18 critical care medicine, is that right?
19 A That's right.
20 MR. : I have no questions at the present
21 time.
22 DIRECT EXAMINATION (Resumed)
23 BY MR. GASTON:
24 Q Why did you leave after seven months?
25 A I didn't like what I was being asked to do, and there

1 was, there were policies that we were supposed to follow, you
2 know, medical reasons for, for approving or denying claims, but
3 then I would be overridden by, by someone because it would make
4 bad press, or because somebody was threatening to do something,
5 or somebody was connected to somebody. And it was not an
6 objective process, and I left.
7 Q Okay.
8 MR. GASTON: Move that the doctor be considered as an
9 expert witness in the field of medicine with a specialty in
10 family practice.
11 THE COURT: Very well.
12 BY MR. GASTON:
13 Q Doctor, with respect to your testimony today, because
14 this is the first time you're in court, the jury cannot hear
15 your opinions unless you have reached them within a reasonable
16 degree of medical probability. That's fancy legal talk for the
17 simple phrase that you believe something is more likely so than
18 not. When I ask you that question, it simply means that you
19 believe something's more likely so than not.
20 And I would ask you, for the opinions that you've
21 decided to give, it has to be to that degree of legal standard.
22 Do you understand that, doctor?
23 A Yes.
24 Q And are you able to do that today?
25 A Yes.

1 Q Okay. Doctor, in preparation for today's testimony,
2 did you have the opportunity to review some documents and
3 records that were sent to you?
4 A Yes.
5 Q Can you briefly describe to the members of the jury
6 what are the medical records that you reviewed, and what are
7 some of the documents that you also reviewed?
8 A Well, I looked, I reviewed the, the autopsy; the
9 death certificate; the entire hospital chart; some of Dr.
10 's office records; oh, depositions, a variety of
11 depositions from the people I think you've all heard from,
12 except for maybe one or two --
13 Q Did you also review --
14 A -- the images, the CT images. I had some
15 conversations with Dr. (phonetic sp.), the pathologist
16 that was mentioned before. That's about all I can think of
17 right now.
18 Q Okay. After reviewing all the documents in this
19 case, have you reached an opinion within a reasonable degree of
20 medical probability whether Dr. breached the applicable
21 standard of medical care that was required for a similarly
22 skilled doctor treating a similarly -- patient with similar
23 injuries and illnesses within the Maryland medical community?
24 Do you have an opinion?
25 A Yes, I do.

1 Q And, doctor, what is your opinion?

2 A I believe Dr. did breach those standard of

3 care.

4 Q Do you have an opinion within a reasonable degree of

5 medical probability whether the breaches of the standard of

6 care was a proximate cause of 's death?

7 A Yes.

8 Q And what is your opinion, doctor?

9 A I believe that those breaches were the proximate

10 cause of Mr. 's death.

11 Q Doctor, before we go into detail of all of your

12 opinions, can you summarize them to the members of the jury in

13 a couple of sentences as to what breaches you believe Dr.

14 committed that was a proximate cause of Mr. 's

15 death?

16 A Well, he failed to recognize the early signs of

17 shock. He, he failed to address and evaluate, failed to

18 adequately treat it. The shock is cause by internal bleeding

19 from a fracture that he knew about, and failed to consider

20 bleeding as an option, as a possibility, as a likely

21 explanation for why Mr. was going into shock.

22 Q Doctor, what is the type of fracture that Mr.

23 sustained when he fell on th that brought him into the

24 hospital?

25 A He had a comminuted left hip fracture, a left pelvic

1 fracture. Well, I mean more accurately there were three bones
2 that were broken, but the bones that make up the pelvis, and
3 comminuted is too many pieces to really count.
4 Q I show you what's been marked as Plaintiffs' No. 24
5 for identification. And I don't know if you can see that, and
6 hold on one second.
7 You just press this red button here. And there's a
8 pointer. And actually I might stay right here, doc.
9 Doctor, can you explain to the members of the jury,
10 first off, does this exhibit fairly and accurately depict the
11 condition of Mr. 's left pelvic when he entered the
12 hospital at Hospital on
13 A Yes.
14 Q And would it help you to explain your opinion to the
15 jury to discuss with the jury what are the images that are on
16 the exhibit?
17 A Sure. I think it would be helpful.
18 Q Okay. And let's start with the top. Let's go with
19 the top upper left picture image, doctor, right there. And
20 what does that represent?
21 A So, this, this is a reconstruction of taking, you
22 know, a CT scan takes multiple slices through an individual in
23 this kind of plane, multiple slices, and then you can, through
24 a computer, reconstruct those into an image of the bony pelvis
25 in this case, and that's what you're seeing.

1 This is from the front, looking at his front. That
2 would be the tail bone way in the back there. This hole is the
3 pelvic inlet. The bladder sits in there. And then the, these
4 are probably what most people think of the hip bones, the big
5 wings that come out the side there.
6 Now, you can see a little bit of his femur, which is,
7 no, maybe a lot of people consider that to be the hip. Sorry.
8 Anyway, so, what you're seeing here is the fracture, right,
9 hard to hold that steady enough, but the fracture line
10 extending down, and you can see how it, it goes off in a little
11 branch there. And down here it's in lots of little fragments.
12 So, that's why it's comminuted.
13 There's another thing you might be able to see here
14 that the fracture edges are not lined up. For example, right
15 here the edges are pretty well lined up; they don't overlap at
16 all. Here the edges are further apart, and they, it's
17 displaced. That piece of bone is, is displaced; it's knocked
18 out of line.
19 Q What about the center?
20 A The center is a side view, so you're looking at from
21 his, his left looking at, directly on the side, so you can kind
22 of see the outside of the ilium here, the, the wing where the,
23 where the fracture's on the, on the outside of the bone.
24 So, here's kind of the inside, and there's the
25 outside. So, it clearly extends through the bone, and you can

1 see the fracture line going down like that. It cuts across
2 again. That's this part right here, and then it goes down
3 across that superior ramus, that's the top of the pubic bone
4 there.
5 Q And the photograph on the right, doctor?
6 A Sorry. So, I'm sorry. So, this would be his front,
7 and that's his back, again, there's the tail bone.
8 That's, oh, a back view. Now, you're looking at the
9 same. It's direct on, but it's from the back side. So, you
10 can see now the left hip is over here. Again, it's showing
11 that fracture coming down the ilium, and then kind of branching
12 out in these different directions here. It's a little hard for
13 me to see from here.
14 Q Okay. And do we have some other images on the bottom
15 of that exhibit?
16 A Yes. So, it looks like what the artist has done here
17 is draw the, the bony structures, but it's also overlaid some
18 of the soft tissues. You kind of get the layout a little
19 better.
20 Q Okay. And, doctor, can you -- why -- I'm sorry.
21 What, if any, common recognized complications are there from
22 this type of pelvis fracture?
23 A Well, it's actually a fairly reason, it's a fairly st
24 stable fracture as opposed to, you know, if you were to break
25 through a bone, a long bone like this it could wobble like

1 that. You know, that's why it has to be splinted, or, or
2 surgically repaired, surgically fixed, because if it wobbles
3 around like that, those, those loose ends can really do a lot
4 of damage, especially if you have some major arteries running
5 along there.
6 So, it's a fairly stable fracture, so you're not
7 worried too much about that. But what you are worried about,
8 mostly about, and this type of fracture would be bleeding,
9 would be fat embolus could be a possibility. That's where
10 little pieces of the bone marrow actually break loose and get
11 into the bloodstream, go into the lungs.
12 But, primarily, hemorrhage would be the biggest risk
13 of a fracture like this.
14 Q We don't have any blood vessels in that diagram,
15 doctor. Are any blood vessels close to the area of the hip if
16 the pelvis has been fractured?
17 A Well, you have all different size blood vessels. I
18 mean the bones are covered with a tough, fibrous membrane that
19 has blood vessels coursing through it. So, you just have to,
20 would imagine there's all kinds of little blood vessels --
21 Q And how about the middle picture?
22 A -- running all over.
23 The same thing. You'd have blood vessels coursing
24 down here. They would bridge across the hip joint in here.
25 So, yes, blood vessels are all over the place and in close

1 proximity to the fracture.

2 Q Okay. Doctor, have you had the occasion to read the

3 autopsy report?

4 A Yes.

5 Q Okay. And can you tell the members of the jury if

6 there's any indication in the autopsy report of any bleeding

7 inside of Mr. 's body that was found on autopsy?

8 A Yes.

9 Q And would it be helpful to show the members of the

10 jury the autopsy report itself, and then to read from the

11 actual page of the autopsy report where the bleeding was?

12 A Yeah, that would be helpful.

13 Q I have a copy of it enlarged right here, doctor, for

14 you.

15 A Good, because I don't know how this one's laid out

16 here.

17 Q Does that look like the autopsy report?

18 A Okay. That's a page from it.

19 Q And I'm sorry if all of us can't read this, but if

20 you can just read this first sentence here.

21 A Yeah, so this is the autopsy. "Examination of the

22 abdominal cavity revealed soft tissue hematomas dissecting

23 through the fascial planes of the left retroperitoneum hip and

24 left lateral abdominal wall."

25 Q Okay. Let's stop there. What is soft tissue

1 hematomas? What does that mean?

2 A Hematomas are collections of blood. In this case,

3 they're talking about in the soft tissues.

4 Q Plural meaning more than one, correct?

5 A Yes.

6 Q Okay. Now, where are these found in Mr. 's

7 body? And if you can use the pointer, or you can use the laser

8 pointer. On here, where is the coroner describing the area

9 that these are found in?

10 A Yeah. The pointer's not wide enough to really give

11 you a good sense of it. So, fascial planes, you would really

12 need to see muscles to best visualize the fascial planes,

13 because the fascial planes are the, the areas where, where

14 muscles just kind of lay up against each other.

15 So, you have to imagine groups, bundles of muscles

16 all over the place. The abdominal wall, so, they're talking

17 about the left lateral abdominal walls. So, that would be

18 seen, you could see that from this side view here. That would

19 be the left side of the abdominal wall actually extending all

20 the way across to the new line. That would define the left

21 side. So, all around like that.

22 You could see them coming up here too. Here's more

23 of the left side of the abdominal wall all the way up here.

24 And the hip area, of course, as I said, this, you'd see,

25 they're talking about here's the hip. The hip is all around

1 here. The hip is all around here.

2 And then the retroperitoneum is a little hard to

3 explain, but it's --

4 Q Can you explain it on your body if you could maybe

5 point to it?

6 A It's in, it's in the back just inside the back. So,

7 if you had your muscles of your back just inside where your

8 kidneys are, that's the retroperitoneum. It pretty much goes

9 from the ribs, which are even out of the view of this picture,

10 from the ribs all the way down deep into the, into the pelvis.

11 Q Would you describe the area that's being depicted by

12 the coroner where these blood clots are found to be a small or

13 a large area?

14 A I'm sorry. Say that again.

15 Q The area that's being depicted by the coroner, and

16 the area that you've just described for the jury, do you

17 consider that to be a tiny area in the human body or a

18 relatively large area?

19 A That's a large area. I mean you could think of that

20 as a percentage of body area, and it would easily be 9 to 18

21 percent of body area.

22 Q Thank you, doctor. You can have a seat. Doctor,

23 when you reviewed the medical chart, can you tell the members

24 of the jury what Mr. blood pressure was when he entered

25 the hospital?

1 A Yes.

2 Q Do you remember what that was?

3 A The number 88 over 49 is what's in my head.

4 Q Okay. And is that low blood pressure?

5 A Oh, yes.

6 Q Okay. And what is Mr. baseline blood

7 pressure in light of the history that you reviewed?

8 A Well, the, his history said that he had labile

9 hypertension, which is another way of saying difficult to

10 control blood pressure, which means it can be up, it can be

11 down.

12 He also had longstanding hypertension. He was also

13 on multiple, multiple blood pressure medicines. So, the

14 implication is that his blood pressure at base would be higher

15 than the normal person. So, even the, there's something called

16 relative hypotension. So, for a person who normally runs

17 pretty high, even what might be normal for all of us would be

18 low for them.

19 Q Okay. And did one of the doctors, either the

20 emergency room doctor or Dr. , how did they address the

21 low blood pressure when Mr. was first admitted to the

22 emergency room?

23 A Well, the emergency room doctor approximately gave a

24 bolus. You heard that word, a normal saline, which is full-

25 strength IV solution you might want to call it that.

1 Q What's a bolus?

2 A Well, he gave 500 cc's, and a bolus means you, you
3 get it in as quickly as it will go, wide open, the IV as, as,
4 as large as the bore needle that you have, as large as the vein
5 can take poured in there, poured the fluids in.

6 The emergency room doctor did that, re-checked the
7 blood pressure. The blood pressure had come up nicely, so he
8 maintained a pretty reasonably brisk IV solution at 150 cc's an
9 hour still using the normal saline, but using the full-strength
10 stuff.

11 Q And inside the body, how does the infusion of fluid
12 work to increase the blood pressure?

13 A It, it increases the volume. So it's going directly
14 into the vein. And, again, because it's, it's full-strength
15 saline, it's going to keep fluid in the, in the circulatory
16 system. It keeps the fluid. It, it adds fluid, and then that
17 fluid stays in the circulatory system.

18 Once you've do that, because of the physics on how
19 the circulatory system works, you increase the volume, the
20 pressure will go up, assuming other things don't change.

21 Q And should all family medicine doctors know this
22 simple way to deal with low blood pressure is to simply give
23 fluids?

24 A Yes. Yes.

25 Q Is Dr. required to know that, as well?

1 A Yes.

2 Q Okay. So, his blood pressure came up after they gave

3 him some fluids, which I think was a good think, you would

4 agree?

5 A Uh-huh. It got up and stayed up. And, so, he was

6 ready to be transferred up to the medical floor.

7 Q Okay. When he was transferred to the medical floor,

8 what was his condition when he entered the room, and what did

9 the orthopaedic doctor recommend for his course of treatment?

10 A His condition?

11 Q You know, did he still have the fracture?

12 A Oh, yes.

13 Q Okay. All right. So, he's in the room, and did they

14 recommend any type of traction for him?

15 A Yeah, I believed they put him in traction, and he did

16 not think it was operative, certainly, not initially. It was

17 put him in traction and pain control. I believe that was the

18 orthopaedist's plan.

19 Q Okay. And Dr. came in to see Mr. , is

20 that correct?

21 A I believe on that, that morning of the 15th, right.

22 Q Okay. Did he order some fluids for him at that time?

23 A If I could just look, because I tried to, as you

24 heard, it's, it's a little difficult to reconstruct some of the

25 details, but it does appear that Dr. left a telephone

1 order at possibly 11:45 that morning changing the IV to the
2 weaker solution and giving it at a lower rate. He changed it
3 to the half normal saline at 100 millimeters an hour.
4 Q How does the weaker solution -- what is the efficacy
5 of a weaker solution versus a stronger solution? How does that
6 work inside the body?
7 A Well, if you put a, a fluid into, directly into the
8 vein that is lower concentration than the tissues around it,
9 the water will get pulled into the tissues, instead of staying
10 into the blood vessels, so it can have the benefit of hydrating
11 someone.
12 So, if someone tissues and their whole body is
13 craving water, that's a good way to get them water, but it
14 won't do much to help keep up the blood pressure, if anything.
15 Q And, from your recollection of the chart, how was Mr.
16 's condition from the 15th through the 16th? Was his
17 blood pressure stabilized? Was his heart rate stabilized?
18 A Yeah.
19 Q How was he doing?
20 A Yeah, I believe he was pretty good. Now, now, Dr.
21 did say earlier today that, on the 15th and the 16th,
22 he, his blood pressure was fine, it was stabilized, I believe
23 was the word he used. Yet, the nurses did hold three of the
24 blood pressure medicines on the 16th, because his, his blood
25 pressure was low. So, things were starting to happen on the

1 eve of the 16th; the nurses noticed that.

2 Q Okay. And what are some of the vital signs that a

3 doctor, such as Dr. , should be paying attention to for

4 a patient who suffers a pelvic fracture with respect to

5 internal bleeding? What should he be looking for, and what

6 should he keep his eye on?

7 A Well, the vital signs are not called the vital signs

8 for nothing. They are the vital signs, and there are four of

9 them officially. Some people talk about the pain scales being

10 the fifth vital sign, or some people talk about the pulse ox,

11 the oxygen levels in the blood as being a fifth or sixth, but

12 really there's four. There's temperature, there's pulse,

13 there's respiratory rate, and there's blood pressure.

14 And, and those four, if you're paying attention to

15 all four of those things, any doctor should know how to

16 interpret them. So, when you're looking at a fracture, you

17 have concern, a fracture with hematomas now, you would look at

18 temperature first of all, because these hematomas can get

19 infected, so if the temperature's up, you got to start thinking

20 infection.

21 But, more importantly really in, in the, especially

22 in the setting of a declining blood counts, would be the pulse

23 and the blood pressure. Those are the ones you'd really be

24 looking at. Certainly heart, respiratory rate's important.

25 Suddenly, if he started really breathing fast, then you might

1 be worked about one of those embolus things that I talked
2 about, the little fat from the marrow breaking of and going
3 into the lungs.
4 But his, his respiratory rate was fine, and I believe
5 he did not get a fever at all, so, in his case, the
6 abnormalities were in the pulse and the blood pressure.
7 Q Okay. I'm going to put on the screen, which would be
8 page number 10103.
9 A Wow.
10 Q Doctor, that's right up there.
11 A Okay.
12 Q And have you seen this before?
13 A Yes.
14 Q Okay. Can you tell us the importance of the
15 information on this page as it pertains to the treatment given
16 by Dr. to Mr. ?
17 A Well, this is the graphic record. This is a key
18 document that ties together much of the pertinent information
19 that you need in evaluating and monitoring patients. I can't
20 find it in here, but --
21 Q This right here, doctor.
22 A Yeah, I, I can see.
23 Q Okay.
24 A Yeah, forget it. I got it.
25 Q Thank you very much.

1 A So, what do you see? On the top there, you've got,
2 the upper portion, you know, there's three dates across the
3 top, which are kind of cut off here, but there's, and the days
4 are separated by the lines. So, you got the 15th, the 16th,
5 the 17th. They're broken up into four-hour columns. So, it's
6 a linear chronological from left to right of what happened.
7 The different dots, and sometimes they use dots, and
8 Xs, and so on, but it looks like they put dots for the pulse,
9 and, hence, are usually a different symbol.
10 Q (Unintelligible) temperature.
11 A So, those little dots gives you a graphic chart of
12 the pulse. You can see how it goes up, it goes down, or are
13 those temps? I'm sorry. I'm sorry. Those are temps. Sorry
14 about that.
15 Q Okay. That's all right.
16 A So, the pulse is written as a line there, and then
17 the respirations and the blood pressure. As you can see, those
18 were the vital signs. The pain scale is, is trying to become a
19 fifth vital sign.
20 Q Pulse simply means how many beats --
21 A Beats per minute.
22 Q -- per minute of your heart?
23 A Well, the pulse. The nurses are checking a pulse.
24 It's the peripheral pulse usually here, or they could have one
25 of those machines that's just measuring it in the finger. It's

1 not actually the heart rate, because sometimes the beat of the
2 heart may not get transmitted to the pulse, but it's a
3 reasonable representation of the heart rate.
4 Q Let's talk about the blood pressure.
5 A Yes.
6 Q How's he doing on the 16th?
7 A Yes. So, when you look at this one, he starts out
8 the 16th at probably what is somewhere near his baseline. When
9 I say starts out, I mean around 12:00 midnight or so. Yeah, he
10 starts out 12:00 midnight right about there what looks like a
11 150 over 89. And then he goes into 4:00 a.m, 153 over 84.
12 Then 8:00 a.m., 145 over 94. These are probably all around his
13 baseline, 152 over 90.
14 This is where you get to start to see a subtle
15 change. The diastolic is now down to 70; that's the bottom
16 number. And, then, by the evening, by 8:00 p.m., on the, on
17 the 16th there you see the systolic is down, as well, down to
18 119.
19 Q Do you consider that a significant change in blood
20 pressure?
21 A You know, in and of, by itself, totally taken out of
22 context, it probably wouldn't raise too many feathers.
23 Q All right. When you treat a patient --
24 A However, sorry, yeah, you have to look at the total
25 picture. I'm sorry.

1 Q That's okay.

2 A I didn't want to cut you off, but, so, if you look at
3 the other line, remember the vital signs you got to look at all
4 of them. So, you see the pulse going pretty reasonable 84,
5 something, 7, 81, 90, not too bad. But you notice what's
6 happening in here, at the same time that blood pressure's going
7 down a little bit, the pulse is going up, 113, 1, does that say
8 125, I think, but, even if it says 115, clearly over 100, which
9 is, by definition tachycardia which is abnormal.

10 Yeah, a little bigger, yeah, so you can see that. I
11 think that's a 125.

12 Q Okay. And would these charts be available for Dr.
13 to review at anytime he came into the hospital?

14 A Yes. These, these, so, these would be tallied at the
15 end of each shift, so by, by 11:00 p.m., those numbers would be
16 there. Well, if not sooner now that I think about it. They
17 may do them every four hours.

18 There's also those, no, those are just INOs, I'm
19 sorry.

20 Q Okay. So, while you're keeping an eye on the blood
21 pressure --

22 A Uh-huh.

23 Q -- is there any -- and, when you say you have to keep
24 an eye on other things that are going on to get the big
25 picture, what are some of the other things that you have to

1 keep an eye on?

2 A Well, besides the, the vital signs, if you scroll

3 down further on this same graphic record, you have the INOs.

4 You hear that term before, the intake and the output. That's

5 another extremely important thing to look at, especially in

6 someone in whom you're managing their fluids. Somebody who,

7 who is having, you know, who came in with blood pressure of 88

8 over 49, you're really going to want to watch those fluids

9 closely. And, so, that's the next piece that you would look

10 at.

11 And, then, of course, you'd examine the patient, and

12 then you look at labs --

13 Q What does this next piece --

14 A -- and imaging studies.

15 Q -- down here where (unintelligible) that's happening

16 with Mr. between the 16th and the 17th?

17 A So --

18 Q This is the 16th in here, and we have 17th

19 starting --

20 A Yeah. Right. Yeah, so these are the thick, bold

21 lines delineating the 16th. The 17th, this here is the intake,

22 here's the output. And then they tally up all the different

23 sources of the intake, the PO intake, that's by mouth; tube

24 feeding, which is not relevant; IV, which is what we've been

25 talking about; and then other various liquids that might be

1 administered; and they even have a miscellaneous line, I guess
2 you could add things in; and then total.
3 So, there's a total of all the measurable oral
4 intake, again, broken up, in this case, by shifts. So, this is
5 the, these are eight-hour shifts, 11:00 to 7:00, 7:00 to 3:00,
6 3:00 to 11:00, and then a total for that day. So, there's a
7 24-hour total here, 24-hour total here.
8 Q And why is --
9 A The bottom line is output. So, the next section is
10 just output. Again, here, urine that he urinated, urine that
11 was in a Foley, and urine that, I'm sorry, fluids he might have
12 vomited, bowel movements, estimated blood loss, drains if he
13 had any surgical drains, and such. That's what those are. A
14 blank space.
15 There's also something called insensible losses that
16 hasn't gotten mentioned at all, other than the fact that we
17 heard, insensible losses are, are, are fluid that evaporates
18 out of your body that you can't measure.
19 So, if you have a fever, for example, a lot of water
20 is evaporating. If you're perspiring, perspiring profusely, as
21 we heard a lot yesterday, you're going to lose a lot of water.
22 I think we even heard sheets had to be changed; that's how much
23 water came out of him. None of that gets measured in the
24 output line.
25 So, you have to take that into consideration. And,

1 roughly, in an average person you could have as much as 1,000
2 cc's a day of, of insensible losses, bile that gets out, you
3 know, leaks through your gut and goes out, and so on.
4 Q Okay. And, doctor, what, if any, significance is it
5 between the 3:00 to 11:00 shift on the 16th, and the 12:00 to
6 8:00 shift on the 17th with respect to the input and output?
7 A All right. So, the 3:00 to 11:00 on the 16th, and
8 the what now?
9 Q That, and 11:00 to 7:00 on the 17th.
10 A 11:00 to 7:00. All right. So, you know, you could
11 look quickly at the total line. So, his total intake was 650
12 for the eight-hour shift leading up to midnight on the 16th,
13 and then I would have to add these two, because I can't quite
14 make that out, but it looks like it says 215 total intake for
15 the eight hours after midnight. So, for a total of 16 hours in
16 there, he got 650 and 215, 865.
17 Q Okay. And how about the output at that time?
18 A All right. So, output, again, you kind of skim down
19 here. He had 500 cc's in the Foley. It looks like he had a
20 bowel movement. So, he, measurable losses were 500 cc's.
21 So, on, of the measurable intake and output, he does
22 have a mildly positive fluid balance. So, he took in slightly
23 more than he put out just during that eight-hour period of
24 time.
25 When you look on to the 11:00 to 7:00, you see that

1 his intake was less than his output. So, his total output here
2 was, well, it looks like 275.
3 Q And how much of that was urine, and how much of that
4 was vomiting from what was in his stomach?
5 A Yeah, so vomiting, right. They, well, he, this is,
6 we know that he only put out 25 cc's of urine that night.
7 Q Can you give the members of the jury an idea of
8 conceptually how much 25 cc's of urine is?
9 A Well, an ounce of liquid is about 30 cc's. So, an
10 ounce, you know, but I was only able to pour into that cup
11 something like that.
12 Q And what is the normal output of urine you would
13 expect to see in a patient, such as Mr. with his
14 conditions per hour?
15 A Well, before he went into renal failure, you would
16 expect a good 30 cc's or more an hour.
17 Q An hour?
18 A An hour, yeah.
19 Q And, from that chart, what is the total amount of
20 urine output he had for all of the last day of his life?
21 A (No audible response.)
22 Q Is it still only 25?
23 A Well, we looked at the other. Based on this sheet,
24 it's 25, right.
25 Q And we did see a sheet that some unknown

1 technician --

2 A There may have been another 25, or 50, or some, but,

3 again, minuscule amounts, way more than you would, way more

4 than a healthy kidney would be putting out.

5 Q Way less?

6 A Way less. I'm sorry.

7 Q Okay.

8 A Right.

9 Q Now, what do you know from the fact that he only put

10 out 25 cc's of urine for that first eight-hour, that midnight

11 shift on the 17th? If Dr. looking at his chart, what

12 is a reasonable family practitioner, with his skills, treating

13 Mr. , what should he be thinking in his mind about what's

14 going on Mr. 's care?

15 A Well, he should be running through a quick

16 differential of what the causes could be. So one of the quick

17 and easy ones that we think about is, well, maybe there's some

18 kind of blockage. Maybe his kidneys are working, maybe his

19 bladder's full, and maybe he just can't empty his bladder. The

20 Foley, the tube is clogged, or his prostate is enlarged, and

21 pinching off, and he can't void, or there's some kind of glob

22 of bacteria, or dead cell, something like that, so you would

23 want to free up the obstruction.

24 Q Is there any evidence of any obstruction in this case

25 that you're aware of from the chart?

1 A No.

2 Q Okay. What's the next analysis you would

3 (unintelligible)?

4 A And then the next would be to look at the labs to,

5 again, they'll help back you up a little bit on the, on the

6 kidney function, because if the labs are off it means your

7 kidney function's inadequate.

8 Q Okay.

9 A So --

10 Q Page 10143 --

11 A -- the other one. This is, this is the blood counts,

12 so better would be the chemistries. We can look at this now,

13 but it's --

14 Q Well, let's take a look at the blood counts.

15 Actually, I might put them up on the board so everybody can see

16 these. There we go. That might be easier. Okay. We're now

17 looking at page 10143.

18 A Yeah. So, these are the chemistries, general

19 chemistries. The, the different tests which make up, well,

20 usually they're in a, did I do that?

21 Q Yes, you did. It's all right. Just hit the red one.

22 A I got it.

23 Q There you go.

24 A It's like a panel of different chemistries that make

25 this thing up, and then you can see the date. So, it's, the

1 dates and the times either that they were drawn or reported.
2 I'm not sure what those times mean, but --
3 Q Okay. Actually, let me go back. We're one document
4 ahead of ourselves. Here we go. Let's go back to the blood
5 (unintelligible).
6 A So, the same thing here, yeah, you're seeing the
7 hemogram. so, these are the blood counts, complete blood
8 counts, CVC, and then these are the different elements of the
9 complete blood, blood count with the different dates, and the
10 times, and then the results going down like that with little Ls
11 meaning low for some sort of calculated normal, and H for a
12 high.
13 Q What happened to the amount of red blood cells in Mr.
14 's body between the 16th and the 17th?
15 A Well, if we look at the morning of the 16th, 06:40, I
16 mean there's, there's a lot of parameters here looking there,
17 but some of the key ones are these do here, the H&H, the
18 hemoglobin and hematocrit.
19 And, so, if you look at 11.6 for the hemoglobin, 33.0
20 for the hematocrit, and then you go to the left chronologically
21 it's moving this way now, the next, 24 hours later, the next
22 morning, the hemoglobin is now 10.1 and the hematocrit is 28.5.
23 And, then, about 10 hours later, on the 17th also, you see it's
24 now the hemoglobin is 8.7 and the hematocrit's 24.8.
25 Q In simple math, 33.0 minus 24.8, I have 8.5. Does

1 that sound about right?

2 A Yeah, that's, that's right.

3 Q Okay. Now --

4 A Right.

5 Q -- when you take this into account of his dropping

6 blood pressure, his increased heart rate, the perspiration we

7 see, what should Dr. have reasonably concluded that was

8 happening inside of Mr. prior at that time?

9 MR. : Objection. Form.

10 THE COURT: All right.

11 Why don't you rephrase it?

12 BY MR. GASTON:

13 Q Doctor, do you have an opinion within a reasonable

14 degree of medical probability that Dr. should have

15 reasonably considered and concluded what's happening inside of

16 Mr. 's body based upon the information you just presented

17 to the jury?

18 MR. : Objection.

19 THE COURT: I'll permit it.

20 Go ahead.

21 THE WITNESS: Yes.

22 BY MR. GASTON:

23 Q What should he have considered?

24 A He, he should have considered that there was

25 bleeding; that there was; that he was going into hemorrhagic

1 shock.

2 Q Doctor, when a person bleeds, if you can give the

3 members of the jury a description of every day life, what

4 happens to blood pressure when you have a leak or a bleed of

5 the blood that they can sort of understand in their every day

6 life, perhaps, something that happens that they usually do at

7 home. Is there any explanation?

8 A Well, maybe an automobile might be good. If you

9 drive along, and you crack a, you hit a big rock in the road,

10 and it, and it makes a hole in your oil pan, and suddenly your

11 oil drops out of your, your car, I believe there's an oil pump

12 that keeps that oil circulating through the engine as a

13 lubricant, and without the oil in there, there's less to

14 circulate. So, it's not going to get to the engine. The

15 engine, you know, freeze up, melt, the pistons, the cylinders

16 all freeze up. I mean that's the closest thing I can think of.

17 So, in, in the human body, when, when you bleed, now,

18 the human body is more complex because it has compensatory

19 mechanisms. There are, there are things that kick in that your

20 body, your, your, your brain, there's pressure receptors up in

21 the carotid arteries and they can tell that the blood

22 pressure's dropping that you're bleeding, and, so, various

23 responses happen.

24 And, and those responses, for a little while, can

25 help keep you alive, but, eventually, those responses start

1 creating problems in and of themselves, and that's what leads
2 into the downward, downward spiral that's shock.
3 Q Okay. And what are some of the recognized signs and
4 symptoms of shock in the human body?
5 A Yeah. Well, heart rate's going to go up. Blood
6 pressure variably will drop. You may see acidosis, something
7 we hadn't looked at on the blood test. You may see renal
8 shutdown. These are some of the early things. Sweating,
9 confusion.
10 Shock is progressive, so I'm not sure at what point
11 you're talking about, but early on a hallmark would be
12 tachycardia, heart, increased heart rate.
13 Q Dr. , was there any indication in the chart
14 that Mr. was suffering from some mental confusing on the
15 17th?
16 A Yes.
17 Q You heard the witnesses, the actual persons who were
18 in his room relayed to you as sometimes he knew where he was,
19 sometimes he didn't know where he was, sometimes he's seeing
20 his dead father. What do those types of presentations from a
21 patient indicate to a doctor, such as a family practitioner or
22 yourself? What's going on inside his brain?
23 A Yeah. That, that's a sign that there, there, there
24 could be other causes for that, but, in this situation, it's,
25 it's the sign of inadequate profusion. There's not enough

1 blood, not enough oxygen, not enough sugar getting up to his
2 brain to work properly, so he's going to be confused.
3 Q Doctor, in this case, do you have an opinion what is
4 causing Mr. 's kidney to only produce 25 cc's of urine
5 during that midnight shift on the 17th?
6 A Yeah. The same process. The kidneys are not getting
7 the blood flow. There's an inadequate profusion. There's not
8 enough oxygen rich, fuel rich blood getting to the kidneys for
9 them to filter properly.
10 Q Is the liver also affected by lack of red blood cells
11 going through the liver and oxygen?
12 A Yes.
13 Q Is there a blood test that was done in this hospital
14 that if Dr. had looked at it, he would have been able
15 to tell there was a problem with the liver, as well?
16 A Yes.
17 Q And what is that type of test, doctor?
18 A Well, they're commonly called liver function tests,
19 or liver enzymes. The liver, the cells in the liver produce a
20 variety of enzymes, and, when there's damage to the liver,
21 because it's getting inadequate blood flow, those enzymes will
22 leak out.
23 So, you would see them, well, here, they begin right
24 about here pretty much. The AST, the ALT, the (unintelligible)
25 bilirubin --

1 Q Okay.

2 A -- that little cluster.

3 Q Now, on the 16th, the day before --

4 A Yes.

5 Q -- what were those values at?

6 A So, if you skim down, and you can even use the Ls and
7 the Hs to help you there, there are no Ls and Hs. So, very
8 briefly, and then if you look at each individual, and, yes,
9 they're clearly in the normal ranges.

10 There was not one done the next morning, but there
11 was a set done at 4:00 p.m. on the 17th or so, and you see
12 marked elevation in the liver enzymes. What was a baseline of
13 32 is now 849, I think that says, that's the AST and the ALT
14 was 20, 33 maybe, and that's up to 887.

15 Q Do you have an opinion within a reasonable degree of
16 probability what caused such a marked elevation in the liver
17 enzymes in Mr. ?

18 A Yeah. Well, in conjunction with the creatinine doing
19 a very similar thing, he was going to have had a renal failure,
20 or liver/kidney failure due to shock.

21 Q In your opinion, should Dr. have been able to
22 recognize that Mr. was going into hepatorenal failure,
23 even though he's not a nephrologist, but a family practitioner?

24 A Yes, absolutely. Yeah, no question about it.

25 Q Was there any notation in the chart that you could

1 find, or any testimony from Dr. today in court where he
2 reasonably reached a conclusion that Mr. was suffering
3 from internal bleeding causing his kidney failure, his liver
4 failure, and the lack of oxygen to his brain causing his
5 confusion?
6 A No.
7 Q Does the standard of care in Maryland for a
8 physician, such as Dr. , in your opinion, require him to
9 be able to do that and to treat that condition?
10 A Yes.
11 Q What is the treatment that he gave, if at all?
12 A Well, he says, he said he dealt with it. And I
13 looked at the orders. He wrote an order to transfer to an
14 intermediate care unit, and he, and he wrote a note to call an
15 intensivist. It, it, it seemed to kind of stop at that point.
16 It --
17 Q Was there any fluid given? I know there's maybe some
18 problems with the chart, but in the best you could figure
19 out --
20 A Yeah.
21 Q -- and given Dr. the benefit of the doubt,
22 what is the most fluid, if he got every single drop that was
23 ordered, that Mr. received?
24 A Yeah. Even, yeah, if that were the case, the amount
25 of fluids, even that he ordered, or he said he ordered, or

1 looks like maybe he ordered, even that amount was inadequate.
2 I mean the amounts he was ordering were, were barely
3 maintenance levels on somebody who's coming in perfectly
4 healthy with normal kidneys and normal blood pressure not going
5 into shock, that would have been okay.
6 But, but, clearly, a man who is behind in many liters
7 of fluid behind, and long periods of times with IVs out, this
8 was totally inadequate amount and type of fluids to give.
9 Q Okay. I'm not asking for the exact cc amount, but do
10 you have an opinion within a reasonable degree of probability
11 what is the amount of IV solution and the type of solution that
12 Mr. should have had beginning on the morning of the 17th
13 where we see his condition really declining? What should a
14 reasonable doctor, such as Dr. , have prescribed at that
15 point in time?
16 A So, the morning of the 17th his creatinine was, help
17 me if that says 3.5 or 5.5.
18 Q That's 5.5
19 A 5.5. And his (unintelligible) is still high 56, his
20 blood pressure that morning was already low, he was
21 tachycardic, the day before he may have been in an even
22 balance, although I still think he was still in a negative
23 fluid balance from the two previous days, I'd have to say
24 easily 3,000 cc's at a minimum, not all at once, but --
25 Q And how many cc's --

1 A Those are 1,000 cc bottles.

2 Q 1,000? 1,000, one, two, he would have needed another

3 one in the beginning of the day. Do you know what is the total

4 amount that he received for the full day in fluid?

5 A On the 17th?

6 Q Yes, sir.

7 A It's less than 1,000 cc's.

8 Q On the chart it looks like 690.

9 A Well, and that was, that was all mostly done at the

10 code when they didn't, they gave him a bolus of IV, but, before

11 the code, you know, it was a few hundred cc's.

12 Q Now, we talked about fluid that he needed much more.

13 Do you have an opinion within a reasonable degree of medical

14 probability if Dr. had given the amount of fluid that

15 you recommend, in your opinion, what would have happened to Mr.

16 's condition?

17 A Well, I, I believe that his blood pressure would have

18 gone up, his heart rate would have slowed down. We saw that

19 happen earlier in the emergency department when they did that.

20 His renal function would have returned to normal, as we saw it

21 do after they, they adequately managed his fluids.

22 I had no reason to suspect, unless he was at that

23 point of no return. There is a point where the shock becomes

24 irreversible, but for much of the 17th all well up into the

25 late afternoon, early evening of the 17th, I still believe it

1 could have been reversed with large amounts of fluids wide
2 open.
3 Q Which means if Dr. had followed your
4 recommendation, would Mr. have died?
5 A No.
6 Q He'd still be alive?
7 A I believe so.
8 Q Now, doctor, we also talked about the drop in
9 hematocrit and hemoglobin. There was an eight and a half point
10 drop over a 24-hour period. Can you tell the members of the
11 jury how significant that is when we know that, from '
12 through October ' , Mr. 's hematocrit, which means the
13 percentage of red blood cells, was in the 40s, and he came in
14 the hospital 33.3, and now he's down to 24.5? I mean how
15 significant is that 24.5 based upon what his history is?
16 A Yeah, that's significant. There's no question that's
17 significant. The, you know, the 33 was a drop. It's an
18 abnormal amount. It's not an amount that's incapable life,
19 with life taken in context with other things. If his blood
20 pressure's good, if his heart rate's not too fast, if he's
21 mentally clear, if he's doing well, a 33.3 you wouldn't bat an
22 eye at, maybe, you know, recommend some iron or something like
23 that to build it back up again; you'd monitor closely.
24 But when that hematocrit got below 30, when it
25 started getting down 25, 24, especially when he was not getting

1 a whole lot of fluids. I don't want to confuse things, but
2 this has been talked about a little bit before. If you're
3 giving somebody a lot of fluids, you, you will water it down.
4 The hematocrit will tend to go down, because you're adding
5 fluids in there dilutes it out, but, as we saw, he got
6 minuscule amounts of fluid.
7 Q Now --
8 A It was not, it was not enough to dilute the blood
9 out. So, that was an honest to God drop in hematocrit; he was
10 losing blood, he was losing blood.
11 Q And did you also take into account the approximate
12 amount of blood that the nurses needed to draw for blood tests?
13 Did that have any significant affect on the drop in hematocrit?
14 A Again, people in the hospital there, there, there
15 always tends to be this downward trend in hematocrits, but, but
16 not drops that significant, no.
17 Q Okay. And can you tell the members of the jury, in
18 your opinion, should a family practitioner, such as Dr.
19 , be able to calculate what the relative loss of blood
20 is in volume when you have a drop in hematocrit from 33.0 to
21 24.8 over a 24-hour period? Should a doctor be able to do that
22 with the skills, and the training, and education experience
23 that Dr. had?
24 A Should he be able to come up with a reasonable
25 estimate amount of blood that he lost?

1 Q That's my question.

2 A Yes. Yes, absolutely.

3 Q In your opinion, what is the reasonable estimate of
4 loss of blood? And if you can explain the difference between
5 the whole blood and the red blood that occurs when you have an
6 8.5 drop in hematocrit.

7 A Yeah. All right. So, the, the quicky, easy rule of
8 thumb that, that every medical student learns early on is that
9 a drop of three points in the hematocrit is equal to one unit
10 of blood.

11 Now, that could be a unit of whole blood, a unit of
12 packed cells, which are two different things. Most the time
13 we're not transfusing whole blood. Most of the time we're,
14 we're giving people packed cells. So, one unit of packed cells
15 should bring, the reverse of that is if you give somebody one
16 unit of packed cells, their hematocrit will come up three
17 points.

18 Q And that's all the red blood cells squished down, and
19 everything else taken away from it so it's only red blood cells
20 that's being given in the packed cell, right?

21 A That's what's being given, right. Once, of course,
22 it gets in the blood, it disperses all out, and now your
23 hematocrit starts coming up because you still have
24 approximately the same volume of blood. Now, there's a little,
25 bit does pull some fluids in, and maybe if you're also giving

1 IVs, you know, it gets a little complicated, but, but it will
2 raise up mathematically by dumping cells into somebody's
3 relatively fixed volume of blood.
4 Q So, by way of example, if Dr. had given Mr.
5 only one pint of packed red cells, how would that
6 hematocrit come up from 24.8? What would it come up to?
7 A Well, you could say up to approximately 28. It would
8 go from 25 to 28.
9 Q Twenty-eight. And if he had given two units of
10 packed cells, where would he be at?
11 A Up to a nice comfortable 31.
12 Q Okay.
13 A Over that magic 30.
14 Q And do you have an opinion whether or not Dr.
15 had given one to two pints of packed red cells, would Mr.
16 have had any improvement with his physiological state?
17 A Yes. Yes.
18 Q What is that improvement, doctor?
19 A You could have seen everything from a complete
20 resolution of the tachycardia, and the hypotension it could
21 have completely gone up to normal. His mental confusion could
22 have gone completely away at that point.
23 Q How about the tissues receiving the additional oxygen
24 that those red blood cells carry, would you expect to see any
25 improvement in his failing kidneys, and the liver problem, as

1 well?

2 A I think you would also have to give fluids, as well,

3 in order to get that. Yeah, there's no way you could get away

4 without giving fluids. You could not just give packed cells.

5 If you want to fix everything, you got to do fluids, number

6 one, and packed cells.

7 Q And would the combination of fluids and packed cells,

8 in your opinion in this type of case, would it assist with the

9 kidney failure, and the liver failure, and to what degree?

10 A Again, if we had, if it had started early enough on

11 the 17th, I think it would have reversed everything.

12 Everything would have gone back to the way it was, the way

13 before he fell.

14 Q Now, we have Mr. going into a code on the 17th

15 at about 21:10 hours. Did you notice that in the chart,

16 doctor?

17 A Yes.

18 Q Now, I do think we have a -- in the hospital, do you

19 usually keep a record of the code, and the CPR, and what

20 happened, and what the doctors do during the code?

21 A Yes.

22 Q And do you have a copy of that document here in this

23 case, as well?

24 A Yeah, we have a few things. There are a few, or at

25 least one note just sort of a perverse note in the chart, and

1 then there's also the, the, I don't know what they call it in
2 this hospital, but it's the code sheet, the --
3 Q Here we go. I have it right here, doctor.
4 A You found it? Here you go. CPR record; that's what
5 they call it.
6 Q Yes. At page 10059 (unintelligible). Okay. At the
7 top of this page, what is the time that the patient was found?
8 A It looks like 22:19. That's 10:19 p.m.
9 Q Now, when the patient was first found, what is PEA
10 mean?
11 A That's pulseless electrical activity.
12 Q In layman's terms, does that simply mean his heart
13 stopped beating?
14 A Yes. Well, yeah, that's right. Not, not beating
15 enough to generate a pulse.
16 Q Okay. It's not pushing the blood through the human
17 body.
18 A Uh-huh.
19 Q Now, pupils.
20 A It says they're fixed and dilated.
21 Q What does that mean at the time they first found him?
22 A That means, by the time whoever came there and
23 checked the pupils, by 22:19, presumably, he had already had
24 enough anoxia, his brain had not gotten enough oxygen, so it
25 was not functioning normally.

1 Q Does it indicate some brain death to the brain
2 tissue, death to the brain cells?
3 A Yes. Certainly, if, if that continued like that,
4 that's a way of telling if somebody is quote/unquote "brain
5 dead."
6 Q And the patient remained pulseless and unresponsive.
7 That means his condition at 22:19. Did it ever change?
8 A Yeah, I think the, the code went on for approximately
9 30 minutes, and it looks, according to that, he, he never had a
10 pulse. They were never able to, to get his heart to start
11 beating properly again, nor did he wake up.
12 Q Doctor, in this case, you've heard Dr.
13 explain his contention to the members of the jury that he
14 contends that the reason Mr. died was not because he
15 didn't do anything, but because Mr. took a cup of
16 Kayexalate, drank it, and that cup of milkshake solution went
17 directly down his windpipe, and into his lungs, and then 40
18 minutes later he died because of that.
19 I'll ask you a question. Have you reviewed this
20 entire chart?
21 A Yes.
22 Q In your opinion, is there any evidence in the medical
23 chart to suggest that that is what happened, and that is what
24 killed Mr. ?
25 A Certainly, not what killed him, and the chart, other

1 than the autopsy report, there's nothing to suggest anywhere
2 that he aspirated, except during the, the code when he did
3 vomit, when they were trying to intubate him and he vomited.
4 and it's quite possible at that time, he's not breathing, he's
5 lying down, they're doing CPR on him, it's quite possible some
6 of that got, the vomitous went down into the lungs.
7 Q I mean before he went into a seizure, is there any
8 indication?
9 A No, nothing before then.
10 Q And we did hear from some eyewitnesses.
11 A Uh-huh.
12 Q In your experience as a medical provider, as a
13 physician, if someone's drinking a whole cup of this, and it's
14 going directly down into the windpipe, what is the physical
15 reaction that you would expect to see in a patient, and what
16 you would have expected to see in Mr. if that had
17 actually happened in this case?
18 A He would have coughed. He would have gagged. He, he
19 would have showed some signs of distress while that was
20 happening.
21 Q Do you believe he would be able to continue to inhale
22 the solution for as long as it took him to drink it without
23 have any sign of outward affect?
24 A I mean a cough generates an incredible amount of
25 force. It could have just blown it right out of his hand. No,

1 I don't see that he could have continued to, to try to get that
2 down if he was, if he was choking on it --
3 Q Doctor --
4 A -- if he was aspirating it.
5 Q -- how many years have you been a practicing
6 physician?
7 A Like 25, 26 years. Sorry, if I'm not accurate there.
8 Q Have you ever come across a case, or ever heard of a
9 case from any of your colleagues that a patient, such as Mr.
10 , drank Kayexalate, and it went down his entire windpipe,
11 and it was silent without any type of outward expression, any
12 type of difficulty, and that was the sole, proximate cause of
13 the patient's death? Have you ever heard of that happening?
14 A No. No.
15 Q Doctor, did you have a chance to review the death
16 certificate?
17 A Yes.
18 Q Did Dr. write anywhere on the death
19 certificate that Mr. died of Kayexalate aspiration?
20 A No.
21 Q If he had believed that at the time, would he be
22 required to put that on the death certificate?
23 MR. : Objection.
24 THE COURT: Overruled.
25 THE WITNESS: If, if he believed that, that

1 aspirating Kayexalate was either the final event that caused
2 his death, or a contributing factor, he would have been
3 required to write that on there, yes.
4 MR. GASTON: Your witness.
5 THE COURT: Mr. , you wish to cross-examine?
6 MR. : Yes. Thank you, Your Honor.
7 THE COURT: All right.
8 CROSS-EXAMINATION
9 BY MR. :
10 Q Good afternoon, again, sir.
11 A Yes. Hello.
12 Q You attempted to look into Robbins' "Textbook of
13 Pathology" to try to get some numbers on the degree of blood
14 loss, and how much blood would be in a hematoma, and you were
15 unsuccessful, is that correct?
16 A Yes.
17 Q And other than that attempt to look into how much
18 blood is in a hematoma from Robbins, you did not conduct any
19 other specific literature search, is that right?
20 A Literature? No.
21 Q You've never done an autopsy, correct?
22 A No, I have.
23 Q You have done an autopsy?
24 A Yes.
25 Q And after your residency, have you ever done an

1 autopsy?

2 A No.

3 Q And you don't know specifically what is the specific

4 definition of "shock," is that correct?

5 A Of, "shock," in general, or --

6 Q The term "shock," S-H-O-C-K.

7 A The definition?

8 Q Yes, sir.

9 A Well, I think I know it.

10 Q You don't know what is the specific definition of

11 shock. That was my question, sir.

12 MR. GASTON: Judge, it was answered by the witness.

13 He says, no, I know it.

14 MR. : I didn't hear it. I'm sorry.

15 MR. GASTON: Yes. I'm sorry, counsel.

16 BY MR. :

17 Q You said you know it?

18 A Yes.

19 Q Okay. You have your deposition up there, sir?

20 A I do.

21 Q You do? Okay. Great.

22 A Oh, well, you didn't say anything about that.

23 Q Let me ask you. You were deposed in this case

24 , about 65 days ago, correct?

25 A , correct.

1 Q You were under oath at the time, is that right?

2 A Yes.

3 Q And I'm asking you the question, at page 56, line 5:

4 "Right. And in order to have, I guess to get the

5 diagnosis of shock, do you need to have more than just

6 tachycardia? Do you need to have all three of these symptoms?

7 "Answer: I honestly don't know. I don't know the

8 specific definition of what, some medical diagnoses have very

9 specific criteria. You have to have one of this, one of that,

10 or two of that major/minor criteria. I don't know if there are

11 other specific criteria. They probably do exist. I'm thinking

12 of septic shock, which does have some specific indicators."

13 Was that your answer then, sir?

14 A Yes. Well, you read that accurately, yes.

15 Q Now, you've spent some time going through this entire

16 hospital record, is that correct?

17 A Yes.

18 Q There are a multitude of doctors that have seen this

19 patient at Hospital, correct?

20 A Multitude of doctors who saw the patient at

21 .

22 Q That was my question. Did you understand it?

23 A Well, I'm not sure what "multitude" is.

24 Q Okay. Well, he was seen by the ER doctor, correct?

25 A Yes.

1 Q He was seen by Dr. , correct?

2 A Yes.

3 Q Seen by Dr. , correct?

4 A He was --

5 Q Seen by Dr. , correct?

6 A Yes. Yes.

7 Q Dr. consulted with an nephrologist, correct?

8 A Don't know if the nephrologist saw him, but, yes.

9 Q Out of all of the pages you have up there, and all
10 the medical records, and even in the autopsy, which is a long
11 report, can you tell this jury how many times you saw the word
12 S-H-O-C-K?

13 A In the medical record, no, I couldn't tell them.

14 Q Can you tell us if you ever saw it? And, if you can,
15 please tell me where it's located.

16 A I, it may not appear in there. I don't know. I
17 mean, I, I just don't, there's got to be millions of words
18 there. To say that the word "shock" doesn't appear anywhere in
19 there, or does it appear and how many times, is going to be a
20 Herculean task.

21 Q Well, let me ask you. I mean you practice medicine,
22 don't you?

23 A Yes.

24 Q And you came in this courtroom, and you told this
25 jury that my client breached the standard of care of a

1 reasonable competent doctor in not recognizing shock, is that
2 correct?
3 A Yes.
4 Q Don't you feel that you have an obligation to look to
5 see whether or not at least one doctor who saw this patient
6 thought that there may have been or recorded the term "shock"
7 in the medical records? Did you at least give him the courtesy
8 of looking for that in the chart?
9 A I, I looked at his notes, and there's really very
10 little there to show what he was thinking.
11 Q My question wasn't that, sir.
12 A I looked at his responses and his actions, and
13 there's nothing there to show that he recognized shock.
14 Q Please listen to my question.
15 A Okay.
16 Q Did you look in the hospital record to see whether
17 anybody who had an M.D. at the end of his or her name ever
18 recorded the word "shock"? Did you give that courtesy to Dr.
19 to look to see whether anyone else even considered it?
20 A Sure. I, I looked at the impressions of all the
21 doctors --
22 Q Okay.
23 A -- to see what they were thinking.
24 Q And you never saw the word "shock" in this entire
25 medical record, is that right, sir?

1 A I'd want to go back to the emergency department, but,
2 no, yes, you're probably right. I don't believe they used the
3 word "shock."
4 Q Okay. Now, did you ever see in this medical record
5 anyone who saw this patient who recorded that, other than the
6 fact that there was a hematoma present, this gentleman had
7 extensive internal bleeding?
8 A Was there anything besides the multiple hematomas
9 that said he had extensive internal bleeding?
10 Q Correct.
11 A In the entire thing, including the post-mortem exam?
12 Q No, I'm talking about the hospital records.
13 A Hospital records. Okay. Right. So, the hospital
14 records, anybody else, anybody use the word "internal
15 bleeding," is that the question?
16 Q Yes, that's the question.
17 A No, nobody used that word.
18 Q Nobody used it. Now, you --
19 A Those words.
20 Q -- believe that it wasn't until , at 6:57 a.m.,
21 that Dr. first became aware that this patient has what
22 you believe to be signs and symptom of shock, is that correct?
23 A Yeah, it was about, right, 6:57, is that what you
24 said --
25 Q Yes.

1 A -- a.m. on the 17th? That's when the nurse called
2 him.
3 Q Right. And, you know, before we get into what
4 happened then, you use the word "hematoma," and use the word,
5 you know, "bleed," well, we've heard a lot about this.
6 A Uh-huh.
7 Q I think you've described it as a "localized pocket
8 encapsulated of blood, as opposed to a "free-flowing blood," is
9 that right? That's what a hematoma is, is that correct?
10 A A collection of blood, right.
11 Q In fact, you actually educated me, because hematoma
12 means in Latin a bump of blood, right?
13 A Right, literally, oma's a bump.
14 Q Yes. Okay. Now, it's your opinion that, from 3:00
15 p.m. on th until about 24 hours later, Mr. had a
16 total fluid intake of 800 to 900 the entire time. Is that what
17 your testimony was at the deposition?
18 A You're asking me about what I said in the deposition,
19 or what? You'd have to point that out to me the page, so I can,
20 but (unintelligible).
21 Q Page 73, line 16.
22 A Oh, 73, line 16. It says there's a question. That
23 was a question.
24 Q That's the question, but I'm directing you to the
25 answer.

1 A Oh, okay. That's what the note ways. He then
2 received, well, a fluid intake of about eight or 900 cc's from
3 3:00 p.m. th. It's a little hard, because my answer's
4 kind of choppy there. I remember that, though, because the
5 thing is you're looking at totals for an eight-hour period of
6 time. So, if it says 400 or it says 50 cc's during this eight-
7 hour shift, you don't know if that 50 cc's was at the beginning
8 or the end. So, when do you actually start the time ticking?
9 So, you, you know, time, you can look at time in, in
10 blocks of minutes or blocks of hours, or eight-hour blocks. In
11 this case, they're eight-hour blocks, so I'm not sure if that's
12 answering your question.
13 Q You agree, at best, there appears to be some
14 confusion on the part of the nurses at the hospital as to where
15 and when they recorded the INO, is that correct?
16 A With the nurses, the nurses did, there's some kind of
17 discrepancy, right, between the, the, sort of the day sheet
18 they use, and then the, then the graphic sheet that we looked
19 at.
20 Q Okay. Dr. does not administer the IV fluids,
21 correct?
22 A That's right.
23 Q Now, can we agree that on or about 8:00 a.m., on
24 th, when he came in, he ordered a bolus of 500 cc's, and,
25 after that, 100 cc's per hours, is that correct?

1 A Well, actually, on the, on the morning of the 17th,
2 first he said to leave it out, leave the IV out. Then he
3 ordered a PICC line, and he requested IV fluids, but he knew
4 there was no access, so it was just theoretical. I mean to
5 order IV fluids when there is no line, he would have known that
6 Mr. wasn't going to get it.
7 The only bolus I see comes sometime in the middle of
8 the day, and that was from Dr. .
9 Q He would have known he would not have gotten it
10 because he had no access to the line, is that your testimony?
11 A That, that, the first, right when, when there was no
12 line, he would have known it's impossible to get IV fluids if
13 there is no line.
14 Q All right. Now, when did he get the peripheral line
15 in? Did you look in the chart for that?
16 A Yeah, that's, that's, again, lack of times on things
17 makes it very difficult, but he, apparently, he went down, and,
18 and, according to Dr. 's testimony, around 10:00 a.m. he
19 was back around checking to see if the PICC line had been put
20 in.
21 And, apparently, they didn't have to put the PICC
22 line in. They were able to get a peripheral line, so
23 presumably at 10:00 a.m., whether he actually saw it himself,
24 or whether the nurse or somebody told him that there was a, a
25 line there, he was aware of a line. But, but there's, it's,

1 it's, you can't tell if he actually ordered fluids at that
2 point.
3 Q Well, you sat here on the first row and listened to
4 his testify earlier today --
5 A Right.
6 Q -- at 10:00 a.m., he recorded in his own handwriting
7 that there was IV fluids infusing at the time, right? Remember
8 that?
9 A He, he did write that. Well, I'm not sure if he
10 actually said he saw a bag hanging with a, with a plastic tube
11 going into the patient's vein and fluids going in infusing. I
12 don't know that he actually said that.
13 Q All right. So, your opinion is, you don't know when
14 fluids started then on the 17th, is that right?
15 A I know what the MAR says.
16 Q Okay.
17 A That's the document you haven't mentioned yet.
18 Q Now, here's my question. Can you agree that the
19 order that was given to the nurse by Dr. was sometime
20 at around 8:00 to 9:00 a.m. on the 17th for a 500 cc bolus in
21 100 cc's? Was that order reflected in the chart?
22 A My, the, the, the, I have more accurately around
23 10:00, 12:45, because that's the only time that's written on
24 that order is 12:45 when the nurse, I believe, noted that,
25 12:45. And, and it was 500 cc's is illegible. It says

1 something 500 cc's, and then I don't know if it's then 100 cc's
2 an hour, or 500 cc's at 100 cc's an hour.
3 Q Okay.
4 A It's illegible. And it's half normal saline.
5 Q And then there was --
6 A It's not a bolus.
7 Q -- another order that he had bumped it in the
8 afternoon to 200 cc's per hour, is that correct?
9 A There's no date, and no time on that one. No date,
10 no time on that order, and it's not in his handwriting.
11 Q Well, he couldn't, because it was a verbal over that
12 was given to the nurse from his office, is that right, or you
13 don't know?
14 A Nobody knows. There's no date, there's no time.
15 Q Did you look at his hospital -- excuse me, his own
16 office record to confirm whether or not it was done that
17 afternoon?
18 A The, the one that's dated th on another
19 patient's paper?
20 Q Yes.
21 A th.
22 Q Okay. So, you don't believe that he ordered 200 cc's
23 per hour, and you believe that somebody else called him and
24 gave an entry to the nurse at some other time, other than
25 th for 200 cc's per hour? Is that your testimony?

1 A That was too much. That was too much to answer yes
2 or no to.
3 Q Okay. What didn't you understand about the question?
4 A Did I think somebody else called in or somebody --
5 Q Yes. There's an order in the chart for 200 cc's per
6 hour --
7 A Yes.
8 Q -- okay? And you say that the nurse didn't put a
9 date or time on it --
10 A That's right.
11 Q -- okay? We do know it certainly is after the first
12 order of 500 bolus, 100 cc's, is that right, or you don't know
13 that?
14 A It's a free-standing piece of paper. There's no way
15 to tell the order.
16 Q Okay. So, you don't know whether that was done on
17 the 15th, the 16th, or the 17th, is that right?
18 A Direct me to it. There may be another order written
19 below that possibly, and that, that might have a, a date or a
20 time on it, but at least we would know it occurred before then.
21 MR. GASTON: Can I have the page, counsel?
22 THE WITNESS: See if I have that.
23 MR. : 10083.
24 MR. GASTON: Thank you.
25 THE WITNESS: Yes. Okay. So, there is below that an

1 order that says "hold IVIG pending labs, read back verbal order
2 Dr. 5-17 at 16:20." So --
3 BY MR. :
4 Q But I'm looking at --
5 A The thing above that.
6 Q Right. And it says 200 cc's per hour --
7 A It says, "increase IV fluids at 200 cc's per hour,
8 CBC, CNP at 17:00, read back verbal order Dr. ," and
9 that has no date or time. It presumably happened sometime
10 before 16:20. It could have been 16:19. It could have been
11 anytime, or it could have been the day before, or the day
12 before that.
13 Q Did you determine when that lab he ordered at 17:00
14 what day they were done?
15 A No, but what I did look at, again, was the, the MAR,
16 which is the --
17 Q Okay.
18 A -- documentation of the administration of all
19 medications and IV fluids.
20 Q Okay. So, in order to determine whether Dr.
21 breached the standard of care in setting the amount of fluids,
22 you don't know when and how much he provided any orders on
23 , is that correct?
24 A No, that's not.
25 Q Okay. Then tell me what did he order on 'th?

1 A On, on th, sometime in the middle of the day,
2 so the nurse writes 12:45, he did order 500 cc's of D5 half
3 normal saline.
4 Q And that's all you think he did that entire day?
5 A I, he, he, he has recollection of calling it, of
6 calling that in. I, I believe that was his testimony earlier
7 today. And I have no reason to doubt that, but it, it's not,
8 it's not in here factually or whatever. I mean, the date is
9 not there to back that up.
10 Q Okay. So, you disregarded it because there wasn't a
11 date recorded on the order by the nurse who got a verbal order
12 from Dr. , is that correct?
13 A Well, I didn't disregard it, because this, this
14 morning is the first time I heard about it. So, now I'm trying
15 to piece it together and see, well, does, does it back it up.
16 And, again, if you look at the MAR, it does no show that that
17 was done. So, it is possible Dr. called that in --
18 Q Did you make --
19 A -- and it is possible the nurse didn't take the order
20 off, and it is possible that the nurse never ordered the fluids
21 from the pharmacy, and never hung the fluids. I mean, but I
22 don't, I don't know precisely what happened.
23 Q Did you determine how much was ordered by Mr. ,
24 as far as the IVs?
25 A Yeah. Yes, I did that.

1 Q Okay. And how much was ordered by Dr. ?

2 A Dr. also ordered 500 cc's, right around that

3 same time, this time of normal saline.

4 Q You say right around the same time. Right around

5 what same time?

6 A . Again, it's, it was a verbal or telephone

7 order, and it says, there's a thing that says 12:45. I need to

8 look at that myself, because I'm looking at my notes, but, and

9 maybe it's not a verbal. That might, that might be, hang on a

10 second.

11 , oh, yeah, this one. I don't know, because I

12 don't know what Dr. 's writing is like. It's very neat

13 printing, and then it's signed, and, and the nurse took it off.

14 So, it's not written as a verbal order. So, the presumption is

15 Dr. wrote for the Kayexalate normal saline 500 cc's times

16 one, stopping the Lovenox, getting an ultrasound of the

17 kidneys, and then it says, "too late patient deceased." And

18 then the date is 12, the date is that the nurse, Nurse

19 (phonetic sp.) signed it off , at 12:45 p.m.

20 Q Okay. So, you believe that Dr. ordered the

21 500 cc bolus sometime around 12:45, and that Mr. ordered

22 the 500 cc's about the same time both at 12:45, correct?

23 A I, I don't believe Dr. ever ordered a bolus

24 on that day.

25 Q You don't. Okay. So, you don't think Dr.

1 ordered a bolus, but you do believe that Dr. ordered a
2 bolus about 12:45, is that right?
3 A Yes.
4 Q Okay. And that's what you believe was the full
5 extent of any orders for IV fluids that day, is that right?
6 A Yes.
7 Q You don't disagree that the last blood pressure that
8 was taken of Mr. was 103 over 65 at 8:00 p.m., is that
9 right?
10 A I'm not going to disagree with that, no.
11 Q You're not familiar with the IVIG treatments that Mr.
12 was receiving, is that right?
13 A Minimally.
14 Q Minimally. And you don't prescribe IVIG treatments,
15 do you, sir?
16 A No.
17 Q And your opinion is that the renal dysfunction that
18 occurred in this particular case was caused by shock, is that
19 right?
20 A Yes.
21 Q And --
22 A I was say "renal failure."
23 Q Renal failure. You believe that he was in acute
24 renal failure on admission, is that correct?
25 A Yes.

1 Q So, when he was admitted, on , he was suffering
2 from acute renal failure, is that correct?
3 A A mild form, yes.
4 Q And did you look to determine what his creatinine was
5 on th?
6 A th, yes.
7 Q All right. And is creatinine a good way to measure
8 as to whether you have acute renal failure?
9 A Taken in conjunction with some other parameters, yes,
10 that's one of them.
11 Q And on his creatinine was normal, is that right?
12 A Yes.
13 Q Okay. Now, do you know whether there are any side
14 effects from the IVIG and acute renal failure?
15 A Are there side effects in acute renal failure?
16 Q Is there any risk of renal failure --
17 A Yes.
18 Q -- with an IVIG?
19 A Yes.
20 Q Okay. And what is the side effects of IVIG and renal
21 failure?
22 A Well, side effects is not a good, it's not, those
23 words don't go together. Side effects of renal failure is not
24 really a term we --
25 Q Okay.

1 A -- would use. And the symptoms --

2 Q Okay. That's a poor question. All right.

3 A -- of renal failure, yeah.

4 Q Let me ask you this. Can IVIG cause acute renal

5 failure?

6 A Yes, it can.

7 Q Okay. And is there a PDR that describes exactly what

8 can occur when someone's getting IVIG treatments?

9 A It may not explain exactly, but, but they, the PDRs

10 do carry warnings and such.

11 Q You looked at the PDR, is that right?

12 A No. I mean I have looked at the PDR, but not for,

13 not, not in this case not for IVIG.

14 Q Okay. So, when you tried to determine what was the

15 cause of the acute renal failure, you didn't look back to see

16 what were the side effects of the IVIG that was given on

17 as to whether that could be a possible cause of renal failure,

18 is that correct?

19 A No. Actually, I have. Since, since my deposition,

20 at which time I admittedly had not thought much about the IVIG,

21 there was a lot of discussion about it, and I have since then

22 done some research on the subject.

23 Q Okay. So, you did some research on what was the

24 cause of the acute renal failure after you issued your six-page

25 report, and after we took your deposition, is that correct?

1 A I, I, what I, and I can tell you, specifically, that
2 I did.
3 Q All right.
4 A But, yeah, I, I, I looked into seeing, can IVIG cause
5 renal failure, what's the incidence, can it cause renal failure
6 bad enough to kill someone? Those are the kind of things I
7 looked into.
8 Q And the answer was yes, is that correct?
9 A No.
10 Q Oh, okay.
11 A The, the answer was it's extremely rare. There's
12 only be 50 reported case of renal failure in somebody receiving
13 IVIG since 1987, since it was first reported. So, since 1987
14 until recently, 50 cases nationwide were reported. Of those,
15 there was only five fatalities, and they died from other things
16 like strokes and such.
17 Q What is a black box warning in the PDR?
18 A It's something that drug companies require to put in
19 their package information; the FDA requires it.
20 Q As a result of testing that particular drug, is that
21 correct?
22 A The FDA making some kind of determination, usually in
23 cahoots with the drug company, and whether they're going to
24 issue a black box, or pull it off the market, and all those
25 kind of things.

1 They're warnings to warn physicians to be careful
2 when they're prescribing a medication.
3 Q And is there a black box warning to doctors who
4 prescribe IVIG to warn them that patients have died from acute
5 renal failure as a result of IVIG?
6 A I don't know precisely what the, what the black box
7 warning is.
8 MR. : May I approach the witness, Your Honor?
9 THE COURT: Yes.
10 BY MR. :
11 Q Let me show you what is the exhibit from Dr.
12 (phonetic sp.) deposition and ask you have you seen
13 that before?
14 A Actually, I don't recall seeing this.
15 Q So, you haven't reviewed the PDR and the IVIG?
16 A That's right.
17 Q So, take a few moments and look at the black box
18 warning they have for IVIG, and see whether it says that -- it
19 warns people who prescribe it that someone can die of acute
20 renal failure as a result of an IVIG treatment.
21 MR. GASTON: Objection as to what can happen, Judge.
22 THE COURT: No, I'll permit it.
23 THE WITNESS: Well, if you give me a little leeway in
24 explaining why this is not similar to Mr. 's situation,
25 but, but I can read that to you. It says, "IVIG products have

1 been reported to be associated with renal dysfunction, acute
2 renal failure, asthmatic nephrosis, and death. Patients pre-
3 disposed to acute renal failure, including any patients with
4 pre-existing renal insufficiencies, diabetes, age greater than
5 65, volume depletion, sepsis," something I can't even read
6 "paraproteinemia, patients receiving no nephrotoxic drugs."
7 (Unintelligible.)
8 "While these reports of renal dysfunction and acute
9 renal failure have been associated with the use of many
10 licensed IVIG products, those containing sucrose as a
11 stabilizer account for a disproportionate share of the total
12 number."
13 I've read that too.
14 Q And you said you actually looked to a study to see
15 how many people have died from from IVIG as a result of acute
16 renal failure, is that correct?
17 A Yeah. Yes, and even more in, in that particular
18 study they mention the pathology of the type of renal failure
19 that they've had.
20 Q And that was in the ,
21 is that right?
22 A No. I don't think that's, I'd have to --
23 Q Can we agree in the article that you read that those
24 people that died died and had acute renal failure about two to
25 three days after they took the IVIG?

1 A Right. And then the people who had renal failure,
2 after their first exposure to medication, the average onset was
3 about three days. It varied from one to ten days, but the
4 average person it was about three days.
5 Q But you eliminated that as any cause of the renal
6 failure in this case --
7 A Well, he --
8 Q -- even though at the time of your deposition you
9 didn't even know much about IVIG, is that right?
10 A Well, I knew about IVIG.
11 Q Did you look at the PDR?
12 A No.
13 Q Okay. Now, rhabdomyolpysis, tell the jury what is
14 rhabdomyolysis.
15 MR. GASTON: Objection. Not covered on direct.
16 THE COURT: Overruled.
17 THE WITNESS: What? What am I supposed to do now?
18 MR. GASTON: You can answer.
19 BY MR. :
20 Q You can answer the question.
21 A To the question about, yes, say that again. I'm
22 sorry. Rhabdomyolysis?
23 Q Correct.
24 A Rhabdo for short, when muscles are damaged or other,
25 either through a traumatic injury, or chemical injury, or

1 something toxic injury to the muscles, they will be, you know,
2 the muscle breaks down and released CK, creatinine kinase,
3 creatinine kinase, which can be toxic to the kidneys.
4 Q So, the muscle obstruction comes from the fact that
5 there's trauma to the body, is that correct?
6 A Or other things, or other toxic things.
7 Q Did you look to see whether or not Mr. had
8 elevated CPK that would be at least indicative of
9 rhabdomyolysis?
10 A Yes, I looked at it, and I, and I also saw that that
11 was at his baseline level.
12 Q Okay. Did you look? His baseline was 500, is that
13 correct?
14 A Uh-huh.
15 Q Okay. You have to say yes or no because --
16 A Yes.
17 Q -- they're recording this.
18 A Sorry. Yes.
19 Q Okay. Thank you. Did you look to see whether there
20 was any subsequent CPK done after the 500 to see whether there
21 was an increase from that baseline?
22 A Yes.
23 Q All right. And was there an increase?
24 A Yes, there was.
25 Q And what was that number? Tell the jury.

1 A Roughly 2,000.

2 Q Four times it went up, is that right?

3 A Approximately.

4 Q Right before he died it was 2,200, is that correct?

5 A Approximately, yes.

6 Q And is that consistent with rhabdomyolysis, that

7 finding, that CPK?

8 A Well, if I further recall, they didn't do the

9 isoenzymes, they didn't sub-type it. You heard that CK is also

10 produced by heart muscle, and, as well as skeletal muscle. So,

11 they didn't do that break down. So, it's hard to tell what the

12 source of it was. The presumption is that it was from, from

13 the injury, from the trauma; that's why it went up.

14 Q But rhabdomyolysis can be present at levels of 2,200,

15 is that correct?

16 A Yes. Oh, yes.

17 Q And rhabdomyolysis can cause acute renal failure, is

18 that correct?

19 A Right. Yes.

20 Q But you eliminated that also, but did you look into

21 that also as a possible cause?

22 A Well, when you say I, I eliminated it, the treatment

23 would have been the same, IV fluids. That's what you do to

24 somebody who's got rhabdo, lots of IV fluids. You want to

25 flush that stuff out of the kidneys. You don't let them sit

1 there not urinating overnight, and not giving them adequate
2 amounts of fluid.
3 So, you know, whether it was an acute tubular
4 necrosis from shock that caused his kidneys to fail, or whether
5 he had some degree of chronic kidney failure, or whether the,
6 the, the CK was, was affecting his kidneys, the treatment was
7 still the same, fluids, he needed IV fluids.
8 Q You believe that the recommendations that were made
9 by Dr. , the intensivist, were reasonable, is that
10 correct?
11 A I think they were a reasonable starting point. They
12 were reasonable from his point of view, from the very narrow-
13 minded specialist's plan, yeah.
14 Q From a narrow-minded specialist's point of view?
15 A Well, I shouldn't say narrow-minded. From a narrow-
16 focused. I'm sorry. Bad choice of words.
17 Q I see. Okay.
18 A A narrow-focused specialist's point of view, that was
19 a good place to start.
20 Q That's what you told us in your deposition, but you
21 have had other instances, in this case where you've reviewed
22 it, where you have stated and you believe that Dr.
23 reached the standard of care, is that correct?
24 MR. GASTON: Objection. Can we approach?
25 THE COURT: Very well.

pei

1 (Bench conference follows:)

2 MR. GASTON: This line of questioning was covered in

3 your chambers before trial. I wanted to know whether Dr.

4 was going to claim that any other doctor breached the

5 standard of care. I said Dr. 's not a defendant in this

6 case, he's not going to be mentioned in this case. Dr --

7 THE COURT: Dr. you mean.

8 MR. GASTON: -- Dr. , and Dr. not

9 claiming that any other doctor breached the standard of care,

10 and neither are we. This is a red herring, and counsel said,

11 we're not going to be going there. Now, he's going there.

12 Now, he's dragging in some other doctor who's not

13 here, and it doesn't matter if four, or five, or six other

14 doctors breached the standard of care; it only matters if Dr.

15 does, because what is the jury going to do with that

16 information? It's just going to confuse them. It's not going

17 to assist them in determining whether Dr. breached the

18 standard of care in this case.

19 MR. : He called my client and asked him

20 specifically whether or not he agreed with, or did Dr.

21 and Dr. (Unintelligible) agree with the treatment plan on what

22 occurred. Dr. was testifying that he feels that what

23 was done by Dr. was appropriate.

24 I am offering it to impeach him, because he, at one

25 point in time, felt that Dr. was negligent and breached

1 the standard of care.
2 Dr. was managing this particular patient, and
3 managing subsequent to my client's involvement in this
4 particular case, and that Dr. , another expert and
5 actually, in this instance, he will testify also that he could
6 rely upon, in part, on Dr. 's recommendations.
7 So, I believe that I am entitled to get into his
8 opinions as to how earlier he feels that he breached the
9 standard of care.
10 THE COURT: So, it's a prior inconsistent statement?
11 MR. : Correct.
12 MR. GASTON: Your Honor, I didn't ask Dr.
13 whether or not Dr. 's care was appropriate. I never
14 touched that. I never went there.
15 Counsel wants to use or counsel wants to open the
16 door on himself to get a statement from the doctor, and then
17 impeach him with something else later. That's inappropriate.
18 He can't do that when the second part of it is prohibited. He
19 can't ask the doctor, do you think it was okay? Yes. And then
20 say, ah ha before you did you said it wasn't, and you said he
21 breached the standard of care. But he already said that he's
22 not going to go there, so I don't think he can open a door
23 himself on that just to bring in what would be otherwise
24 objectionable testimony.
25 I did not go over that on direct with him, and Dr.

1 hasn't claimed anyone else did either. It's confusing
2 as all get out.
3 THE COURT: I mean, you're stuck with his answer. He
4 gives you the answer, it's collateral, you wouldn't be able to
5 impeach him.
6 MR. : No. He gave me the answer he thought
7 it was appropriate, and I'm trying to impeach him now because
8 he said before, in his report, you know, the report saying that
9 he was, in fact, negligent. (Unintelligible).
10 MR. GASTON: It's still collateral. Extrinsic
11 evidence is not permissible on a collateral matter.
12 MR. : And there's no new evidence in all that
13 he has at all from the time he authored his report up until the
14 time that he now changes his opinion.
15 MR. GASTON: It's still collateral, Judge. He's
16 stuck.
17 THE COURT: Yes. I'm going to permit it.
18 MR. : Okay. While we're up here, just to
19 save some time, he has also opined that the hospital staff at
20 Hospital were negligent. And, in fact,
21 you've heard him about who recorded what or whatever. Okay?
22 So, I believe I'm also entitled to get into the fact that he
23 believes that the hospital staff were negligent, and, also that
24 Dr. was also negligent, because he has already
25 introduced evidence through my client that he relied, and could

1 rely on Dr. 's assessment.

2 And, also, as far as the staff is concerned, staff is

3 responsible for making the recording of the different labs.

4 And I think I'm entitled to explore that also.

5 MR. GASTON: Judge, he's doing exactly what they said

6 they weren't going to do in your chambers. He said he's not

7 going to claim that anyone else was responsible. It's not a

8 defense. If it's a defense to this case, that's something

9 different, and it is not. It is not a defense in this case.

10 So, it's like me asking Dr. about not signing

11 the death certificate. It's highly prejudicial if you use it

12 for the wrong purpose. They're going to use it for the purpose

13 of the defense to this case.

14 THE COURT: Yes. I'm reversing myself. I sustain

15 the objection.

16 MR. GASTON: Thank you.

17 MR. : Just for the record --

18 THE COURT: Mr. Gaston?

19 MR. GASTON: Sorry, Judge.

20 THE COURT: It's okay.

21 MR. GASTON: I was a little too excited.

22 MR. : I just want to put a proffer as I would

23 be asking questions that Dr. breached the standard of

24 care, that the staff at Hospital breached

25 the standard of care, and Dr. breached the standard of

1 care in executing the certificate (unintelligent), opining that
2 all three had breached the standard of care. And for the
3 reasons I've set forth, I believe I'm entitled to ask those
4 questions of him on cross-examination.
5 THE COURT: All right.
6 (Bench conference concluded.)
7 BY MR. :
8 Q I apologize. I may have asked you this question
9 before, but you never took it upon yourself to look at the
10 autopsy slides at all, is that right, sir?
11 A That's correct.
12 Q When you initially reviewed this case, you wanted to
13 have two areas, you used the term "fleshed out." That is, what
14 happened to Mr. before he went to the hospital, and what
15 happened in the last few hours of his life, is that correct?
16 A Yes.
17 Q So, what you did is you called Ms. up and
18 talked to her, is that right?
19 A That's right.
20 Q And you also had the second, and that is that you
21 wanted to determine how extensive the hematomas were on
22 autopsy, and if Dr. , who performed the autopsy, could
23 tell you what was the size of the hematoma, is that right?
24 A That's right.
25 Q So, you didn't know how much blood was in the

1 hematoma, because that's why you went over to the textbook on
2 pathology; you couldn't find that. And then you went and tried
3 to call up Dr. , who you don't know at at all, is
4 that right?
5 A No, I've never met her.
6 Q I know you work there, but you don't know her at all?
7 A No.
8 Q But she is at , is that correct?
9 A Right.
10 Q And you called her up to try to determine how much
11 blood was in that hematoma, is that correct?
12 A Right. Right.
13 Q And she could not remember anything about that
14 particular autopsy --
15 A Uh-huh.
16 Q -- is that correct?
17 A That's right.
18 Q The cardiac enzymes were normal on admission, is that
19 right, sir?
20 A No, there was actually an elevation, the cardiac
21 enzymes. Whether that was done in the emergency department or
22 on admission --
23 Q Do you remember testifying in your deposition, page
24 48, line 20:
25 "Question: You would agree that the cardiac enzymes

1 were normal on admission?
2 "Answer: No."
3 Is that right?
4 A I said no, they were not normal.
5 Q Okay. But the EKG was normal, is that right?
6 A It may have showed signs of tachycardia. I don't
7 recall.
8 Q Now, you would agree that was reasonable for Mr.
9 to be placed on an anti-coagulant by Dr.
10 initially, is that right?
11 A Yes.
12 Q And you were not able to detect a hematoma on the CT
13 scan here, because you have a hard time seeing it yourself, is
14 that right?
15 A That's right. A soft tissue hematoma is difficult to
16 see, because there's no contrast.
17 Q We can agree if a patient's receiving a lot of IV
18 fluids, there H&H can decrease, is that right?
19 A That's right.
20 Q And you believe it was reasonable for Dr. to
21 take the information that he had from Dr. , and carried
22 out the plan with the suggestions and recommendations made by
23 Dr. , is that right?
24 A In conjunction with his, his own thinking, and, and,
25 and other recommendations of other specialists, if there were

1 any.

2 Q And you noted that Dr. -- I think we covered

3 this before -- wrote a note that saw no evidence of any acute

4 ischemia causing hemodynamic instability, is that right?

5 A That's what his note says.

6 Q You saw no harm in providing Kayexalate to Mr. ,

7 is that right?

8 A I wouldn't have ordered it, but I didn't see any harm

9 in doing it.

10 Q And you believe that there was clearly hypo, and I

11 say hypoperfusion in the brain of Mr. , is that correct?

12 A Yes.

13 Q That there was decreased blood flow; that he wasn't

14 getting oxygen into his brain, is that correct?

15 A Yes.

16 Q Now, did you go and look to see whether or not there

17 was any indication of hypoperfusion in the pathological

18 analysis of the slides of the brain?

19 A I didn't look at slides, but I did read the autopsy

20 report.

21 Q And the autopsy report shows no evidence of any

22 hypoperfusion of the brain, is that correct?

23 A I don't think an autopsy can show hypoperfusion,

24 because the person is deceased, so there's going to be

25 hypoperfusion everywhere. Nothing is perfusing when someone's

1 deceased.

2 Q I see. So, it's your opinion, even though you're not

3 a pathologist, that there would be no evidence of hypoperfusion

4 of the brain on autopsy? Is that your testimony? Is that what

5 you're telling this jury?

6 A If, if the hypoperfusion got to a point where there

7 was infarct, in other words, where it, it, you know, again,

8 everything is, there's gradients of things, so you can have a

9 low perfusion, and then you can have it to a certain point

10 where the tissue actually dies. That's what heart attacks, and

11 strokes, and things like that are, are points when the,

12 there's, the blood flow is so inadequate that the tissue

13 actually dies, and that you could see at autopsy.

14 Q The autopsy showed that the brain was normal, is that

15 right?

16 A I would have to look at it to say that it was

17 completely normal, but there was, as I recall, there was no

18 sign of any infarct, no sign of stroke or anything like that.

19 Q And you would defer to a pathologist on a

20 pathological diagnosis, is that right, sir?

21 A Yes.

22 Q Did you review the transcript that was taken of Dr.

23 , the other expert in this case?

24 MR. GASTON: Objection. Can we approach?

25 THE COURT: All right.

1 (Bench conference follows:)

2 MR. GASTON: I didn't ask him any questions about

3 testimony from Dr. , not his thoughts on it, not his

4 comments on it, so I don't know where he's going with this on

5 an opinion from an expert that we haven't heard from yet

6 period. So, I don't know why he's asking him questions about

7 somebody else's deposition testimony.

8 THE COURT: Well, we're about to find out.

9 MR. GASTON: That's why I'm objecting, because it's

10 going to be the same thing. Do you agree with Dr. , or

11 do you agree with this? And to me it doesn't matter whether he

12 agrees with any other expert that we haven't heard from yet.

13 THE COURT: Well, when he's asked the question, you

14 can objection.

15 MR. GASTON: Thank you.

16 (Bench conference concluded.)

17 BY MR. :

18 Q Did you review the deposition of Mr. 's other

19 expert, Dr. ?

20 A It was a, I don't think it was called a deposition.

21 It may have been videotaped testimony.

22 Q Yes, sir.

23 A Is that the same thing?

24 Q Either way. It could be in writing, it could be in a

25 video. Did you review either one?

1 A I reviewed the written, like a transcript of that.

2 Q Okay. And did you know that Dr. feels that

3 Dr. --

4 MR. GASTON: Objection.

5 THE COURT: Overruled.

6 BY MR. :

7 Q You noted and your review of Dr. , who is a

8 naphrologist, testified that he believes that 2,000 cc's would

9 have met the standard of care if administered on th, is

10 that correct?

11 MR. GASTON: Objection.

12 THE COURT: Overruled.

13 THE WITNESS: I'm not sure he gave, he, he could hone

14 it down to just 2,000 cc's. If I remember correctly, he was

15 doing the same thing I was doing, in trying to come up with an

16 exact number, and he may have given a small range.

17 BY MR. :

18 Q I didn't hear you say 2,000. Do you think 2,000 was

19 have met the standard of care?

20 A Well, the standard of care is you start to give the

21 IV fluids. You, you don't, the standard is not to say, to do a

22 calculation and determine that this person needs X number, and

23 then order X number.

24 The, the, the standard of care is that you initiate

25 the treatment, you re-evaluate how it's working. So you give

1 them that bolus of fluids, and then you either come back
2 personally, or you call back, or you ask the nurse to call you
3 with the result, with the blood, call me with the vital signs
4 after the bolus, and then you make another determination if
5 they need more.
6 It's a constant reevaluation. So, when, when you're
7 asking about a specific number, is that the amount you're
8 asking that you start out with, or is that the amount that you
9 think is going to get you where you need to go.
10 The, the starting is pretty easy. You start out with
11 a liter or 500 cc's. But, then, trying to estimate what is it
12 eventually going to take to correct things is not so easy,
13 because of those insensible losses that I was talking about.
14 You know, you can easily lose a liter of perspiration just like
15 that. And, so, we don't know how much he truly needs.
16 And, so, the numbers I came up with were minimums,
17 and I believe Dr. 's also talking about a minimum.
18 Q And do you agree with Dr. 's assessment that
19 the standard of care would have been met by Dr. , if he
20 would administer between two and 3,000 cc's on th?
21 A I'm not sure Dr. said that. But what I
22 would say is that if he had given enough IV fluids to start
23 bringing up his blood pressure, lowering his heart rate,
24 improving his renal perfusion so that his kidneys start working
25 again, and his brain starts functioning normally, then he's

1 given him the right amount of fluids, then he's met the
2 standard of care.
3 Q So, you can't really put a number on it, is that what
4 you're saying?
5 A A number on what exactly?
6 Q A number as to what the standard of care required.
7 A That's right. I, I can't give you an exact number
8 that over, you know, what are you talking about his lifetime, a
9 day, a minute? When you're asking about a volume of fluid,
10 there, there's no way predict or accurately estimate. It's a
11 total ball park figure.
12 Q You have only some records of the hospitalization.
13 Did you get prior records for Mr. and look at them?
14 A Yes.
15 Q Okay.
16 A I got some of Dr. 's office records.
17 Q All right. Other than Dr. , did you go back
18 and look at anybody else's records?
19 A There may have an emergency room visit or two. I
20 didn't spend much time on them at all, I don't think.
21 Q You didn't spend too much time looking at this prior
22 records, is that right?
23 A The emergency room visits; they were unrelated,
24 and --
25 Q And, so, can we agree that wouldn't it be important

1 to find out what his prior medical history is, in terms of
2 determining the cause of some of those problems?
3 A Right. So, what I did was, right, I tried to find
4 every medical problem he ever had. You don't need to read the
5 whole, every, every word to figure that one out. I, I wanted
6 to see what previous labs were. I wanted to see what other
7 previous consultants had said. I was trying to build a problem
8 list on, on Mr. . I, unfortunately, didn't have that kind
9 of thing, so I was trying to build one with the data that I
10 had.
11 Q Okay. And that's to determine what the cause of
12 these problems were that he had on 15 and 17
13 (unintelligible), is that right?
14 A Right. Uh-huh.
15 Q Now, you wrote a six-page report, and you have seven
16 lines of history in this patient, is that correct?
17 A I would say it's probably not far from seven lines,
18 yes.
19 Q Did you, in your report, indicate that Mr.
20 suffered from depression?
21 A I don't remember if I put that in there or not.
22 Q Can we agree it's not in there?
23 A If you say so.
24 Q Did you put in the report anything that Mr. had
25 any problems with alcohol intake?

1 A I don't recall. I remember looking at that, and, but
2 I don't, don't think that I put it in there, no.
3 Q Okay. Now, you have the records. Ms. supplied
4 a document to , and it's at 10022. He was
5 seeing 17 different physicians. Did you get all of those
6 records and see what problems he was having?
7 A No.
8 Q You reviewed the autopsy report, is that correct?
9 That's at , 016.
10 A I'm assuming it's the autopsy report, so, yes.
11 Q Okay. And I'm not going to go through and pull this
12 up. I just want to ask you, in that report, they went back and
13 did an analysis of the history of Mr. . And on 12-12-04,
14 he had problems with memory, anxiety, depression, and
15 difficulty concentrating, is that correct?
16 A If you don't mind, I'd like to look at that. What
17 was the number again?
18 Q Its -- that's an abbreviation for
19 -- 016.
20 A Yes. Yeah, I know they did. They, they did
21 something similar as to what I did, I assume, is they went
22 through and it seems they spent a little bit more time on some
23 of the neurologic things, but, yes, they tried to summarize his
24 medical history.
25 Q Are you discounting that he had major problems with

1 his peripheral neuropathy?

2 A No. No, I, I'm not characterizing --

3 Q Back on 12-12 --

4 A -- whether it's major or minor. I know he has

5 peripheral neuropathy.

6 Q Now, you note in there that there's a history that he

7 stopped smoking sometime around 1980 cigars, and drinks

8 approximately two alcoholic drinks every day for 20 years, is

9 that right?

10 A I remember seeing something like that, yes.

11 Q Okay. And if you turn to page 17, "he has had

12 numerous falls leading to injury to his head, and back, and his

13 hands were shaky," is that right?

14 A Uh-huh, at times.

15 Q And on 5-10-05, "the patient was advised to

16 discontinue his alcohol intake, or at least reduce it, which

17 was thought to be contributing to his condition," is that

18 right, sir?

19 MR. GASTON: Objection.

20 THE COURT: Overruled.

21 THE WITNESS: I mean I, I don't, I don't see the line

22 that you're reading, but it would make sense for somebody with

23 neuropathy, because alcohol can be damaging to nerves too.

24 BY MR. :

25 Q Okay.

1 A So, it makes sense. You'd want to eliminate all of
2 the possible contributing factors.
3 Q And he was given Effexor because of his tearfulness
4 and his sadness as an anti-depressant, is that right?
5 A That's what it says here, yes.
6 Q Now, they record, at page 18, that he had two falls,
7 the first while getting out of a chair, and then, second, while
8 walking back to the kitchen on , is that right?
9 A I think it was two falls, right.
10 Q Okay. Now, did you look in the emergency room record
11 to see what type of history Mr. gave, as far as his
12 alcohol intake at 10013?
13 A I don't think I actually looked at that.
14 Q Okay.
15 A The admission database form?
16 Q 10013.
17 A Uh-huh. Admission database. That should be under
18 maybe social history, psycho/social, here we go. Alcohol he
19 says, it says three drinks possibly says a day for a long time.
20 Q So, he was drinking three drinks per day for, in his
21 words, a long time, is that right?
22 A Uh-huh. Yes.
23 Q And if you look at the social history, at page 10003,
24 that history that he gave at that time was three to four drinks
25 of alcohol per day, is that correct?

1 A Do you want me to verify that? This is actually from
2 the discharge summary. Yeah, this, it's in his discharge
3 summary somebody put that in there.
4 Q Yes, (unintelligible) on autopsy, is that right?
5 A Yes.
6 Q Okay. Now did you look to determine whether or not
7 any of the signs and symptoms that he had at
8 Hospital may be as a result of delirium tremens, DT's?
9 A Uh-huh. Yes, I considered that.
10 Q Okay. Can we agree that heavy sweating is a sign or
11 symptom of DT's?
12 A Yes.
13 Q Can we agree that confusion and anxiety is a sign and
14 symptom of DT's?
15 A Confusion and hallucinations. I'm not sure anxiety,
16 but --
17 Q Elevated heart rate is a sign of DT's, correct?
18 A Yes.
19 Q Disorientation is a sign, is that correct?
20 A Yes.
21 Q Jittery movements will be a sign, is that right?
22 A Jittery, more tremors, but, yes.
23 Q And there was a sign of some jittery movements by the
24 nurse that night, is that correct?
25 A Uh-huh.

1 Q And, so, that's six signs and symptoms that are all
2 consistent with the DT's, is that right?
3 A Let's, let's, the (unintelligible), some confusion,
4 tachycardia. What were the other ones? I got three.
5 Q Okay. Let me just go through them. Heavy sweating,
6 confusion --
7 A I go that.
8 Q -- anxiety, elevated heart rate, disorientation,
9 jittery movements.
10 A Oh, yeah, that's four then. Well, the, the, the
11 confusion and the anxiety, all that's one, I mean you, you
12 wouldn't call those separate things.
13 Q In general, in DT's have an initial onset about 48 to
14 72 hours after the last drink, is that correct?
15 A Yes.
16 Q Now, you heard Mr. (phonetic sp.) testifying
17 that that was some of the issues that was being explored by Dr.
18 , is that right?
19 A Yes.
20 Q You eliminated that completely, is that right?
21 A For a good reason.
22 Q For the signs and symptoms that you --
23 A For a good reason. He didn't have hypertension.
24 Q I'm just asking. You eliminated that as a
25 possibility, is that correct?

1 A Yes.

2 Q Okay. Now, in looking at the determination as far as

3 the renal failure, you eliminated IVIG, and the black box, and

4 rhabdomyolysis, didn't consider them at all, is that right?

5 A I considered them, but I eliminated them.

6 Q How much did you consider them when you didn't even

7 give my client the courtesy of looking at the PDR to see what

8 they say about IVIG?

9 A My, my initial impression was the, the only things I

10 could recall were big problems with IVIG, because I don't

11 initiate that in patients, so I'm not completely familiar with

12 all the warnings and so on.

13 The only thing I could think of was anaphylactic

14 allergic reactions. These are human products, so it is

15 possible, like if somebody has a transfusion reaction, they

16 cold have a reaction to IVIG.

17 That did not happen in this case. So, I, I, I, at

18 that point, eliminated it as a consideration. Later on, when I

19 heard more about it, and I looked into it, and I got more

20 information about it, more facts in, in here, thoroughly

21 eliminated.

22 I mean it's, it's no longer a consideration in any

23 way in my mind that IVIG had anything to do with this, other

24 than the fact that it may have caused him to be dizzy and fall

25 in the first place, because he was having some hypotension.

1 Oh, that's the other thing, hypotension problems from IVIG.
2 Q And I assume, since you don't even have anything
3 about a history of alcohol in your six-page report, that you
4 never even considered DT's as a possible cause?
5 A No, I did consider it. I did consider it.
6 Q Did you determine as to what his alcohol intake was,
7 and record it in your report, sir?
8 A No.
9 Q Thank you.
10 MR. : Court's indulgence.
11 THE WITNESS: What?
12 (Discussion off the record.)
13 MR. : No further questions.
14 THE COURT: Mr. Gatson?
15 MR. GASTON: Your Honor, I want to read into the
16 record Dr. 's sworn deposition testimony, and then I'm
17 going to ask the doctor a question about it.
18 The deposition testimony is --
19 MR. : Well, Your Honor, perhaps, we can at
20 least -- it's the first time I've heard about his reading in a
21 portion of his deposition. At least maybe find out before I
22 can voice an objection.
23 MR. GASTON: I'm going to tell you the page number
24 and line, and if you'd like to approach you can. Pages 144 --
25 MR. : Just a second.

1 MR. GASTON: Yes. Okay.
2 MR. : Okay. Thank you.
3 MR. GASTON: It begins at line 6, and goes through
4 page --
5 MR. : What page?
6 MR. GASTON: -- 144. It begins at line 6 and goes
7 through page 145, at line 14.
8 MR. : Can we approach?
9 THE COURT: Sure.
10 (Bench conference follows:)
11 THE COURT: Line 44, on what page? What number?
12 MR. GASTON: Line 6.
13 THE COURT: Line 6? That's a question.
14 MR. GASTON: It is. It's a question I asked the
15 doctor.
16 THE COURT: Okay.
17 MR. GASTON: I think it's fair. He went into all
18 this alcohol and DT's.
19 THE COURT: I know what you're saying. I know what
20 you're saying.
21 MR. : I don't know if the question, because
22 there's no answer on page 144. I think he's looking to 145,
23 line 5.
24 THE COURT: 145.
25 MR. GASTON: Yes, keep going down.

1 THE COURT: Line 7.

2 MR. GASTON: Yes.

3 MR. : All I'm objecting to is this long

4 question of which there was no answer.

5 MR. GASTON: No, there was, though.

6 THE COURT: What's that?

7 MR. GASTON: There was an answer to that question,

8 because I reiterated it. They have to hear the first part to

9 understand the reason why he had to answer.

10 THE COURT: Well, why don't you just do it with this

11 one. Start here. "I need to know if there's any, if you are

12 claiming that any of Mr. 's conduct himself --

13 MR. GASTON: "Contributed to his death."

14 THE COURT: -- "what he did or didn't do contributed

15 to his death."

16 MR. GASTON: Thank you, Your Honor.

17 THE COURT: And then --

18 MR. GASTON: Yes.

19 THE COURT: -- finish up the --

20 MR. : Then, well, the only objection I have

21 at this point is that we're not contending that alcohol was the

22 cause of his death.

23 THE COURT: Well, it's been raised. I think it's

24 fair redirect.

25 MR. GASTON: Thank you.

1 (Bench conference concluded.)

2 REDIRECT EXAMINATION

3 BY MR. GASTON:

4 Q Doctor, if you can listen to this question and

5 answer, please, and then I have a question for you. This is a

6 question that I asked Dr. under oath at his deposition.

7 "Now, is the time that I need to know if you are

8 claiming that any of Mr. 's conduct himself, what he did

9 or didn't do, contributed to his death."

10 There was an objection by counsel.

11 His counsel says:

12 "Do you understand the question?"

13 Dr. says:

14 "Yes. Whether he did anything to contribute. Well,

15 number one, one thing he did was to continue to drink alcohol.

16 That has been noted in several places."

17 I asked the doctor:

18 "How did his consumption of alcohol proximately

19 contributed to the cause of his death?

20 "I'm not claiming that there was a proximate

21 contribution.

22 "That's fair enough, doctor. That is a fair enough

23 answer. Anything else you can think of that he did or didn't

24 do that proximately contributed to the cause of his death?"

25 Dr. says:

1 "No."

2 Dr. , do you agree with Dr. that Mr.

3 's alcohol consumption had nothing to do with the

4 proximate cause of his death?

5 A Yes.

6 Q Do you agree with Dr. that there's nothing

7 that Mr. did or didn't do that contributed to the cause

8 of his death?

9 A Yes, I agree with that.

10 Q Dr. , why did you eliminate DT's or delirium

11 tremens as a cause of Mr. sweating, confusion, and

12 those type of signs on the day he died? You were trying to

13 give your explanation, but I don't think you did. Do you have

14 an explanation for that?

15 A Well, one of the hallmarks, not the singular

16 hallmark, is an elevated blood pressure, the blood pressure.

17 And somebody going through alcohol withdrawal, their blood

18 pressure is through the roof.

19 And if you take somebody who's got chronic

20 hypertension like Mr. did, his numbers would be, you

21 know, 240 over 120, numbers higher than they were anywhere. He

22 didn't even come close to that. And, as we saw, most of the

23 time he was at a low blood pressure.

24 The timing also, because he came in with the

25 hypotension, and it just doesn't fit. It just doesn't fit.

1 Q Dr. , there was some testimony as to what is
2 the exact amount of fluid, what is the exact amount of cc's
3 that Dr. had to give in order to reverse all of this
4 situation, and I think you testified there's no way you can
5 tell the exact amount of fluid, you have to see how the patient
6 progresses. Was that fair?
7 A Yes.
8 Q What is a minimal amount of fluid, in your opinion,
9 that Dr. should have given to Mr. to try to
10 reverse his kidney failure, to try to reverse his liver
11 failure, to try to reverse the problems with the function of
12 the brain that is a breach of the standard of care? What is
13 the minimum amount that he had to at least start him on?
14 MR. : Objection.
15 THE COURT: I'll permit it.
16 Go ahead.
17 THE WITNESS: Well, two days prior, on the 15th, when
18 he came to the emergency department, he was given, you know,
19 roughly 500 to 1,000 cc's of fluid. And, by the next day, his
20 creatinine had come down to normal, his blood pressure was
21 fine. So, that's what one liter did at that point.
22 By the 17th, when his creatinine was up to 5, it was
23 quite a bit higher, so to, to, to bring everything back down it
24 would, it would be approximately three times that amount, so
25 somewhere around 1,500 to 3,000 cc's of fluids to get things

1 started, to get things moving in the right direction.

2 BY MR. GASTON:

3 Q Did Dr. ever even do that?

4 A No.

5 Q I want you to draw your attention to page 185 of the

6 chart of Hospital.

7 A 100185 or --

8 Q Actually, you know, it's in Tab No. 1, which is

9 actually Dr. 's own notes. 0185.

10 A Okay.

11 Q And this would be the intensivist, Dr. 's

12 consultation report?

13 A That's correct.

14 Q Under cardiovascular, there's a statement the patient

15 has tachycardia. What does that mean?

16 A That's a rapid heart rate.

17 Q Okay. "I suspect this is related to pain and

18 intravascular volume depletion." Now, can intravascular volume

19 depletion encompass lack of fluid, and also internal bleeding?

20 A Yes.

21 Q So, when counsel said that there's nowhere in the

22 chart did anyone say there was internal bleeding. From the

23 medical terminology that Dr. used, does that also suggest

24 there was internal bleeding going on at that time?

25 A Well, let me just review this thing here. I mean

1 what he's saying he's describing a man who's in shock; he's
2 just not using that word. He's got tachycardia, intravascular
3 volume depletion, hypotension, needs to be addressed with fluid
4 hydration. That's what you, that's someone who's in shock.
5 Q And it also includes internal bleeding, as well,
6 within that definition?
7 A Yes. Yes.
8 Q Counsel brought up Mr. 's depression. Did Mr.
9 die of depression?
10 A No.
11 Q Okay. Did Mr. die of mental confusion?
12 A No.
13 Q And why do you believe that the IVIG treatments that
14 Dr. gave to Mr. on the 14th was not a proximate
15 cause of his kidney failure or had anything to do with his
16 death? Can you explain that in a little more detail?
17 A Well, as far as the, the death, you have the autopsy,
18 and, and that shows, and now it's getting technical, but it
19 shows ATN, acute tubular necrosis. It has a particular
20 pathologic finding when they looked at the kidneys, and that's
21 not the type of damage you see from IVIG. IVIG causes damage n
22 a different part of the kidneys, the grimelius.
23 Q So, the autopsy report, does that support your
24 opinion that Mr. 's IVIG treatment did not contribute to
25 his death?

1 A Yes.

2 Q Thank you.

3 MR. GASTON: That's all the questions I have.

4 MR. : I think I have an exhibit up there.

5 THE COURT: Very well.

6 MR. : Can I just take a look at it and see if

7 that's what I'm looking for.

8 THE WITNESS: Well, it's no labeled, so I don't know

9 if it's --

10 MR. : Oh, okay.

11 THE WITNESS: -- legit or not.

12 THE COURT: Right.

13 MR. : Just the Court's indulgence.

14 THE WITNESS: Am I excused?

15 THE COURT: Not yet.

16 RECROSS EXAMINATION

17 BY MR. :

18 Q Is acute tubular necrosis another term for acute

19 mental failure?

20 A It's probably a, one of the more common reasons for

21 it, yes.

22 Q Okay.

23 MR. : I don't have any questions.

24 THE COURT: All right.

25 Thank you, sir. You may be excused.

1 (Witness excused.)

2 THE COURT: Members of the jury, that concludes

3 testimony for today. We're going to resume tomorrow. I do

4 have a couple of matters at 9 o'clock, so we'll resume tomorrow

5 at 9:30.

6 So, just be outside the courtroom at 9:30. Leave

7 your notepads behind face down in your seats. Do not discuss

8 this case with anyone, including each other. Avoid all contact

9 of any kind with any of the participants of this trial. See

10 you tomorrow at 9:30.

11 The Court's in recess.

12 THE BAILIFF: All rise.

13 THE CLERK: The Court stands in recess.

14 (End of requested portion of proceedings)

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