IN THE DISTRICT COURT OF HARRIS COUNTY, TEXAS
151st JUDICIAL DISTRICT

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| REED FRANK ZEIGLER AND COLLEEN McCARTHY ZEIGLER | ) | |
| V. | ) | CAUSE NO. 2016-77555 |
| HUNG T. NGUYEN, M.D. AND HARVINDERPAL SINGH, M.D. | ) | |

VIDEOTAPED DEPOSITION OF BRIAN CARMINE, M.D., an expert witness in the above-entitled cause, taken before Susan Lozzi, Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, pursuant to the Texas Rules of Civil Procedure, at Rubin Rudman, LLP, 53 State Street, Boston, Massachusetts, on Tuesday, February 20, 2018, commencing at 1:57 p.m.

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ALSO PRESENT:
Cuirey Eckmayer, Videographer

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P-R-O-C-E-E-D-I-N-G-S
THE VIDEOGRAPHER: Today is 2018, February 20th. This is the deposition of Brian Carmine, M.D., in the matter of Reed Frank Zeigler, et al. vs. Hung T. Nguyen, M.D., et al.
We're on the record at 1:57 p.m. Will counsel please states their appearances, after which the court reporter will swear in the witness.
MR. ENGELHARDT: Steve Engelhardt for the Plaintiffs.
MR. SERPE: John Serpe for Dr. Singh.
MS. NOLAN: Angela Nolan for Dr. Steven Ugbarugba.
MR. HUGHES. Matthew Hughes for Dr. Patel.
BRIAN CARMINE, M.D., having been sworn to tell the truth, testified as follows:
DIRECT EXAMINATION BY MR. SERPE:
Q. Would you state your name, for the record.
A. Brian Carmine.
Q. And what do you do for a living?
A. I'm a general surgeon, minimally invasive surgeon.
Q. And where do you practice?
A. I practice here in Boston at Boston

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Medical Center.
Q. All right. And for the people in the jury, Boston, Massachusetts?
A. Yes.
Q. All right. There's a couple other Boston's, but you've been in Boston. It looked like following your medical school training, you were -- you did advanced training here and have stayed in the area?
A. Yes.
Q. All right. And are you board certified?
A. I am.
Q. Okay. And tell us where you have privileges.
A. I have privileges at Boston Medical Center and at Boston Children's Hospital.
Q. And do those hospitals have an affiliation with Harvard or is that a different hospital group up here?
A. Boston Children's has an affiliation with Harvard.
Q. I got you. And then Mass. General was a different hospital?
A. Mass. General's a different hospital.
Q. Okay.

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A. There's a lot of hospitals here.
Q. I know. Okay. Doctor, let me -- let me ask you first, you've been retained as an expert witness on behalf of the Plaintiffs in this case correct?
A. Correct.
Q. And how many other times have you been retained as an expert witness?
A. It would be difficult for me to say. I probably review about two or three cases a month.
Q. Okay.
A. So I've been doing that for about four to five years, so however that averages out.
Q. And how do the cases come to you? Is there -- if somebody was looking to hire you, is there -- are you listed in a -- with any of these advocacy groups or exert witness groups?
A. Yeah, the majority of my cases come from a firm here in town. I'd say that's probably where 90 percent of my cases come from.
I -- I somehow found or I somehow got into a -- something called the Expert Institute, and I got a bunch of e-mails from them and -- and every now and then I'll get a case and -- and every now and then I'll get an e-mail directly from somebody

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who is a friend of a friend who I had worked with before, but I would say it's primarily this one firm in town, Expert Institute, and then a scattershot of direct referrals.
Q. And what's the firm in town?
A. Lubin & Meyer.
Q. Plaintiffs or defense?
A. They're plaintiffs.
Q. Okay. And what -- is the Expert Institute something where -- do you have a contract with them?
A. No. To be honest, I have no idea even how I got on their e-mail list.
Q. Okay. So are there times when the Expert Institute e-mails you or calls you and says will -- here's a case potentially for you to review?
A. Yeah, usually it's a e-mail that says we -- we this have case. It might fit your specialty. You click on it. It lists the defendants and -- and conflict, no. You click on that and it gives you the details of case.
Q. Okay. And then do they bill for your time or how does that work?
A. No. So usually what happens is, is you read the case. If I feel like it's something I can speak knowledgeably on, I will say, yeah, I can

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speak knowledgeably on this and then -- and then it's usually followed, you know, a few days to a week later by a direct e-mail saying, you know, they -- they reviewed your responses and the -- and then from that point you're just dealing with the attorney directly.
Q. Okay. How does the Expert Institute get paid on that, if you have any idea?
A. I have no idea.
Q. Okay. How many times have you given a deposition?
A. Twice.
Q. Okay. And what were the other two cases about?
A. One was a case on a gentleman who had perforated diverticulitis. That one was just for a cause that -- I think it was a case against a radiologist whether or not they missed a read.
Q. Okay.
A. So I was just brought on to discuss what are the -- what can happen with missed perforated diverticulitis, and the other case was a case where when closing the abdomen, the intestine was punctured.
Q. Okay. And what are your -- let's go

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through your fee schedule for doing expert work.
A. Yeah.
Q. Tell me about that.
A. So it's -- it's $500 an hour for the initial review of the documents with a minimum of two hours and then deposition or trial is $2,500 for a half day, 5,000 for a full day.
Q. I asked you about depositions. How about testifying live at a trial? Have you done that?
A. I ended up testifying live in a trial on the diverticulitis case.
Q. Okay. Where -- where was that case? Where was trial?
A. It was here in Massachusetts. I think it was -- it was in a town called Lynn, if I remember correctly.
Q. Okay. Do you know what happened, what the outcome was of the case?
A. I believe they did not win or they -- they found for the defense.
Q. Okay, got you. Happens sometimes. All right. And is the -- the money you charge, do you have any -- let me step back from there. Affiliations with a medical school?
A. Yes. I am a assistant professor at the

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Boston University School of Medicine.
Q. Okay. And is that a paid or unpaid position?
A. It's complicated. So technically I am paid by Boston University, but there's -- the way the healthcare gets reimbursed, it's essentially the hospital pays the university who then -- the university's essentially a middleman for the hospital's money.
Q. Okay.
A. But that's -- so, yes, the paycheck has the university logo on it, but -- but the dollars come from the hospital.
Q. Understand. What -- in terms of your practice, in terms of your academic practice, are you involved in doing classroom teaching?
A. Yes.
Q. All right. Tell me about that.
A. So I am very involved with the residents, so it's an academic medical center. Pardon me. So it's academic medical center.
I'm very involved with training the residents, the -- as well as the medical students both at Boston University and then the Harvard medical students who occasionally cross my path when

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I'm over at Children's. I'm also the associate director of simulation at our Simulation Center at Boston Medical Center where we run a number of similar scenarios, skill tasks for the residents, nurses.
Q. Got you. How about -- do you -- do you walk into a classroom and teach people or is it mostly clinical bedside teaching?
A. No. I do -- I do formal lectures.
Q. Okay.
A. Yeah.
Q. Is that -- do you teach a specific course?
A. There's a few topics that I teach sort of over and over again but mostly related to surgical -- specific -- specific surgical topics.
Q. Okay.
A. But, no, there's no course that I teach, for instance, for a whole semester beginning to end. Nothing like that.
Q. What about -- I know you mentioned you do work at the Children's Hospital, as well. What's the breakdown in your patient population between adult and child?
A. Oh, I would say 90 percent adult and then 10 percent, and the -- the children are adolescents.

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Q. Okay.
A. So teenagers.
Q. Okay. So you, for example, don't do general surgery on a newborn or a three- or four-year-old?
A. No.
Q. Okay. So I'll circle back to what I was going to ask before. When you do bill on cases, do does that go directly to you or do you have some arrangement with the university or the hospital about splitting your fees?
A. Again, you'd have to talk to our -- to our money people essentially how it works, but, yeah, no, I bill -- we bill directly to the insurance company for a surgeon's fee but then there are, these days, especially in Massachusetts, nobody can survive on a surgeon's fee alone.
So, for instance, if we do a case like a gastric bypass or a colectomy, a case that will stay inpatient, really the hospital generates a fair amount of revenue from that inpatient stay. They then send that revenue back to what's called our Faculty Practice Foundation.
Q. Okay.
A. And a supplemental portion of our paycheck

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comes from that foundation.
Q. All right. How about for your expert witness work? Does that go just directly to you?
A. That goes just directly to me.
Q. Okay.
A. Yes.
Q. Got you. And what percentage of your income do you think comes from doing the expert witness work?
A. Oh, probably -- I'll have to think about that. Probably 10 -- less then 10 percent. I would say between 5 and 10 percent.
Q. Okay. How many hours have you spent working on this case?
A. This case specifically?
(Pause.)
A. I wouldn't even -- this was -- this has been a long one. I wouldn't even know where to -- to guess, but -- so the initial review, it was a good solid three hours of -- of even just sorting out those notes and then we prepared a report. You know, I would say probably a total of about eight or nine hours.
Q. All right. And I'm assuming that -- I think you mentioned prior to our getting started

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that you -- had you been provided with all the records as far as you know in this case?
A. As far as I know.
Q. All right. And I assume that with later hospitalizations, that -- I don't know. If you spent eight or nine hours, I'm assuming you didn't read every page of those records?
A. So top to bottom, I didn't. The -- the majority of my time was spent on the initial hospitalizations and then the -- up to -- he was transferred to I believe a place called St. Luke's.
Q. Right.
A. And through the course of that hospitalization. There was a lot of notes of things that happened in rehab. There was a lot of nursing notes and essentially notes of -- page after page of vital signs, labs, dressing care, things like that. Those were -- obviously didn't spend -- spend as much time on those.
Q. Okay. What depositions have you reviewed?
A. I believe I've seen Dr. Singh's.
is it Dr. Ugbarugba?
Q. I think we call him Dr. Ugbarugba for --
A. Dr. Ugbarugba.
Q. -- for easy sake.

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A. And Dr. Patel's.
Q. Okay. Read any family member depositions?
A. In the very beginning I did read a deposition I believe from either his mother or father. I don't remember.
Q. Okay.
A. But that was -- that was from I think -- that was when I first got the case if I remember correctly.
Q. All right. And what did you do to prepare for the deposition today?
A. I just reviewed my report and the facts of the case. The report's pretty long and I -- I like to highlight what I think is the pertinent points.
Q. Okay.
A. And then I didn't see the depositions until just a few weeks ago, so those are pretty fresh in my mind.
Q. Okay. How about meetings with counsel?
A. No. I just -- I just had lunch with Mr. Engelhardt here, and I would say that was our only real formal meeting about this.
Q. Okay. Well, what pearls of wisdom did he give you about the deposition today?
A. Say the facts as I see them, so...

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Q. Okay. All right. Easy enough.
A. Yeah.
Q. All right. So I looked up a little bit about the bariatric surgery practice at your -- that you're engaged in because you're listed as maybe the -- as the No. 2 person at the weight loss surgery clinic at Boston Medical Center. Does that sound right?
A. That sounds right.
Q. Okay. So let's talk about that. What percentage of your surgery work is bariatric?
A. These days it's more and more, so I'd probably say two-thirds maybe climbing up to 75 percent.
Q. Now, and let me draw a distinction. I know that you list various types of bariatric surgery or the center does, and I -- do you perform all three types of surgery?
A. I'm not sure what three types are listed, but all we're doing -- probably -- probably what is listed is the gastric bypass, the sleeve gastrectomy and the lap band.
Q. Exactly.
A. Yeah, the lap band we're not doing anymore.

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Q. No lap bands. Why -- why are lap bands out?
A. They don't really have long-term durable weight loss, certainly not compared to the other two procedures. They come with a number of long-term side effects and complications.
The band is a machine and you think, you know, like any machine, like a car or a hot water heater it breaks down over time, and it was touted as being the safe alternative to some of the other operations, and the other operations now are done with such frequency that the safety profile really has approached that of the lap band --
Q. Okay.
A. -- with a better result.
Q. Was there a period in time in your career where you were doing lap band surgery?
A. Yes.
Q. Were you part of any studies that were looking at the long-term outcomes with lap band?
A. Not formal studies, but all of our patients did go into a database and that database goes into a national database and that is part of what has been used to look at the -- the overall long-term outcomes of a band.

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Q. In your personal practice, were you -- was it your belief that people doing the lap band when you were performing the surgery were not doing as well long-term as -- as the alternatives?
A. Yes.
Q. Okay. And then that was I assume formalized in some peer review studies?
A. Yeah.
Q. Okay. So let's go back to your training. Where were you trained in doing bariatric surgery?
A. So it started during my residency at Boston Medical Center. And especially my -- my fourth and fifth years, that's where I became interested in the minimally invasive surgery.
My mentor at that time, who's now my partner, was interested in hiring me and so we -- I stayed on one more year as a fellow.
But also I was a -- essentially had attending privileges at the hospital, so I took some general surgery call during my fellowship and then stayed on as planned as a -- as a partner and that's where I've been ever since.
Q. Okay. Let me break that, two questions. First of all, your mentor, would that be Dr. Hess?
A. Yes.

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Q. Okay. And you are now partners with Dr. Hess?
A. Yes.
Q. All right. And then you -- you've mentioned twice now "minimally invasive surgery." Tell -- tell the jury what that is.
A. So "minimally invasive surgery" is a way to approach commonly done operations, operations that were previously done through what we call a laparotomy incision, which is a large incision down the middle of the stomach.
It's a way to do that through smaller incisions to improve recovery time, healing and all the complications that go along with such a large incision.
Q. All right. So going back to your training, in other words, what type of surgeries were you doing in your residency on bariatric patients?
A. I would be the first assist on the gastric bypass. Back then we were still doing the lap bands. That was -- at that time those were the two operations that we were primarily doing. We didn't start doing the sleeve until after I was an attending.

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Q. Okay. So give me an idea in terms of your training, would it have been under Dr. Hess?
A. It would have been Dr. Hess, and the other partner at that time was a man named Dr. Miguel Burch, B-U-R-C-H, who has since moved to Los Angeles.
Q. Okay. So you would, I'm assuming, scrub in on bariatric surgery with either of those two doctors as a -- in your residency training?
A. Yes.
Q. All right. And tell me, did you keep any kind of surgical logs about how many patients you assisted with?
A. Yeah, in order to graduate, we have to log the cases we do. We have to meet certain numbers, so, yes, every case I would have logged into that electronic database.
Q. And how many bariatric surgeries do you think you assisted on during your training?
A. Just residency or residency and fellowship?
Q. Residency and fellowship.
A. Probably 250 to 300.
Q. Okay. Is that more bariatric surgery than many general surgeons take in a -- in a general

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surgery residency and fellowship?
A. Yes.
Q. All right.
A. Not fellowship but residency, yes.
Q. Okay. Was your fellowship just in general surgery? Was it specialized in bariatrics?
A. Specialized in minimally -- minimally invasive surgery.
Q. Okay.
A. The majority of which was bariatrics.
Q. Okay. And so I'm assuming that since you've been in your residency training or while you were in your residency training, Boston Medical Center has been a bariatric center of excellence?
A. Yeah.
Q. All right. I don't know if that's -- if that's a term of art, but kind of a place where you get a lot of referrals from the community for people who are having bariatric surgery?
A. Correct.
Q. Okay. I didn't do this prior to the deposition but let me ask, do they rank bariatric programs? Are you aware of any rankings where Boston Medical Center is ranked versus other people?
A. No. They -- they have this thing called

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Healthgrades. I'm not really sure what goes into that. I know a lot of it's insurance data, so we sort of informally look at that to kind of stratify ourself amongst the other programs.
If you ever want to use that in your -- your logo, you pay Healthgrades some exorbitant fee to use their data.
Q. Okay.
A. So we've never done that, but that's -- and we don't really know where that data comes from so we don't put a lot of stock in it.
Q. All right. Again, I don't know. Does U.S. News & World Report rank bariatric programs, to your knowledge?
A. No.
Q. All right. So tell me, for the Boston area, do you consider -- do you all have programs you consider kind of peer programs to yours in terms of being a bariatric center of excellence?
A. Yes. Yeah.
Q. What would the peer programs be in the Boston area?
A. Essentially almost every hospital because every hospital wants a bariatric surgery program. I would say -- the ones I would say are on par with us

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would probably be Brigham & Women's Hospital. That's B-R-I-G-H-A-M & Women's, and the Massachusetts General Hospital.
Q. Okay. So all three of those centers you would consider to be kind of centers of excellence for bariatric surgery?
A. Yes.
Q. All right. And do you all get referrals from other hospitals of bariatric patients for you to evaluate?
A. Like community hospitals?
Q. Sure.
A. Or -- pretty rarely do we get direct referrals from the hospital. We get a number of patients who are operated on elsewhere who come to us for second opinions, but I don't -- I don't necessarily know that they're specifically referred by the other hospitals.
Q. Okay. That's a good point. Bariatric surgery generally is elective surgery, true?
A. True.
Q. All right. And in looking through the materials from Boston Medical Center, it looks like if somebody comes into the Boston Medical Center -- do they advertise the bariatric program in the

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community?
A. I don't believe that they advertise it, no.
Q. Okay. But people find out about Boston Medical Center and so I assume there's a stream of people who come -- coming in for possible evaluation?
A. Yes.
Q. All right. So what's the -- start with the minimum for bariatric surgery at Boston Medical Center. In other words, what formula do you guys use to say this person is a possible candidate on the minimal side, minimal weight gain?
A. So minimal weight we use what most people use, which is what's called the 1991 NIH Consensus Criteria. And essentially all that says is we take something called the Body Mass Index.
Q. Right, BMI.
A. BMI, which is the ratio of your weight to your height, and anybody with a BMI over 40 is a candidate for weight-loss surgery.
Q. Okay.
A. Or anybody with a BMI greater than 35 who has what we call weight-related comorbidity or an illness that can be directly tied to their obesity.

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The three that most people look at are diabetes, high blood pressure and sleep apnea.
Q. Okay. And so just to give -- does it matter -- the BMI, does it take into account somebody's height, sex, et cetera, or no?
A. It doesn't take into account gender. It takes into account height.
Q. Okay. So give me an example for somebody who's 6-foot. What kind of weight are we talking about that would get you up to about 40 BMI?
A. So 6-foot, that's a tough one. My -- my prototype is the 5-foot-4, 240 pounds, which is the typical woman, that's a BMI of 40. 6-feet you'd probably have to be over 300 pounds.
Q. Okay. But just -- I'm just wanting to give the jury some pictures to the kind of -- that would be would the type of patient that you would see on --
A. The -- the lower end, yeah.
Q. Yeah, okay. Now, what about on the higher end of -- of BMI's? Is there a -- is there a BMI that someone might be so obese that you wouldn't consider doing bariatric surgery?
A. That's a bit of a difficult question. The -- certainly when somebody gets to a very high

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BMI, we're talking BMI's in the 80's, 90's, often there's a psychologic comorbidity that goes along with somebody being that heavy.
That -- that would -- you know, an untreated depression, a binge-eating disorder. Things that would not make me think they would be a good candidate for weight-loss surgery.
So when you get to these very, very extreme BMI's, you have to be really careful that -- that you're not doing something that's going to cause them long-term harm or putting them through the risk of an operation that it might fail. I've certainly done it, but you have to be very careful with those extreme BMI's.
Q. Okay.
A. The largest I've ever done is 97.
Q. 97 BMI. What --
A. Yes.
Q. Give me an idea of what the weight was on that patient.
A. I think it was 520 pounds.
Q. Okay. Okay. So let's go back to training. Okay? During your training, fellowship and residency, what do you think the largest patient was that you operated on?

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A. In training? Probably maybe 70 to 75 was probably the largest in training.
Q. Approximate weight?
A. So that's -- you're looking in the -- in the low 400's.
Q. Okay.
A. 400 to 450.
Q. And how many patients do you think you did at that weight during your training?
A. During my training? Maybe five.
Q. Okay. And during training for patients who would be in the low 400's, I'm assuming that that -- those would be the types of cases where you would be more assisting Drs. --
(Pause.)
A. Hess and Burch.
Q. Thank you.
A. Hess and Burch.
Q. They're here somewhere. Okay, yeah. Hess and Burch. True?
A. I didn't understand the question.
Q. Yeah, sure. I'm assuming that in your training for someone who would be at -- in this very high weight, 400's to 450's, those would be more situations where you would be observing and

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assisting as opposed to being the primary surgeon or not. I'm kind of curious.
A. Yeah, it depends. It -- again, it depends on the case and how far along I was in training, but, yeah. Yes.
Q. Okay. Are there cases now that you ask Dr. Hess to assist you with?
A. Yes.
Q. Okay. Which I'm assuming are patients with unusual presentations?
A. Correct.
Q. All right. Are the types of bariatric surgery you're doing currently all minimally invasive?
A. Yes.
Q. Okay. Have you done a -- I call it an open surgery. Is that the right term?
A. Yeah.
Q. Okay. Have you done an open surgery on a patient more than 400 pounds ever?
A. Yes.
Q. Okay. How many times?
A. I'd have to think about it, but maybe a dozen.
Q. Were all of those bariatric procedures or

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some other --
A. No.
Q. -- procedures?
A. General surgery.
Q. Okay. As a general -- what's -- what's the biggest weight of someone that you've done an open procedure on or the highest weight?
A. Maybe around 500 pounds.
Q. Okay. Is there -- are there technical issues in performing a surgery, say, on someone who's 500 pounds versus 300 pounds?
A. Yes.
Q. Additional technical hurdles?
A. Yes.
Q. All right. Tell me what those are.
A. At that point to get into where the organs are or the abdominal cavity, you -- you have to retract the abdominal wall.
And as you can imagine, these patients who are 500 pounds, the abdominal wall is very thick. You're talking about retracting 40, 50 pounds for a long period of time.
So, again, you -- you really have to make sure your exposure's good. A lot of times you'll use these self-retaining retractors, things that

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will hold that back for you. We try, if we can, to not do open surgeries on these patients. It's the -- it's the laparoscopic surgery that saves you a lot of this effort and work but sometimes it's just not possible.
Q. Okay. Is there a weight where you would -- if a patient showed up at the clinic and you were evaluating them that you would say I think that you're -- you're so morbidly or super morbidly obese I would not recommend surgery?
A. It depends on the surgery and it depends on -- it depends on the distribution of the weight, as well.
Q. Okay. Well, let's go to the procedure I think we'll talk about today, cholecystectomy.
A. Mh-hmm.
Q. You've done that both minimally invasive and open?
A. Yes.
Q. All right. And how many have you done in patients you considered morbidly obese? And give me your definition of "morbidly obese." Is that greater than 40?
A. Greater than 40.
Q. Okay. Greater than 40.

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A. I'd have a hard time giving you a number, but I would say 150 to 200 morbidly obese cholecystectomies.
Q. Okay. I see as term in the literature called "super morbidly obese." Do you recognize that term?
A. Yes. It's a bit of a -- it's a bit of an antiquated term. I think mostly because it's -- it sounds like a sharp term.
Q. What's the new term?
A. We -- we consider all obese morbidly -- morbid obesity.
Q. Okay.
A. So that's -- again, some people even say a BMI of 30 is -- is morbidly obese because once you're obese, it's -- it's all morbid.
Q. Okay.
A. But -- but, yeah, the -- the classic terminology is a BMI over 40 is morbidly obese, a BMI over 50 is super morbidly obese.
Q. Okay.
A. And the real medical terms were for every additional 10 points, you would add another super. So a BMI over 60 would be super super morbidly obese.

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Q. Okay. Let's plug in for the first time Mr. Zeigler for a minute. What was his BMI when he first appeared at Cy-Fair Hospital?
A. I'm not sure I ever had his height, so I wasn't able to calculate it.
Q. Okay. If -- I think some of the records refer to a BMI of 71. Does that sound like the general vicinity?
A. Given the weight I know that he was, that -- that seems plausible.
Q. Okay, fair enough. Let's talk about 71 for a minute under which you said when people use the super, that would get you 40 --
A. That would be three supers.
Q. 50, 60, 70.
A. Yeah.
Q. Super super super morbidly obese?
A. Yes.
Q. All right. Do you guys -- in the day did you use that?
A. We did in the day, yeah.
Q. All right.
A. But as the proportion of the population that we saw got bigger and bigger and, in fact, the -- the rates of BMI's that are 50, 60 and 70 are

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actually growing faster in America than the rates of people in the BMI's of 40's, so as we started seeing more of these patients, we just stopped using that label. It sounded a little absurd to -- to say it out loud.
Q. Got you. Would you ever say to a patient, sir, you're super super super morbidly obese in the day or no?
A. No.
Q. All right.
A. Not -- not to the patient.
Q. You would use that internally, though?
A. Yeah.
Q. You might talk about it. Okay. America has an obesity crisis. We agree on that?
A. Correct.
Q. All right. And you're telling me statistically it's -- we're -- we're getting more into the super obesity even if we're not using that term --
A. Yeah.
Q. -- higher and higher BMI's?
A. Correct. The patients who are -- those BMI's are -- are increasing more rapidly than the BMI of 40 patients.

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Q. Okay. Got you.
(Pause.)
Q. So let me circle back to patients you've evaluated for a cholecystectomy, if you've ever said to a patient I think that your -- I know you wouldn't say super super super morbid, but -- but your -- your obesity makes me feel as though the risks outweigh the benefits of the surgery?
A. No. I've -- I've never said that to somebody. I'm trying to imagine a -- a case where I would.
You know, I think if it was somebody who came to my office with -- with symptomatic gallstones, you know, they say if I eat a fatty meal, I have some pain, but it doesn't look like a -- you know, a pancreatitis or a cholecystitis, which is an inflation of the gallbladder or an infection.
So it's a -- it's a case that I would recommend a cholecystectomy for more -- for most people for. I think in a case like that, if I saw somebody who I felt was so large I would probably start them on some type of pre-op diet for a month or so.
Q. Okay.

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A. Get their weight down and then do it.
Q. All right. Do you have doctors -- I asked before about hospital -- not transfers but referrals to your center. Do you have doctors in the community who refer patients to the weight-loss clinic?
A. Yes.
Q. Okay. And have you had general surgeons in the community who will refer patients down to your center?
A. No.
Q. Okay. So, for example, you might have a family doctor who would refer to a -- refer to a patient somewhere in the community that would say I recommend you go to Boston Medical Center for evaluation?
A. Yes.
Q. All right. How far is your geographic reach in terms of having patients sent to your center for bariatric surgery?
A. The -- the war for the outlying communities with all these hospitals, everybody has sort of these geographic regions. You know, I would say the farthest we go is probably out to the -- what we call the Cape and Islands, which is Martha's

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Vineyard.
Q. Okay.
A. Most of that -- I'd say that's the furthest we go, but we also extend West out to a town called Framingham, which is about 20 or 30 miles away from here.
Q. Okay. Do you ever get patients from other states or international patients who come here for bariatric evaluation?
A. Not to Boston Medical Center. I will get that at Children's Hospital.
Q. Okay.
(Pause.)
A. Well, actually, let me take that back. We do get a fair amount of Vermont and New Hampshire patients.
Q. All right.
A. Yeah.
Q. How about international? I mean, --
A. Not international.
Q. Okay, got you. And I guess -- you mentioned earlier. Let me ask in your own personal practice whether -- I'm assuming that as you've done more cases, you've become more proficient in bariatric surgery?

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A. Yes.
Q. All right. And is there a -- is there a number of cases that any bariatric surgery organizations hold out as showing competency in terms of you need to do X number of cases before they think you've hit your technical high point?
A. Yeah, there are -- there are some -- and, again, these are old studies, but there are some studies that -- that suggest what the minimum number of cases you should do before you can be considered safe to do the operation on your own. Depending on what study you read, that says 25 to 50 cases.
Q. Okay.
A. Most people agree these days that the -- the best metric is the number of cases you do per year. It's -- it's -- it's to continually be doing cases and that number, the -- the certifying organizations recommend a minimum of 25 cases per year.
Q. All right. So if you had a surgeon who's out at a community hospital that does do some bariatric surgery that does five cases a year, your view would be that that's probably not enough to -- to get that person to the technical proficiency level?

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A. I would agree.
Q. All right. And even though it doesn't sound like those guys refer patients to you, you probably would say if -- if somebody called you and said, hey, I've only done five of these cases this year or that's my average, you would probably say, well, you know, I'd recommend you send them down to our center?
A. Yes.
Q. All right. You think that would be safer for the patient?
A. Yes.
Q. Okay, fair enough. And, you know, I'm mixing bariatric surgery -- bariatric surgery to me would encompass the two or three procedures you mentioned earlier, correct?
A. Correct.
Q. Does a cholecystectomy on a super morbidly obese patient, does that count as bariatric surgery or no?
A. No.
Q. Okay. So I guess I haven't been precise, but if I went through that same sequence of questions to you, if you're doing cholecystectomies on morbidly obese patients, is there a number you

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think you should have accomplished prior to doing a cholecystectomy on a patient, you know, on any of your patients?
A. Yes.
Q. What do you think it is?
A. Again, I'd be hesitant to guess, but I -- I would say those same studies probably put it on the order of ten to 25.
Q. Okay. A year?
A. Those would be just the --
Q. Leading up to?
A. Leading up to it, correct.
Q. Okay. Through training?
A. Yes.
Q. All right. With at least the assistance of a more experienced general surgeon?
A. Yes.
Q. All right. How about if your -- from your perspective trying to keep your proficiency in doing morbidly obese cholecystectomies, what -- what number would you suggest for a general surgeon for that?
A. I don't -- that's a difficult question to answer. You know, it's -- it's a fairly simple in theory operation. You know, you're finding two

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structures and dividing them. Things like bariatric surgery, it's a little more technically challenging. It's a lot of sewing, a lot of stapling, which really aren't involved in a gallbladder, so I don't think I can quantify it like that.

You know, additionally, in -- in most patients, having gallstones is a disease of the morbidly obese. Increasing weight is increasing frequency of gallstones.

So really even in training the -- the majority of patients that you're operating on have some degree of obesity. It's -- it's rare to find a thin person with gallstones.

Q. Okay.

A. It happens.

Q. All right. So that -- what you're telling me is it's hard to come up with a number that you would want someone to perform on an annual basis for you to say, you know, I would be comfortable telling a patient, yeah, that doctor has got the -- the requisite amount of experience?

A. Yes.

Q. Okay. Are there residents -- you still have residents and fellows in the program?

A. No fellows anymore but residents, yes.

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Q. Got you. Are there some residency programs where doctors receive some training in bariatric surgery but not to the extent that, for example, you underwent at Boston Medical Center?

A. Yes.

Q. All right. And are there programs where a doctor might have, for example, in residency training never been asked to assist in a patient that was greater than 400 pounds?

A. These days unlikely.

Q. Okay.

A. Yeah.

Q. Well, if Dr. Singh was trained 15, 20 years ago?

A. That's -- that's about right. You'd have to go back to before 2000 --

Q. Okay.

A. -- to get that experience, yeah.

Q. Got you. But in other words, if a -- someone had gone through a general surgery residency not at a bariatric center of excellence back prior to 2000, it might not surprise you if they said, you know, I've never operated on anybody greater than 400 pounds?

A. If they said that back then --

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Q. Yeah.

A. -- coming out of their residency?

Q. Right.

A. Yes. That would -- that's -- that's plausible, yes.

Q. Okay, got you. And what's the factor, the difficulty factor going from someone who's 400 pounds to somebody who is, say, 580 pounds from a technical -- technical viewpoint?

A. A couple things. The -- and the biggest thing I worry about is visualization. If we're talking about a laparoscopic operation, the way a laparoscopic operation works is you blow the abdomen up like a beach ball. You fill it carbon dioxide and that gives you the room you need. It creates the theater that you need to do the operation.

If someone has a very large abdominal wall, if they are near their all-time maximum weight, for instance, you might not have a lot of working room to work with.

Additionally, with a gallbladder, the liver can be fatty and large, so it can be difficult to retract the liver in a patient like that as well.

Q. Okay. So -- and it sounds like -- how much of the -- of the kind of workup for somebody

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who is BMI say around 70 who needs -- who doesn't -- is not there for bariatric surgery but is there for cholecystectomy or another kind of surgery, how much of the kind of program at Boston Medical Center do you go through with a patient like that?

A. So with a patient like that who is seeing me in my office and I've got a little time to -- to think about things and plan things, I'd probably have them see a nutritionist and a dietician; maybe consider weight-loss medication.

I'd put them on a pre-op, what we call partial liquid diet and then obviously depending on -- well, not even depending on their age. With a BMI of that high, I would -- I would make sure I get clearance from their internal medicine doctor or a cardiologist as well.

Q. Okay.

A. And an anaesthesia evaluation.

Q. Okay. What about the psychological counseling that I know you guys tout at Boston Medical Center?

A. Yeah, that -- that wouldn't really play into a cholecystectomy. You know, that's a -- they -- they have a medical reason for needing an

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operation so that -- that wouldn't play into it.
Q. Okay. Mr. Zeigler was 20 years old?
A. I believe so. 19 or 20.
Q. Yeah, 19 or 20. I thought in your report you said 20, but he -- he may have had a birthday at some point during the -- during the time of treatment. What -- have you seen 19-year-olds before with BMI's of 70?
A. Yes.
Q. Okay. How many?
A. Well, again, I do the operation at Children's Hospital, so probably two dozen maybe.
Q. Okay. And as a 19-year-old, I'm assuming that's where you would see him, at the Children's Hospital versus some -- versus Boston Medical Center?
A. 19 could be either place.
Q. Okay.
A. Yeah.
Q. But you reference that you've seen him at the Children's Hospital.
A. Yeah, I was thinking about teenagers.
Q. Okay.
A. So -- but, yes.
Q. All right. Do they have specialty

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facilities at Boston Children's Hospital for taking care of BMI 70 patients?
A. Yes.
Q. All right. Incidentally, in Mr. Zeigler's case, do you have an opinion as to what -- how it was that he got to be up to about 580 pounds at age 19?
A. You know, I don't have, you know, enough of the chart to -- to really opine on that. You know, I could -- you know, I could certainly make some guesses.
You know, it is -- it -- there was obviously a genetic predisposition. We know that. For most patients who are obese, the come from obese parents, and that's obese biologic parents.
We -- we know that by studying adopted children that if two obese parents put a child up for adoption, that child will likely still grow up to be obese even though it was not raised by those parents.
There can be some genetic factors. By that I mean genetic mutation factors, syndromes that can to lead somebody being that large, but typically to be -- to be that large at such an young age, there's often a psychological morbidity as well.

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Q. Okay.
A. Or -- or some type of eating disorder.
Q. Yeah, there was reference in Dr. Nguyen's records I think to him going to McDonald's and eating like 80 dollars' worth of McDonald's at a sitting. Do you remember seeing that?
A. I don't remember seeing that, no.
Q. All right. Is that something you've heard before in terms of when you've taken care of these kind of patients?
A. When evaluating these type of patients, yeah.
Q. Yeah. You get histories like that.
A. Yes.
Q. All right. Were you able in looking at any of the records to identify a specific genetic mutation that led to Mr. Zeigler getting to that state?
A. No.
Q. Okay. Or any other metabolic disorder that was causing him to get to that -- that weight?
A. I didn't -- I didn't see a workup, but -- but, no, I didn't see it.
Q. Okay. All right. So -- oh, one thing they do emphasize in the records is insurance

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verification, which I assume you guys -- and precertification. That's something that you have people at Boston Medical Center that do those things?
A. Correct.
Q. Okay. We've established I think bariatric is -- is an elective surgery?
A. Yes.
Q. So if somebody comes in and they're super morbidly obese, no insurance, you guys don't do that surgery?
A. We -- we do do the surgery. That's -- that's because we're in Massachusetts, so we have socialized medicine here, so --
Q. Okay.
A. -- a patient like that would -- would fall under what's called Health Safety Net and -- and would get the operation.
Q. Okay. Incidentally, you've never been licensed to practice in Texas, correct?
A. No.
Q. I think -- I'm suspecting no one in Texas would say we have a socialized medical system. Do you know anything about the Texas medical system?
A. I've -- I've learned a bit from it reading

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this case, so, yes, I've -- and I would agree with your statement.
Q. No socialized medicine in Texas?
A. Correct.
Q. Okay. So what you're telling me is in Massachusetts, if a patient like this showed up, no insurance, you all would be able -- your support staff would be able to sign them up and there would be reimbursement?
A. Yes. He would get the exact same treatment as anybody with insurance.
Q. Okay. Got you. All right. What do you know -- what do you know about the medical community in Houston in terms of bariatric centers of excellence and -- do you have colleagues that practice in Houston?
A. I don't, no.
Q. Okay. So what do you know about it, if anything?
A. Nothing.
Q. All right. You've heard of the Texas Medical Center?
A. Yes.
Q. All right.
A. And -- and I have been to Houston and

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taken a couple courses there.
Q. Okay.
A. And I was just talking with Mr. Engelhardt about it. It's an impressive campus with lots of hospitals.
Q. Lots of hospitals. I don't know if it's as many as Boston, but it's a lot. Where -- where did you take courses in Texas?
A. I believe I was at the -- the University of Texas Medical Center --
Q. Right.
A. -- for one and then another one I was at some industry building doing a cadaver lab for another.
Q. Okay. Was the course you took at University of Texas having to do with bariatric surgery?
A. Sort of. It was for learning how to place an adjustable -- or an intragastric balloon. Pardon me.
Q. Okay. And do you know anything -- do you know where the Cy-Fair Hospital is in relationship to the Texas Medical Center?
A. No.
Q. All right. And do you know the numbers of

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bariatric patients they do versus hospitals in the medical center?
A. No.
Q. All right. So my focus today is on Dr. Singh, who's a general surgeon, correct?
A. Yes.
Q. All right. And let's see if we can just acknowledge or get to if we're on the same page about -- this was not an office visit he had with this patient, correct? He was called in as a consultant in the hospital?
A. Correct.
Q. All right. And there's references to Mr. Zeigler being about 580 pounds when he got to the Cy-Fair Medical Center, correct?
A. I don't remember the exact weight but something in that ballpark.
Q. Okay, great. So -- and he was -- he had symptoms of gallstones, true?
A. He seemed to have pancreatitis.
Q. Okay.
A. Yes.
Q. Which can be related to gallstones?
A. To gallstones, correct.
Q. All right. Preliminary question on that.

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Gallstones at times can be diagnosed by ultrasound?
A. Yes.
Q. All right. Super morbidly obese patients, that -- that may not be -- it's not foolproof?
A. It's not foolproof for detecting it. We -- we use two terms called sensitivity and specificity. Sensitivity means how -- if -- how likely is it to detect something.
Q. Okay.
A. Specificity means that if it -- if it -- you have a finding, how likely is that finding correct or how does it rule it out.
Q. Okay.
A. So somebody who's large, if you have an ultrasound that doesn't show gallstones, you don't know. They may still have gallstones.
Q. Okay.
A. But if you do the ultrasound and it shows gallstones, it's very, very, very likely that those gallstones are there.
Q. Okay.
A. If you manage to see them, they're there.
Q. And -- and ultrasound was done at Cy-Fair on Mr. Zeigler during his initial hospitalization?
A. Yes.

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Q. Have you reviewed that -- the actual ultrasound as opposed to just the report?
A. Just the report is all I saw.
Q. Okay. Do you interpret ultrasounds directly?
A. Ultrasounds are a bit difficult to interpret because usually what you get are just frozen images of whatever the radiology tech has saved.
So it's a bit difficult to interpret those rather than if you were there yourself moving the probe back and forth and constructing the 3D image in your mind, so I can look at them, but they are difficult to interpret --
Q. Okay.
A. -- outside of that setting.
Q. Well, do you ever go down and run the ultrasound yourself?
A. No.
Q. Okay. Do you ever go bedside with the ultrasound technician and watch the ultrasound?
A. Rarely.
Q. All right. So you generally just get a report?
A. (Witness nods.)

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Q. True?
A. True.
Q. And for purposes of pancreatitis, what you're looking for is are there gallstones or are there not gallstones?
A. That's one of the things we look for, yes.
Q. Okay. And can we agree for purposes of our discussion, let's leave it at people who are super morbidly obese in terms of -- of what you would kind of look at. Fair?
A. Yes.
Q. All right. So the ultrasound said or suggested there might be gallstones, correct?
A. Correct.
Q. All right. And you gave a -- and so Dr. Singh comes bedside, meets Mr. Zeigler and they have discussions about his condition, correct?
A. That's my understanding, yes.
Q. All right. And initially -- and -- and his attending physician is Dr. Nguyen, true?
A. Yes, I believe so. I know he was his primary care doctor.
Q. Primary care, yeah, but he admitted him to the hospital.
A. Okay.

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Q. He was following him in the hospital. Do you agree with that?
A. I believe so, yes.
Q. Okay, fair enough. So Dr. Singh comes in. I think we're in agreement that you don't operate or do a cholecystectomy in a situation where the patient's having acute symptoms of pancreatitis?
A. Correct. I would agree.
Q. You -- medically you calm him down and then you talk about the surgery?
A. Yes.
Q. All right. And so let's add in the -- and I think you've said that it's common to do the surgery at the end of the hospitalization when the patient's pancreas has calmed down?
A. Correct.
Q. Okay. Let's talk about the complicating factor of BMI 70, super morbidity. Super obesity, morbidity. That can obviously complicate the picture of the patient, true?
A. True.
Q. All right. And you as the surgeon have to make an assessment as to although if this patient weighed 200 pounds, I might do it one way; if they weigh 580 pounds, there's a lot of other

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considerations I need to take into account?
A. Yes.
Q. All right. Are there complications that can occur when you do a minimally invasive procedure on a patient that weighs 580 pounds that normally don't occur in someone who weighs 200 pounds?
A. Yeah. Yes.
Q. What are they?
A. Mostly you get the complication of the operation, itself, not -- or pardon me. Of the anesthesia, itself.
So you can have cardiac issues, have pulmonary issues, difficulty ventilating the patient, difficulty waking the patient up.
Then you also get into all the problems you can have that I mentioned earlier with adequately visualizing the anatomy you need to see.
Q. Okay. So when it's difficult to view the anatomy, what are some of the risks that you would tell a patient who weighed 580 pounds about a cholecystectomy?
A. So I would say that you're at increased risk of some of the known complications of a cholecystectomy, which is injury to the -- you know, injury to the bile ducts, bleeding and liver injury,

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I would say are the three main ones in this setting.
Q. Okay. So do you agree that in general the -- the discussion with Mr. Zeigler went along the lines from Dr. Singh of I think you would benefit by going to a medical center hospital, one of the ones in the Texas Medical Center as opposed to here at Cy-Fair?
A. That's what it seemed like. It seemed like he said he'd be -- and I believe he does bariatric surgery.
Q. Right.
A. But not on the very, very large patients. It seemed like he felt that if they could find another surgeon that was more comfortable doing it --
Q. Sure.
A. -- than he -- than he, that that would be his preference.
Q. Okay. So let's talk about that for a minute. Do you have the right as a surgeon with any patient to say, first of all, I don't want to be your surgeon?
A. I think it depends on the setting, but -- but, yes, there are -- there are ways you can fire patients.

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Q. Okay. Or just say somebody walks into your room and says, doctor, I'd like to be evaluated and after a discussion with them you say I'm not going to operate on you. I don't want to operate on you. You have that right.
A. Again, I think it depends on the setting.
Q. Okay.
A. I think certainly in the office for an elective case more so than -- than for an emergency case.
Q. Okay. All right. Well, let's go to the emergency case. You get called in as a consultant in the hospital.
You can certainly -- you can certainly tell the attending physician here's my assessment of what this patient needs and I don't think I'm the right guy to operate on this patient. You could tell a surgeon that -- I'm sorry. You could tell an attending physician that?
A. I'm not sure. I'm not sure about that.
Q. Okay. You're not sure?
A. Yeah.
Q. All right. Well, let's break it down. I mean, it could be I don't like that guy. That guy's a jerk. I don't want to operate on him. Is that an

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okay thing for you as a general surgeon to say I'm not going to do it; find yourself somebody else?
A. No. I would have no patients.
Q. All right. So you're -- okay. So the fact that, for example, the patient is just a jerk or has a bad attitude -- let's just leave it a jerk. You'd say I can't -- I still have to operate on the guy even if he's a jerk?
A. Yes.
Q. All right. Let's go to a different scenario. You've got somebody who is -- who tells you they're not going to be compliant with your -- with your instructions.
Do you have the right as a surgeon to say I don't want to -- I don't want to operate on you if you're not going to -- if you're not going to follow what I tell you to do?
A. Again, it depends on the case, but -- but, for instance, for bariatric surgery, absolutely that patient would not get an operation.
Q. Okay.
A. But -- but for an urgent or emergent case, no, you still have to do it.
Q. Okay.
A. You just document what the patient said.

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Q. Okay. All right. Now, how about the situation where the patient is beyond what you feel technically comfortable doing? Okay? I assume that's a individual choice for any general surgeon based on their training and experience.
A. Within certain parameters.
Q. Okay.
A. Yes.
Q. In other words -- how many general surgeons do we have in the US?
A. Oh, not enough but a lot.
Q. Okay.
A. Thousands.
Q. Thousands.
A. Yeah.
Q. Okay. And I assume they've come from a variety of training programs. Some in the U.S.? Some foreign?
A. Yes.
Q. And there's tremendous variety in the -- in the quality of training programs?
A. Yes.
Q. And there's tremendous difference in the kind of patients you might see if you're at a residency program in place X versus some other place

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in the country depending on the center that you're associated with?
A. Yes.
Q. All right. In other words, I assume anybody who does general surgical residency at the Boston Medical Center is going to get exposed to a fair amount of bariatric surgery?
A. Yes.
Q. And there may be other very good general surgery residency programs around the country where that would be minimal. You might only have minimal experience with bariatric surgery?
A. Yes.
Q. All right. That doesn't mean that you're a bad general surgeon. It just doesn't mean the center you're training in, that's just not the population that they have?
A. Correct.
Q. All right. And when you get to -- when you get to the point of what your trainer experiences, do you know how many patients Dr. Singh had been operated on who was -- who were greater than 400 pounds?
A. No.
Q. You think it's important to know your

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limitations as a surgeon in terms of your experience level?
A. Yes.
Q. All right. And is it also important as a surgeon to take into consideration even if I technically know how to do this surgery, if I've never done it before on a patient who weighs 580 pounds, I'm going to hesitate to do that surgery because I don't think -- I'm not sure I have the technical proficiency to do it as well as somebody who's done it multiple times?
A. To hesitate, yes.
Q. Okay. All right. So we can hesitate. Why can't you then as a general surgeon simply say, look, I'm the wrong guy to do your surgery because I haven't -- I don't have an experience level of operating on somebody who's 580 pounds?
MR. ENGELHARDT: Objection to form.
MR. SERPE: Okay. Go ahead.
A. So I think that if you're going to do that, you have to find a place for them to go. The analogy would be, you know, the trauma patient, the person who comes into some community hospital with -- with gunshot wounds that the person never sees. You -- you know, you -- you ideally would

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like to stabilize that person and get them to some place who does a lot of those, but a lot of times there's not time to do that.
A lot of times those places -- places are closed for referral. They're on diversion and you're stuck. You know, you're outside your comfort zone, but you're all there is. So, again, I think you look at each situation and how it stands and -- and you evaluate it.
Q. Okay. Let's go with your analogy for a minute. You're -- first of all, if I was going to tease out a standard of care that says you have to -- are you telling me that you have to find a doctor to take the patient?
Is that what you're telling me? If you're not going to do it because you don't feel technically like you're -- you're the -- the right guy to do the surgery?
A. Yeah.
Q. Okay.
A. I would say yes, yeah.
Q. All right. So how do -- where I would determine that that is the standard of care for Dr. Singh? If Dr. Singh wanted to know if that's the standard of care for him, where would I find

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that guideline or that policy? Is it a policy of the American Society of Surgeons or whatever the general surgery board is?
A. No. I mean, I think it's -- I think it's more ethics than policy. You know, you -- if -- if you know, if you feel like you are not able or for whatever reason, you know, to do an operation, then you have to -- but you feel the operation is the next right thing to do, I think that the onus falls on you to do it.
Now, that's -- can I -- can I find a policy? No, but -- but I -- I -- I don't think that the next step is to just throw up your hands and -- and do nothing.
Q. All right. Well, let's -- let's go with policy for a minute. What's your -- you're board certified. What group makes you board certified?
A. The American Board of Surgery.
Q. Okay. American Board of Surgery. You're telling me they don't have a -- do they issue bulletins and --
A. Oh, yeah.
Q. -- and statements and comments on things?
A. Yes. And maintenance of certification and all that.

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Q. Okay. And you're telling me the American Board has never pronounced that, hey, if you have a patient that you're not comfortable operating on because of your training or lack of training in a patient, that you have to then get them to someone who will take care of them? There's no policy that says that?
A. I don't think there's a policy with the American Board of Surgery, but -- but, I mean, there are certainly policies against what's called patient abandonment.
Q. Okay. Well, it's not your position in this case that Dr. Singh abandoned Mr. -- Dr. Singh abandoned Mr. Zeigler. You're not saying that?
A. No. He appeared to continuously consult on him while he was in hospital.
Q. Okay.
A. Yeah.
Q. All right. And did you understand that the plan at the time of Mr. Zeigler's initial discharge from Cy-Fair was that he was going to lose some weight?
A. Yes.
Q. I'm going to break it down, but let's start with that.

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A. Yes.
Q. Lose weight.
A. Yes.
Q. Okay. And that's a reasonable recommendation to make to somebody who weighs 580 pounds?
A. Yes.
Q. All right. He said he was going to seek out and get some insurance. That's okay, isn't it?
A. I don't remember that -- that stipulation.
Q. Okay, fair enough. If that is something Mr. Zeigler communicated to Dr. Singh, said I'm going to go and get insurance, as a surgeon, you'd say good. You ought to do that?
MR. ENGELHARDT: Objection. Form.
A. Yeah, again, I don't have a lot of experience with how -- how it works in Texas. Again, in Massachusetts they get their insurance while they're in the hospital.
Q. Got you. And it's really not -- I assume like a lot of general surgeons you're not really concerned about insurance one way or another. It's your patient; you're going to operate on them?
A. Correct.
Q. Okay. But if there was a discussion at

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Cy-Fair with Mr. Zeigler about him going out and obtaining insurance, you would have no objection to that or no -- you wouldn't say that's -- you know, don't do it?
A. I would discuss with them what their plan for it was, though. You know, it's -- it's -- just saying, you know, go get insurance, there's often a lot more to it than that. I presume there was some reason he didn't have insurance.
And -- and whether or not he was going to be able to overcome those barriers to get insurance again, again, I -- I personally wouldn't feel comfortable stipulating -- stipulating that to a patient.
You know, go get insurance and come back because, you know, if you're seeking private insurance in a state that doesn't have, you know -- or the country now with the Affordable Care Act, this is obviously before all that.
Q. No. This was --
A. No, this was after it.
Q. This is Affordable Care.
A. Yeah. Then -- then I think that that's -- that can be a big hurdle for a patient to clear.

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Q. Okay. And then let me go to -- the third leg of it is that Mr. Zeigler was going to seek a second opinion at a different institution.
A. Yes, I do recall reading that.
Q. And you're okay with that?
A. I am okay with that in -- in general, but he -- in my opinion he still wasn't ready for discharge yet.
Q. Oh, you have a problem with him getting discharged from the first hospitalization?
A. Yeah, with nothing done, yes.
Q. Okay. Are you critical of Dr. Nguyen for discharging him?
A. I mean, at that point I don't think Dr. Nguyen had any choice, it sounds like, but -- but, yeah, I do not think that the patient should have been discharged without either a cholecystectomy or an ERCP.
MS. NOLAN: Objection. Nonresponsive.
Q. Okay. Okay. So let's -- let me circle back. Okay? Assume with me that Mr. Zeigler has a conversation with Dr. Singh and the discussion is, look, I -- you've been telling me I should go to a -- one of the medical center hospitals that's got more experience in dealing with somebody in my

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weight range.
A. Yes.
Q. I know I need to lose weight. I'm going to lose weight and I'm going to go ahead and get some insurance, and that's the discussion that takes place. Okay?
A. Okay.
Q. Are you -- are you critical of Dr. Singh for saying, okay, that's a reasonable plan --
MR. ENGELHARDT: Objection. Form.
MR. SERPE: Let me finish.
MR. ENGELHARDT: I thought you were. I apologize. That's a long-ass question.
MR. SERPE: It is a long question.
Q. Are you critical of Dr. -- are you critical of Singh for saying, okay, Mr. Zeigler. That's a plan. Go ahead and do that?
A. Yes.
MR. ENGELHARDT: Note my objection.
MR. SERPE: Yes, we got your objection.
Q. Okay. And why are you critical of him on that?
A. For the same reason that the patient should according to the current literature, standard

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of care, should not have left the hospital without some type of temporative measure -- temporizing measure, pardon me, either like an ERCP or the definitive treatment, which is a cholecystectomy.
Q. Okay. And the problem I've got I think with the literature that you are referencing is that literature is not specific to super super super morbidly obese patients, correct?
A. No. It's specific to all patients, but, no, not specifically to morbidly obese patients.
Q. Okay. And if Dr. Singh says, look, if the guy was 200 pounds, I would have done exactly that. My -- my difficulty is he was 580 pounds and that was way beyond anything I've ever -- any patient I've ever done a procedure on in my life and I wasn't comfortable doing it, are you really critical of him for that?
MR. ENGELHARDT: Hold on. Objection. Form. Go ahead and answer.
A. I'm critical for him not seeking definitive treatment somewhere.
Q. Okay. Can we at least agree you're not critical of him for saying I'm not going to operate. I don't feel comfortable operating given my training and experience?

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A. I'm not critical of him saying he's not comfortable. I'm critical of him not doing anything when it seems like there was no other option.
Q. Well, why wouldn't it be an option to go to a medical center hospital and see someone who has experience like you've got in terms of doing procedures on patients who weigh 580 pounds?
A. They can do that, but it should have been set up as a direct transfer.
Q. Okay. And although the patient, you agreed, was stable to be transferred when he left the hospital at Cy-Fair?
MR. ENGELHARDT: Objection. Form.
A. To be transferred, yes. He was stable to be transferred.
Q. Okay.
A. Yeah.
Q. But -- but medically his -- his pancreatitis was stabilized at the time he was discharged from Cy-Fair, correct?
A. Correct.
Q. Okay. Okay. I'm going to circle back one more time just to make sure. Is there any article, any policy, published by anybody that says there's an obligation on the part of Dr. Singh to find

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someone that will say I'll undertake this patient's care? Is there anything published anywhere that says that?
A. Not that I'm familiar with.
MR. SERPE: All right.
(Pause.)
MR. SERPE: Yeah, let's take a quick break.
THE VIDEOGRAPHER: Off the record.
(A break was taken from 3:07 p.m. to 3:23 p.m.)
THE VIDEOGRAPHER: The time is 3:23 p.m. We are on the record.
BY MR. SERPE
Q. Okay. Doctor, while we were on the break, I looked at one of the answers. I did ask you whether it's your opinion that Dr. Singh abandoned the patient and as I understand your testimony, you do not believe he abandoned the patient?
A. I'm not sure what the criteria is for patient abandonment, but, no, it seemed the whole time he was there he followed him and there was a plan. I just didn't agree with the plan.
Q. Fair enough. And in the -- and I'll show you this record. It's Bates No. 328 from the

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Cy-Fair records from the next hospitalization, the December 19th hospitalization.

I'm going to read you a sentence and then just show it to you where -- this is Dr. Nguyen's note, and it says as part of the history he was found to have gallstone pancreatitis but did not have surgery due to his extreme overweight and high risk. The patient elected to go home and treat conservatively and had planned to go somewhere else for a second opinion when he has insurance [as read]. Let me just show you that note and ask you if I read that correctly.

(Reviewing document.)

A. Yes, that is what it says.

Q. All right. Did -- did you rely on that in forming your opinions in the case, that -- that information from Dr. Nguyen?

A. I wasn't sure if this information for Dr. -- this is at this point thirdhand information. This is what he is telling Dr. Nguyen was the plan from Dr. Singh, so I didn't know really what to make with that sentence.

Q. Okay. Do you know whether Dr. Nguyen and Dr. Singh discussed the plan at the time of Mr. Zeigler's initial discharge from Cy-Fair?

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A. That, I don't know. There -- going way, way back I do remember there was some sort of discussions that Dr. Nguyen and Dr. Singh had spoken face-to-face.

I read something about some discussion that happened in a hallway. I think that was in the parents' depositions.

Q. Okay.

A. But, yes, nothing -- nothing I could find in the chart in terms of direct communication, but that often is the case.

Q. Okay. And I think that I'll circle back just one more time. Just in terms of deriving a -- a standard for Dr. Singh as a general surgeon as to whether there is -- whether you can identify anything that's published anywhere that would say he has an obligation not just to advise the patient but, in fact, to secure another doctor to take over the patient's care, if there's anything you can -- you can refer me to.

A. I can't refer to any publication.

Q. All right.

A. Yeah.

Q. Let me get an agreement with you that if there's any literature that you intend -- strike that. Is there any literature you're relying on in giving your opinions in this case?

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A. There -- there is the seminal article, and I'm blanking on the author or the source now, but it is widely cited of the timing of a cholecystectomy after gallstone pancreatitis.

Q. You reference that in your report.

A. Yes.

Q. And -- and essentially, as I understand it, it says you either do it during the same hospitalization or shortly thereafter.

A. The article doesn't really make that fine a recommendation. What the article says is that if you don't do it during the index admission, you have a 25 percent chance of developing pancreatitis again. It's either within four or six weeks. I don't remember which one.

Q. Okay. All right. Let me ask you, medically you reviewed the autopsy report?

A. I did.

Q. No gallstones on autopsy?

A. Yes.

Q. Does that, therefore, indicate to you Mr. Zeigler didn't have gallstones?

A. No, that does not indicate that.

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Q. All right. What happened to his gallstones?

A. He had an ERCP done at St. Luke's, I believe, --

Q. Okay.

A. -- which stents open the bile duct. He also had a -- what's called a percutaneous cholecystostomy tube to decompress his gallbladder, and this tube was being flushed, so all these are ways that stones can exit the gallbladder.

Q. But does anyone ever say they actually observed a gallstone? I mean, is there any physical finding where somebody's like there's the gallstone or there's multiple gallstones?

A. No. A lot of people think gallstones are like pearls on a pearl necklace. Typically, especially in the patients who have gallstone pancreatitis, they're more of a sludge or a mud and that's not the kind of stuff that you would really observe coming out of a drain, a cloudy drainage could be some of that sludge.

Additionally, if it was passing through the stented bile duct, you wouldn't see it unless somebody was sifting through his stool.

Q. Okay. Would you agree with me

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hypothetically that if Mr. Zeigler didn't have gallstones, that there would be no reason to take his gallbladder out?
A. Hypothetically, yeah. If he doesn't have gallstones, then he doesn't have gallstone pancreatitis.
Q. Okay. So we're in agreement that if you don't have it, you don't take the gallbladder out?
A. Correct.
Q. Okay, fair enough. I think I've explored through my questions what your opinions are as they relate to Dr. Singh in this case. Do you have any other opinions beyond what we've discussed today?
A. Regarding Dr. Singh?
Q. Yeah.
A. No.
Q. Okay. Let me get the -- two-part agreement with you. One is that if you in looking at additional materials in this case formulate any other opinions as they relate to Dr. Singh, you'll let counsel know so I'll get to hear about them prior to trial?
A. Yes.
Q. And if you identify any literature you intend to rely on beyond the study that you've

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talked about, you, again, will let counsel know about that?
A. Yes.
MR. SERPE: Fair enough. I'll pass the witness.
(Pause.)
CROSS-EXAMINATION BY MS. NOLAN:
Q. Dr. Carmine, my name is Angela Nolan. I represent Dr. Steven Ugbarugba. I have some questions for you. I may skip around a fair bit because I am coming behind Mr. Serpe.
May we have the agreement that if I ask you a question that you don't understand, that rather than answer it, you'll let me know so we can work to get on the same page with one another?
A. Agreed.
Q. You understand that you are here as a designated retained expert on behalf of the Plaintiffs and today's my only opportunity to explore with you your opinions in this case?
A. Yes.
Q. You understand you're obligated to give me full and complete responses to my questions?
A. Yes.
Q. In terms of what you reviewed in

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formulating your opinions in the case, I know you said you reviewed some depositions. Did you make any sort of handwritten notes or digital notes or even notes on the actual depositions, themselves?
A. No. My notes were essentially I typed the report as I went.
Q. You say you reviewed your report in preparation for your deposition. What's the date on that?
A. I'm not sure. I don't remember what the final report was.
Q. Well, it's right there on the table, right?
A. Yes.
Q. Yeah, what's the date?
A. May 26th, 2017.
Q. So you reviewed the May 26, 2017, report in preparing for your deposition today?
A. Yes.
Q. Have you invoiced the -- either the law firm for Mr. Engelhardt or the expert locator service for your time spent on this case?
A. Not the expert locator, but, yes, Mr. Engelhardt, and I've sent them to his assistant.
Q. Do you know how Mr. Engelhardt found you

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as a potential candidate to be an expert in this case?
A. I don't know.
Q. Is this an arrangement through the expert locator service?
A. I don't know.
Q. You are invoicing him directly?
A. Yes.
Q. You understand today we are here pursuant to several notices for your deposition. One I'll mark as Exhibit 1 and I'll hand it to you.
(Exhibit 1; so marked.)
(Reviewing document.)
Q. Have you had an opportunity to see that exhibit on behalf of Dr. Ugbarugba?
A. I believe so, yes.
Q. There's a variety of documents that were requested, including invoices. Have you brought those with you today?
A. I did not.
Q. Have you gone through the request for documents and made an effort to bring with you all the documents you have that are responsive to those requests?
A. The only document that I prepared outside

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of the e-mail invoices was the report.
MR. ENGELHARDT: We'll get you the invoices.
Q. Mr. Serpe asked you if you were reviewing on any medical literature in offering your opinions. I see in looking at -- and I'll hand this to you. It's the only copy I have. It says Exhibit 2 on it.
Let me hand you this CV. Let me back up just a bit, give you a chance to take a look at that.
(Reviewing document.)
Q. Is that a current CV for you?
A. Yes. I have a few more publications, but this is the bulk of it, yeah.
Q. Are you relying on any of the publications or presentations or anything that you, personally, have been involved in preparing and offering your opinions in this case?
A. No.
Q. Are there any that you think are pertinent to the issues presented?
A. No.
Q. Are you relying on any society guidelines or recommendations, practice recommendations in offering your opinions?

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A. Yes.
Q. And which ones are you relying on?
A. So, again, the current practice recommendations are cholecystectomy at the time of ERCP -- cholecystectomy at the time of initial admission, or what we call the index admission, once the pancreatitis has resolved or if you deem the patient to be too great a surgical risk, a temporizing ERCP.
Q. And you say that that -- those guidelines are cited in your May 26 report?
A. I'm not sure if I -- yeah. Yes, they are.
Q. And are those the American Society of Gastroenterologists Management of Acute Pancreatitis?
A. That, I don't know.
Q. Have you spoken with either one of the Zeiglers?
A. No.
Q. Have you spoken with any of the treating physicians?
A. No.
Q. Do you know any of these Defendants?
A. No.
Q. Do you have any familiarity with Cypress

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Fairbanks Hospital?
A. No.
Q. Would you agree with me that reasonable physicians can take a look at the same set of facts, yet have differing opinions?
A. Yes.
Q. Okay. And yet both be reasonable?
A. Yes.
Q. You outlined two cases in which you have provided deposition testimony, and I have -- I have an understanding for those, but let me ask you this: How many cases do you think you've reviewed as an expert?
A. Again, it would be a guess, but it's on the order, like I said, about two or three a month for about the past four to five years, so that adds up pretty quickly.
Q. I did some research.
A. Yeah.
Q. And I found that you had documented reviews in Massachusetts, Maryland, New Hampshire and Rhode Island. Are there reviews -- first of all, does that sound right?
A. That sounds right. I think there was a couple out of Pennsylvania as well.

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Q. Reviews in any other states?
A. Pennsylvania is the only one I can think of off the top of my head.
Q. Have you agreed to testify live in this case?
A. Yes.
Q. We're right now set I think in mid-October of 2018. As far as you know, is your schedule available for you to come to Houston and testify in a Harris County courtroom?
A. It should be, yes.
Q. Have you ever had your opinions struck in a case?
A. Not that I'm aware of.
Q. Have you ever testified for a healthcare provider?
A. You mean as a -- as defense?
Q. As -- as a retained expert for the defense.
A. I've never testified.
Q. Have you reviewed cases for healthcare providers?
A. Yes.
Q. In terms of plaintiff versus defense, I mean, how many percent do you think is for the --

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the plaintiff or patient or their family and what percentage is for the healthcare provider?
A. I'd have to go back and look. Again, now that most of my cases come from this -- this firm here in town, which is a plaintiff's case, the number is get being smaller and smaller, but I would say historically it was probably 90/10 but now that -- it may be 95/5 now plaintiff to defense.
Q. Have you ever reviewed any similar cases that dealt with indications or allegations that ERCP should be performed?
A. No.
Q. Do you have any personal malpractice history?
A. No.
Q. Any disciplinary history?
A. No.
Q. When you were initially contacted in this case, what were you asked to do?
A. Oh, I was asked to -- if I would be willing to review the records and render an opinion if I felt there were any departures from standard of care.
Q. Were you asked to focus on any particular specialty or any particular healthcare provider?

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A. I was asked to look at -- I believe initially it was Dr. Nguyen and Dr. Singh.
Q. And did the scope of your review, did that change sometime after that?
A. Pardon me. I think it was Dr. Nguyen, Dr. Singh and Dr. Patel and, yes, the scope then did change. Dr. Ugbarugba, when I -- when I spotted that he declined to do an ERCP, I felt that that was a breach.
Q. Are there any other criticisms you have of Dr. Ugbarugba besides that one you just stated?
A. It's just that one.
Q. Have you ever been asked to evaluate the nursing care?
A. No.
Q. With respect to the medical records that have been provided to you, I'm clear on you have both admissions from Cypress Fairbanks Medical Center. You have a complete copy of the St. Luke's Hospital records?
A. I believe so.
Q. You have a complete copy of the HealthBridge or LTAC records?
A. I believe so, yeah. Those were the paper ones.

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Q. Have you been provided with the medical records for Mr. Zeigler from Dr. Nguyen's office?
A. No. I think I had a few outpatient visits but nothing comprehensive.
Q. Do you think in terms of offering your opinions in this case that it would be important for you to review all of Dr. Nguyen's?
A. I think most importantly it would be the -- the ones leading up to right around the time of admission.
I -- my understanding is it sounded like he had been a patient of his for quite sometime, at least that was the gist I got. He seemed to know the family pretty well and the patient fairly well.
But, however, I think as far as this goes, it's just the -- the constellation of symptoms and treatments leading up to this index admission.
Q. And have you been provided with those portions of Dr. Nguyen's medical records?
A. Yeah, I believe I got one or two notes from before he was sent to Cypress Fairbanks and then I have the note that we saw in-between his admissions.
Q. Are you aware that after his discharge from Cy-Fair on November the 10th of 2014, that

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Mr. Zeigler had some follow-up in Dr. Nguyen's office?
A. I believe so.
Q. Have you been provided with those records?
A. I believe so, yeah. I think that was part of, again, where he had the continued pain and sent him back to the emergency room and then there was some telephone notes, too, if I remember correctly.
Q. Is there anything you've asked for that you've wanted to be furnished with that you haven't received so far?
A. No. The one thing that I didn't initially get that I subsequently got was the autopsy report.
Q. As we sit here today, do you have any plans to do any additional work on this case?
A. No.
Q. You are -- I believe you said you hold yourself out to the community as a general surgeon and a bariatric surgeon?
A. Yes.
Q. You have training of course in general surgery but also in minimally invasive surgery?
A. Yes.
Q. Is there any difference between minimally invasive surgery and endoscopy?

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A. Endoscopy is a form of minimally invasive surgery.
Q. Are you a trained endoscopist?
A. Yes.
Q. What types of endoscopic procedures have you been trained to perform?
A. I will do mostly upper endoscopies, which is an endoscopy through the mouth, and I tend to do these mostly on my bariatric patients for evaluating, and there's a few advanced interventions that we will sometimes offer.
Q. Another term for that type of procedure, EGD?
A. Yes.
Q. What other types of endoscopic procedures have you been trained to perform and you perform in your practice?
A. That's largely it is, again, what we call upper endoscopies or EDG's.
Q. You are not a gastroenterologist?
A. I am not.
Q. Have you ever completed any fellowship in gastroenterology?
A. No.
Q. Are you board eligible in

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gastroenterology?
A. No.
Q. Have you been trained to perform ERCP's?
A. Yes, but I do not.
Q. What type of training have you received to perform ERCP's?
A. As part of our general surgery training, we're required to perform a certain number of endoscopies. I believe it's 50 colonoscopies and 35 upper endoscopies.
In order to get this training, we shadow some of our advanced endoscopists, including the gastroenterologists, and I have seen and participated in ERCP's in training. Never as an attending.
Q. Let me break that down. How many -- specific to ERCP, how many ERCP's were you involved in either shadowing or participating during your general surgery residency?
A. Maybe five to ten.
Q. Now let's break down shadowing and participating. What would be -- what was your level of participation in those five to ten ERCP's?
A. I would say -- I would call it pure shadowing maybe in two of them and then after that,

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the gastroenterologist would let us, you know, attempt to pass the wire, pass the cannula, do what's called the papillotomy or the sphincterotomy is another word for that.
Q. Are you familiar with the -- categorizing ERCP's as basic ERCP's and advanced ERCP's?
A. I'm not familiar with how one would differentiate those two.
Q. Are you -- are you familiar with the differentiation?
A. No.
Q. Do you know whether or not these three to seven or so ERCP's where you, personally, had the endoscopic in your hands whether or not those were basic ERCP's or advanced ERCP's?
A. My guess is that advanced ERCP involves some sort of instrumentation or withdrawal or basket deployment, removing stones, so -- so I would say all of them were for that indication.
Q. Are you familiar with the Schutz scale?
A. No.
Q. Are you familiar with the different levels of ERCP's?
A. No.
Q. If I said let's talk about ERCP Level 1

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to Level 4, would you be able to set forth the different requirements or what would make each one of those each a different level?
A. No.
Q. Since completing your general surgery residency, have you ever again performed an ERCP?
A. No.
Q. Have you ever been involved either in your general surgery residency or since that time in determining the indications for ERCP?
A. Yes.
Q. How so? What's your experience in that regard?
A. I have a fair bit, actually. So a lot of times when we get a consult for cholelithiasis or gallstone pancreatitis, we call our colleagues in gastroenterology to come do an ERCP on some patients we think may still have retained stones in the common bile duct.
Additionally, if you think about the anatomy of a gastric bypass and the fact that a lot of these patients get gallstones after a gastric bypass, a lot of times these patients need an ERCP to get the gallstones out of the bile ducts. The problem is that the bile duct is no longer

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accessible easily from the mouth, so we double-scrub with the gastrologists quite frequently to give them access to the stomach and often we'll perform rendezvous procedures through the -- through the common bile duct to help them extract the stones from the -- from the bile duct.
Q. How many times have you done that where you've double-scrubbed with an endoscopist during an ERCP?
A. Maybe 30 or 40.
Q. When's the last time you did that?
A. Last month. We did one in January.
Q. In terms of those patients where you feel like they may need an ERCP, what I heard you to say is I call in the gastroenterology consults and get their opinion?
A. Yes.
Q. So in terms of the ultimate decision for whether or not a patient is going to need an ERCP, it sounds like you defer that decision to the judgment of gastroenterologists?
A. Ultimately, if they say no, they say no, so -- so, yes, but often -- often they say no and then we discuss.
Q. But in terms of whether or not an ERCP is

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indicated for a particular patient, you are relying on the training and expertise of a gastroenterologist?
A. For the -- for the indications or for performing it?
Q. For whether or not that procedure is going to be performed.
A. I'm -- I'm relying on the gastroenterologist to perform the procedure, yes.
Q. It sounds like the gastroenterologist has some medical judgment they can exercise in terms of whether or not that is, in fact, the appropriate procedure for the patient?
A. Yes.
Q. Of those 30 or 40 patients where you have been involved as a double-scrub, we'll call it, --
A. Yeah.
Q. -- or an ERCP with a gastroenterologist or endoscopist, they are as well, how many of those were patients who were over 400 pounds?
A. So those it was very few because most of those patients were after bariatric surgery. That's why we were double-scrubbing was because the patients had had a gastric bypass and the anatomy wasn't favorable for the gastroenterologist unless

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we let them directly into the remnant stomach, so most of those patients had had good weight loss. In fact, probably none of them were over 400 pounds.
Q. I take it then none of those patients had a BMI in the 70's?
A. Correct.
Q. Do you know whether or not performing an ERCP on a patient who is over 400 pounds with a BMI in the 70's, whether or not that presents any technical considerations for the endoscopist or gastroenterologist?
A. I -- not that I'm aware of, no.
Q. And let's just make sure that we're clear with one another. Are you saying there are no technical considerations for the gastroenterologist in that instance or you're just not aware of them?
A. I'm not aware of them. There are some risks of anesthesia in somebody that large.
Q. And in fairness to you, you don't have any personal experience at participating in ERCP's where you might have learned what the technical considerations would be if the patient is over 400 pounds or has a BMI in the 70's, correct?
A. Correct.
Q. In terms of your hospital privileges,

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you've told us where you have privileges, but do you have privileges to perform ERCP?
A. No. I didn't request them.
Q. The academic appointments that you have, do you train residents in how to perform ERCP?
A. Yes. Well, not how to perform. Pardon me. The indications, yes.
Q. And in that particular training of your residents, in those instances do you teach them that when they think an ERCP is indicated, they should call in a gastroenterology consult for further collaboration?
A. Yeah, the -- so the formal curriculum wouldn't sit -- we wouldn't say that, but, yes, that's what most residents and probably most general surgeons would do in practice unless they were very familiar with ERCP's, and those are becoming fewer and further between.
Q. Why would most general surgeons in their practice call in a gastroenterologist for a patient that they think may need an ERCP?
A. Simply for the numbers that they do. The gastrologists, you know, these days do far more ERCP's and endoscopies than the surgeons do, so if you have one available, you consult them.

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Q. If you found yourself presented with a patient this afternoon --
A. Yes.
Q. -- after this deposition that needed an ERCP, would you feel comfortable given your training and experience in performing the ERCP?
A. No. I would go a different way.
Q. And when you say, "I would go a different way," what would you do?
A. I would either do percutaneous decompression of the liver or a laparoscopic common bile duct exploration.
Q. Is another term for the percutaneous drainage of the liver "cholecystostomy"?
A. No. That's a -- that's a cholecystostomy. That -- that one they drain the gallbladder directly.
Q. Might another direction that you would go in if you were presented with that patient this afternoon be to consult with a gastroenterologist to perform an ERCP?
A. Yes.
Q. Do you perform cholecystostomy in your practice?
A. Not routinely. That tends to these days

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be the interventional radiologists.
(Pause.)
Q. Are you familiar with the risks of ERCP?
A. Many of them, yes.
Q. And can you just kind of outline what those are?
A. There's -- so there's, first of all, the risk of having sedation for the procedure that we talk about with any sort of semi-surgical intervention.
You can actually develop pancreatitis. You can develop perforation of the duodenum or the stomach or the esophagus, as well as bleeding.
Q. Would you agree with me that patients who have active pancreatitis are at greater risk for post ERCP complications?
A. Yes.
Q. I had asked you if you were familiar with the different levels for ERCP. Do you have any basis to dispute that an ERCP in Mr. Zeigler would be a high-risk ERCP?
A. I wouldn't dispute that.
Q. Would you agree that an ERCP in Mr. Zeigler would be a high-risk ERCP?
MR. ENGELHARDT: Point in time.

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Objection. Form.
A. Correct. I -- I agree. It depends on what time we're talking about.
Q. Why does it depend on time?
A. So I think he would have been, for instance, and I know -- I believe your client was even consulted at the first admission, but that would have been a perfect time to do an ERCP on him.
When he came again and it seemed like he had active pancreatitis as well as the setting of a narrowed common bile duct, that certainly would be a higher-risk operation or higher-risk procedure.
Q. Would you agree with me that high-risk ERCP's are associated with a higher risk of morbidity and death?
A. Yes.
Q. We talked about or you had a discussion with counsel for Dr. Singh about practitioners performing procedures that they have a comfort level and a training for. Do you remember that discussion?
A. Yes.
Q. In terms of ERCP, do you know whether or not that same logic applies?
A. I don't -- I've never reviewed any

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articles, but it is intuitive to me that it likely does follow.
Q. Would you agree with me that higher risk or higher difficulty grade ERCP's are best left to advanced endoscopists who are in specialized centers who have that comfort level?
A. Yes, if one's available.
Q. Would you agree with me that it would be unprecedented for a Level 3 or Level 4 ERCP to be performed in a community hospital?
A. I'm not familiar with Level 3 or 4, so I can't comment.
Q. You just can't say one way or the other?
A. Yeah.
Q. Fair enough. We had talked about Cypress Fairbanks Medical Center. Do you know what type of resources or facilities they have that would be available for patients if they had complications from ERCP?
MR. ENGELHARDT: Objection. Form. Go ahead.
A. No.
Q. Would you agree with me that the resources available at any particular facility should also be an important consideration in whether or not to

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perform any procedure?
A. Yes.
Q. And that being particular, the resources that would be available to the physician in the event of management of complications from that procedure?
A. Yes.
Q. You had outlined some of the risks of an ERCP. Would you agree with me that an angiography suite being available would be important for the management of the ERCP complication of bleeding?
A. An angiography suite, yes.
Q. Do you know if Cy-Fair has an angiography suite?
A. I do not know.
Q. Is it your understanding from your review of the medical records and the deposition testimony in this case that certain imaging modalities were not available at Cy-Fair for Mr. Zeigler?
A. That's what it seems. I could never quite figure out exactly what the problem was.
Q. Is it your understanding from your review of the medical records and the deposition testimony that neither CT nor MRI were available at Cy-Fair for Mr. Zeigler?

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A. Yes.
Q. Would you agree with me that having those imaging modalities available would be an important consideration for management of post ERCP complications?
A. No.
Q. And what is the basis of your opinion?
A. Well, the -- you know, the -- the two things that you would worry about and I would say that you might want a CT scanner for would be either bleeding or perforation, both of which there's innumerable other ways to -- to deduce, including just the patient's clinical picture.
Q. Might CT or MRI be useful in just defining the anatomy before performing an ERCP?
A. An MRI more so than a CT.
Q. Would you agree with me that given -- and I'll represent to you there is no angiography suite available at Cy-Fair.
A. Okay.
Q. I'll represent to you and you've reviewed the testimony and although you may not understand the reasons for it, but you're certainly familiar that CT and MRI were not available?
A. Yes.

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Q. Do you know if Cy-Fair -- well, strike that. Would you agree with me that -- that given those limitations, that it would be safer for a patient like Mr. Zeigler to undergo ERCP in a specialized center like the Texas Medical Center?
A. Yes.
Q. Would you agree with me that the lack of an angiography suite to manage any bleeding if there were any MRI or CT, that that would certainly increase the risk for death for a patient like Mr. Zeigler if an ERCP were to be performed at Cy-Fair?
A. Yes. Although not much, but, yes.
MS. NOLAN: And I'll respectfully object to the nonresponsive portion.
THE WITNESS: Okay.
BY MS. NOLAN
Q. I would say maybe being dead's a little bit like being pregnant. It's hard to be a little dead?
A. I thought we were talking about the chances, though.
Q. Hard to be a little pregnant.
MR. ENGELHARDT: Objection. Form.
Q. Are you able to tell the ladies and

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gentlemen of the jury a percentage of risk of death for an ERCP in a patient like Mr. Zeigler?
A. No. It would be speculative, not based on data.
Q. Would you agree with me in a patient like Mr. Zeigler who has -- I'm talking about the second admission, who has presented with active pancreatitis -- I take you agree he did present with active pancreatitis?
A. I agree, yes.
Q. No dispute there?
A. No.
Q. Would you agree with me that in a patient like Mr. Zeigler who presents with active pancreatitis, that that in and of itself places the patient at high risk for a worsening of that pancreatitis should they undergo an ERCP?
A. Yes.
Q. Would you agree with me that -- you have an understanding that within 24 hours or so of this second presentation to Cy-Fair, that Mr. Zeigler had developed what we call ARDS or respiratory problems? He had to be intubated. He had signs of acute renal failure. Generally, multisystem organ failure?
A. I agree.

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Q. You understand he was transferred to the ICU as a result of those problems?
A. Yes.
Q. Would you agree with me that given those -- those problems, the multisystem organ failure and the active pancreatitis that certainly an ERCP being performed on Mr. Zeigler at that time would present with a high rate of mortality and morbidity?
A. No.
(Pause.)
A. Did you say high or higher?
Q. High.
A. High, yes.
Q. I take it from your answer, but if I'm wrong, tell me, you think his risk for morbidity and mortality once he re-presents to Cy-Fair is the same at all times during the admission?
A. When he re-presented?
Q. Yes, sir.
A. No. I think that the -- I think that he -- his risk for morbidity and mortality essentially increased the longer he was there.
Q. And make sure that we're clear with one another. I'm talking about the risk for morbidity

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and mortality associated with performing an ERCP on this gentleman. Are you just saying the longer he was there generally, ERCP or no ERCP, in your opinion his risk for morbidity and mortality was progressively increasing?
A. No. I think in terms of just from ERCP, I think that the -- there was a -- an oscillating risk spectrum over that second admission.
Q. And -- and how did it oscillate, in your opinion?
A. You know, I think that he was relatively high risk in the -- in the very early days when he developed ARDS and all that.
You know, certainly, again, the risk of deepening his sedation and everything that goes along with the procedure made it riskier. I think he relatively improved over the ensuing weeks, in which case it would be a -- a lower-risk procedure.
Q. What about at the time at which efforts were made to have him transferred to Dr. Raijmann at St. Luke's to have the ERCP performed? Do you have an opinion at that time where he was on the risk spectrum?
A. Yeah, I would say he was probably the same place he had been at for weeks at that point, yeah.

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Q. Improved? I think you said improved in the ensuing weeks and lower risk.
A. Yeah.
Q. So that runs through the time at which he was actually transferred out to St. Luke's?
A. Yes.
Q. Would you agree with me that for any procedure, there should be indications?
A. Yes.
Q. Would you agree with me that an ERCP is not diagnostic?
A. No, I would not.
Q. And what's your basis of disagreement?
A. Oh, you can -- it can be diagnostic and therapeutic. It can give you a -- a sense of the biliary tree, whether or not there's any abnormalities with it, which was actually what happened at St. Luke's.
They diagnosed a bile duct stricture, which was probably one of the main things that was making him so ill, and it can diagnose choledocholithiasis, which is the presence of gallstones within the bile duct.
Q. Would you agree with me that an ERCP is useful if the patient has cholangitis and a stone in

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the common bile duct?
A. Yes.
Q. "Cholangitis," that's the first time we've used that term, at least today. What is that?
A. So "cholangitis" is an inflammation, usually an infection of the biliary system within the liver.
Q. Would you agree with me that before an ERCP is performed, there should be some therapeutic reason for it?
A. It -- again, it can be diagnostic or therapeutic, but usually it's done for -- usually it's done because it is diagnostic and therapeutic.
Typically, if you just wanted to make a diagnosis, you could get an MRI or an MRCP, which it seems like was not an option in this case.
Q. So you agree that typically ERCP's are performed when there is a therapeutic purpose for that procedure?
A. I would say the -- the majority of them are, but there's all sorts of diagnostic indications for ERCP's, but in the setting of gallstone disease, it's usually for a therapeutic purpose.
Q. And you would agree that the therapeutic purpose in the context of gallstone disease like

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Mr. Zeigler had is typically because there is a gallstone in -- somewhere in the biliary duct system?
A. Or they've got a narrowed ampulla or they've got a stricture.
Q. Would you agree with me that one of the findings that one may find in a patient who has either a narrowed ampulla, a stricture or a stone in their common bile duct is a dilated common bile duct?
A. Yes.
Q. Would you agree with me these patients who have either the narrowed ampulla, the stricture or the stone in the duct, they are -- one of the signs and symptoms of that also may be cholangitis?
A. May be, yes.
Q. Would you agree with me that cholangitis is a clinical diagnosis?
A. Yes.
Q. Would you agree with me that in making that diagnosis, that can be made by looking at various vital signs for the patient, various signs and symptoms as well as laboratory findings?
A. Yes.
Q. Are you familiar with the term "Reynolds

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pentad"?
A. Yes.
Q. And can you tell the ladies and gentlemen of the jury what "Reynolds' pentad" is?
A. Oh, you're taking me back to my residency days, but it is right upper quadrant pain, jaundice, and I believe an elevated white count and that's the Charcot's triad.
And then the pentad also I believe are the signs of shock, which is I think fever and mental status changes, if I remember correctly.
MR. ENGELHARDT: That's what you had down, right?
MS. NOLAN: Maybe not in that order.
MR. ENGELHARDT: Okay.
BY MS. NOLAN
Q. Okay. And what is -- what are -- and I'm sorry to take you back to your -- to your residency days, but -- but what is -- Reynolds' pentad, what does that show a practitioner?
A. Oh, it's -- it gives you the sign of a patient who is about to seriously decompensate from a bile duct obstruction or cholangitis. I should broaden that.
Q. So this Reynolds' pentad, that's something

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that would be seen in patients who have cholangitis?
A. Yeah.
Q. In your review of the medical records for Mr. Zeigler from his second admission at Cy-Fair, were you able to identify a time at which Reynolds' pentad was present?
A. You know, I think that most of his pain was epigastric, consistent with his pancreatitis. Obviously, once they put him on the ventilator, it's more difficult to discern things like right upper quadrant pain, but, yeah, he certainly had an elevated white count, fever, mental status changes and rising liver function tests.
(Pause.)
MS. NOLAN: And I'll respectfully object as nonresponsive.
BY MS. NOLAN
Q. Are you able to point me to a time in the medical records from Mr. Zeigler from the second admission where you identified he had satisfied that Reynolds' pentad?
A. I'll say no.
Q. You have an understanding my client, Dr. Ugbarugba, was consulted shortly after the second presentation?

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A. Yes.
Q. You understand that he had his initial examination of Mr. Zeigler on December, the 19th?
A. That sounds correct.
Q. Would you agree with me that at the time of the initial examination by Dr. Ugbarugba on December the 19th, that Mr. Zeigler did not meet the criteria for Reynolds' pentad?
A. Yes, although at that point I'm not sure he could have gotten one of the pentad components.
Q. Which was?
A. The pain in the right upper quadrant.
Q. Why do you believe that Dr. Ugbarugba could not have gotten information about that?
A. He was sedated and on a ventilator. Additionally, it's hard to localize pain in the super morbidly obese because it's -- it's deep down in there.
What -- what one might call the -- the right upper quadrant here, on somebody who extends out, you know, 2 feet in either direction, it's hard to get the geography.
Q. I'm going to represent to you that at the time of Dr. Ugbarugba's initial evaluation of this gentleman, he had not been intubated.

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A. Okay.
Q. He had not been transferred to the ICU.
A. Okay.
Q. So let's take that back.
A. All right.
Q. Okay. Let's take a look at his initial presentation and of course Dr. Ugbarugba's initial evaluation of him on the 19th. Would you agree with me that Mr. Zeigler did not at that time exhibit the Reynolds' pentad?
A. Yeah, I'll still say probably unable to determine the location of pain in someone of his size, but, yes, I'll agree.
Q. Would you agree with me that ERCP is not indicated for mild or severe gallstone pancreatitis without cholangitis and in the absence of common bile duct obstruction?
A. Yes.
(Pause.)
Q. Do you know from your review of Dr. Raijmann's ERCP procedure that he performed on January the -- let me get back to my timeline.
(Pause.)
Q. Let me just start that over. Do you know -- from your review of Dr. Raijmann's ERCP

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procedure note from January the 27th, do you know whether or not he had to modify that procedure or address any technical challenges on account of Mr. Zeigler's weight?
A. I don't recall.
Q. Would it surprise you if he did?
A. No.
Q. Do you have an opinion whether or not an ERCP on Mr. Zeigler could be performed in a standard endoscopy suite?
A. It like -- it likely could not have been performed in a standard suite simply because most fluoroscopy tables couldn't support somebody of his weight. They would have had to use an OR table and what's called a C-Arm, which is a type of x-ray.
Q. And is that -- that is, in fact, what was done, correct?
A. I believe so, yeah.
(Pause.)
Q. Do you have an opinion to offer the ladies and gentlemen of the jury in this case of what the cause of Mr. Zeigler's pancreatitis was?
A. I believe it was gallstone pancreatitis.
Q. And I'm not trying to parse this out with you or anything, but I'm being genuine. What's your

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basis for that?
A. Oh, it's -- you know, we -- we talk about common things being common. He had gallstones on his ultrasound. He had pancreatitis.
The other sources of pancreatitis tend to be a little rare as you go down the -- the line. The next most common cause is -- is usually alcohol related. There was no indication that that was a possibility.
The next most common cause is hypertriglyceridemia, which is -- again, from his laboratory values, I don't think his triglyceridemia was high enough to cause that and then you get into rare things like drugs and scorpion bites and -- which I don't think you have that kind of scorpion in Texas.
MR. SERPE: We have a lot of scorpions. Go ahead.
THE WITNESS: I don't think you have that kind. It's a Pacific.
BY MS. NOLAN
Q. So it sounds like essentially the basis for your opinion that Mr. Zeigler had gallstone pancreatitis are the finding of gallstones on his various ultrasounds?

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A. Yes.
Q. I have -- I've read some of your prior deposition testimony. I think you said you rely on whatever the imaging reports are that are provided to you?
A. Yes.
Q. You understand that all of the treating physicians, including my client, Dr. Ugbarugba, relied on the findings from the radiologist, including those from the ultrasound?
A. Yes.
Q. Was that appropriate?
A. Yes.
Q. Within the standard of care?
A. It's within the standard of care.
Q. Do you -- just as we sit here today, do you have a recollection of what his triglycerides, what the -- what the numbers were?
A. Not off the top of my head.
Q. I'll represent to you that the time of his second admission his triglycerides were 350.
A. Yeah.
Q. You would agree with me that's high?
A. That's high.
Q. You would agree with me that meets the

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criteria for hypertriglyceridemia?
A. Yes.
Q. Would you agree with me that that represents a possible or potential cause for his pancreatitis?
A. Unlikely, but possible. Typically, the pancreatitis that we see, you have the triglyceridemia, it tends to be in the thousands.
(Pause.)
Q. Going back to those ultrasounds that were performed on Mr. Zeigler, would you agree with me that those ultrasounds with the exception of perhaps maybe one where there was not visualization, that they were sufficient in evaluating Mr. Zeigler's common bile duct?
A. Probably -- again, we go back to what we were talking about earlier about the limitations of ultrasound in the morbidly obese.
You know, I would say by the time you were trying to penetrate that deep and get measurements, it's probably not the best tool on someone of his size, similar to how we said if they saw no gallstones, I wouldn't have been satisfied with that just because when you get that big, it's just really tough to -- to appreciate the finer things.

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Q. You have an understanding that there are a course -- during the second hospitalization, there are a course of ultrasounds where the radiologist provided a reading regarding the common bile duct diameter?
A. Yes.
Q. You haven't seen those films?
A. I haven't seen the films. Just the reports.
Q. Do you have any reason to dispute the radiologist's findings?
A. No.
Q. And do you have any opinion or any criticism to offer with respect to Dr. Ugbarugba and the other treating physicians relying on that finding with respect to the diameter of the common bile duct?
A. Yeah, I think -- again, I think maybe "relying" isn't the right word, but -- but, yes, taking those findings as part of their -- to formulate their treatment plan.
Q. It sounds like you would agree that for Dr. Ugbarugba, in terms of the reported common bile duct diameter, you would agree that that was one appropriate piece of clinical information for

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Dr. Ugbarugba to consider in terms of whether or not ERCP was indicated?
A. Yes. I would agree that it was important to consider.
Q. Within the standard of care?
A. Yes.
(Pause.)
Q. Do you have an opinion whether or not -- during the second admission whether or not Mr. Zeigler had cholangitis?
A. Yes.
Q. And what is your opinion?
A. I believe he did.
Q. And what is the basis of your opinion?
A. Rising liver function tests, sepsis, fever, high white count and then this was bolstered by the subsequent ERCP which showed a stricture.
Q. Is it your opinion that as a result of the cholangitis, that Mr. Zeigler had infected bile in his biliary system?
A. Likely, yes.
Q. You are aware that Mr. Zeigler underwent two cholecystostomies during that second hospitalization?
A. Yes. In January, I believe.

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Q. Are you aware that for the first cholecystostomy, that some of the bile was actually sampled and sent off for culture?
A. Yes.
Q. And what do you understand those results to be?
A. I believe that they didn't grow back anything on the first sample, if I remember correctly.
Q. Would you agree with me that the results from the initial bile cultures were not consistent with cholangitis?
A. No. I don't think you can draw that conclusion based on what was going on in his clinical course.
Q. Any other basis for your disagreement?
A. I mean, he was on antibiotics. It's the same reason why when we take blood cultures of somebody on antibiotics, you can't rely on those because they're being treated.
Q. Were you able to tell from your review of Dr. Raijmann's ERC -- ERCP report from January, the 27th whether or not he found any findings consistent with cholangitis?
A. No.

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Q. Just couldn't tell one way or the other?
A. Couldn't tell one way or the other.
Q. Do you intend to offer an opinion to the ladies and gentlemen of the jury that Dr. Ugbarugba should have performed a HIDA scan?
A. No. That shouldn't be within his spectrum of care.
Q. Would you agree with me -- do you have an opinion whether or not Mr. Zeigler had necrotizing pancreatitis during the second admission?
A. It's -- it's difficult to say. I think that ultimately at some point that did happen for him, but it's difficult to say if that was his -- what he was initially presenting with, but certainly it showed on his autopsy.
Q. Would you agree with me that a CT would have been useful, were it available, in determining whether or not Mr. Zeigler had necrotizing pancreatitis?
A. Yes.
Q. Would you agree with me that an ERCP is not a substitute for an MRI or a CT?
A. It depends on what question you want answered. I think if you're just looking for the biliary tree, I do think it's a reasonable

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substitute. If you're looking for things like tumors, then, no. It's not equivalent.
Q. Do you have an understanding both from Dr. Ugbarugba's deposition testimony as well as his initial consult in the case that his working diagnosis was gallstone pancreatitis?
A. I believe so, yeah.
Q. I take it given your opinion, that that was an appropriate working diagnosis?
A. Yeah.
Q. Within the standard of care?
A. Yes.
Q. I want to revisit a thought that you had while talking with Mr. Serpe.
A. Okay.
Q. With respect to the role of Dr. Nguyen. And let's talk about the first admission for a moment. You understand Dr. Nguyen was the attending physician for Mr. Zeigler?
A. I believe so, yes.
Q. Have you reviewed the discharge summary?
A. Yes, although I can't conjure it in my mind right now, but that would have been something I would have looked at.
Q. With respect to -- I think you said, and I

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wrote it down somewhere.
MR. ENGELHARDT: Discharge summary the first time?
MS. NOLAN: I'm talking about the first admission right now.
MR. ENGELHARDT: Okay. In November. Okay.
BY MS. NOLAN
Q. You said -- you were asked about the discharge, and I think you said Dr. Nguyen had no choice at that point. Explain.
A. Oh, it sounded like there had been efforts made and, again, this is -- I've sort of just got a glimpse of this in depositions and the charts.
There had been efforts made to get him to another facility. Apparently because he had no insurance, no other facility would take him and there wasn't a surgeon willing to operate on him there.
So, you know, at that -- at that point if no intervention was going to be performed, I'm not sure what the end -- the end date for keeping him there would have been.
Q. In your practice, are you involved at all in transferring patients?

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A. No. I'm usually on the receiving end of that equation.
Q. I take it you are usually the accepting physician for patients who are being transferred because your center is -- provides a higher level of care?
A. Yes.
Q. Would you agree with me that -- let's just talk about the transfer process. Would you agree with me that -- I might not be using the right word and I might draw an objection from counsel and if I do, I do, but would you agree with me there's a lot of red tape?
MR. ENGELHARDT: Objection. Form.
Q. Or do you even have any familiarity with it?
A. So -- so -- again, I'm not sure what it's like in Texas, so I can't comment to that. Here in Massachusetts and Boston where, again, the healthcare system is different, all the surgeons across town all know each other.
It's just a matter of picking up the phone to one of them and saying would you be willing to take a look at this patient for me.
Q. And you don't know if that's -- that's

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what's required in Texas?
A. From what I can tell of Texas, I doubt it.
Q. Let's talk about what you could tell from your review of Mr. Zeigler's medical records.
A. Yes.
Q. What did it look like to you?
A. It looks like they reached out to a number of places. A number of places said no. They -- it seems like they attempted to get him some type of, you know, emergency insurance. Nobody would take him. It -- it just seemed like a very sad situation.
Q. That was evident in the -- the attempts or the efforts that were being made. They were evident in the documentation, both the first admission and the second?
A. And the second admission and to his rehab facility where, you know, he was -- he was sent there. His -- his clothes were still presumably sitting in the room and they refused to take him back. They said he would have to be rescreened again for insurance.
Q. Do you intend to offer any criticism to the ladies and gentlemen of the jury of this case with respect to Dr. Ugbarugba's efforts to get

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Mr. Zeigler transferred --
A. No.
Q. -- to another facility?
A. I'm not sure if he made any direct efforts, but, you know, no.
Q. Do you remember in your review of the medical records and in the deposition testimony what Dr. Ugbarugba's efforts were?
A. I don't recall.
Q. Was it your impression from reviewing the medical records that there were many people involved in the efforts to get Mr. Zeigler transferred?
MR. ENGELHARDT: Objection. Form.
A. There seemed to be a lot of efforts throughout his stays everywhere.
Q. You were -- was it your understanding from the second admission that case management was involved, nurses were involved, individual physicians were involved? Did you see that in the documentation?
A. I saw mentions of it. Most of the direct communication I saw was in the case management notes, but -- but I saw allusions to attempting to get him transferred in multiple notes.
Q. And those allusions to have Mr. Zeigler

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transferred, did you see those documented from the very time that he re-presented to Cy-Fair?
A. I don't remember if it was from the very time, but, yeah, the critical -- the critical care doctor taking care of him mentioned it in most notes that we are awaiting transfer. We are awaiting a bed. We have had discussions, so...
Q. And I kind of want to go back to -- to this -- this notion about Dr. Nguyen. I'm trying to understand why Dr. Nguyen has no responsibility whatsoever in your mind to try to get this -- to get Mr. Zeigler transferred at the conclusion of that first hospitalization.
MR. ENGELHARDT: Okay. Objection. Form.
Q. Let me ask it a different way. Did Dr. Nguyen in your opinion have any responsibility to try to get Mr. Zeigler transferred at the conclusion of that first hospitalization?
A. Yes.
Q. Did you see any documentation in the medical records from the first hospitalization of Dr. Nguyen making any effort to get Mr. Zeigler transferred as an alternative to discharging him?
A. I don't believe I saw it mentioned as an

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alternative to discharging, but if -- again, they're sort of blurring together, but I do remember some allusions to discussions about getting him transferred to a center where they could do his cholecystectomy at that point but nobody was accepting.
Q. And I'm trying to understand, is it your opinion that treating physicians other than Dr. Nguyen may have had more success in getting Mr. Zeigler transferred?
MR. ENGELHARDT: Objection. Form.
A. Again, I -- I can't speak to what it's like in Texas. I only know that, you know, if I've got somebody on the medicine service and I am consulted to do a surgery, if I can't do that surgery, I -- but I believe it's indicated, I find somebody who can.
MR. SERPE: Objection. Nonresponsive.
(Pause.)
BY MS. NOLAN
Q. Given your opinion that Dr. Nguyen did have responsibility to make efforts to get Mr. Zeigler transferred at the conclusion of that first hospitalization, are you critical of him for not doing that?

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A. Oh, I'm not critical -- no, I'm not critical of him not succeeding. It appears he tried.

(Pause.)

Q. Did you have an understanding that later during the second hospitalization, around January the 21st, that Dr. Ugbarugba contacted Dr. Raijmann directly?

A. I was not aware of the direct contact, I don't believe.

Q. Didn't see anything in the medical records or the depo testimony?

A. I don't remember.

Q. If Dr. Ugbarugba contacted Dr. Raijmann directly and asked him to accept Mr. Zeigler for an ERCP when he believed it was indicated, was that appropriate?

MR. ENGELHARDT: Objection. Form.

A. Yes.

Q. Within the standard of care?

A. Yes.

Q. You understand that following Mr. Zeigler's transfer to St. Luke's, do you have an understanding from your review of those medical records that there was no cholecystectomy performed

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on Mr. Zeigler at that facility?

A. Yes.

Q. Do you have any criticisms of his healthcare providers for not taking steps to perform a cholecystectomy once his pancreatitis had calmed down?

A. No.

Q. And why not?

A. So they gave him -- at this point he was quite ill. He had a, you know, tracheostomy tube I believe at that point. He had decubitus ulcers.

I think that they successfully did the temporizing measure, which was to stent open his bile duct, and I think the plan was is to get him better at the LTAC, get his strength back and then do the operation.

MS. NOLAN: I have just a little bit left, but I can see I think our court reporter may like a quick break, so why don't we take a quick bathroom break. Let her rest her hands for a moment. We'll come back and I'll finish up. All right?

THE WITNESS: All right.

THE VIDEOGRAPHER: The time is 4:44 p.m. We are off the record.

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(A break was taken from 4:44 p.m. to 4:50 p.m.)

THE VIDEOGRAPHER: The time is 4:50 p.m. We are on the record.

BY MS. NOLAN

Q. Doctor, we've taken a quick break. Are you prepared to proceed?

A. Yes.

Q. Anything about your testimony you want to change or anything like that?

A. No.

Q. Okay, great. We were talking about the discharge from the first hospitalization. Did you have an understanding from your review of the discharge summary that there were instructions to Mr. Zeigler for him to follow up on an outpatient basis and get a second opinion regarding surgery?

A. I believe I recall reading that.

Q. Did you see any evidence that that was done?

A. No. I didn't see any, again, appointments made for that consultation in the discharge summary.

Q. Do you have an opinion whether or not a reasonable and prudent patient would have followed those recommendations?

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MR. ENGELHARDT: Objection. Form.

A. Yes.

Q. And what is your opinion?

A. That they would have followed the doctor's recommendations.

Q. Given that you didn't see any follow-up appointments or any second opinion, do you have an opinion whether or not the failure to follow those recommendations -- recommendations impacted the outcome?

MR. ENGELHARDT: Objection. Form.

A. Again, I don't know whether they failed to -- to -- to show up to an appointment or failed to try to make an appointment, but, no, I don't think that -- the -- the timeline of this was so short I think anybody who would have seen them, evaluated them, gotten him a date for an elective surgery, I think he wouldn't have made it because it was -- it was only a few weeks.

Q. It sounds like in your opinion you believe this gentleman would have developed recurrent pancreatitis in this interim period regardless of follow-up?

A. Not regardless, but he had a 25 percent chance of it happening in that interval.

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Q. We've had discussions about Mr. Zeigler's BMI being in the 70's, his weight being over 400. Do you have an opinion, based on your education and training and your work as a bariatric surgeon, of what his mortality rate was at the time he re-presented to Cy-Fair?
A. I can't give you a specific number but his mortality rate was quite high.
Q. Would you agree with me it was greater than 50 percent?
A. That -- that seems a little too high. If you had asked me to estimate, I would say 30 to 40 percent, but it was high.
They have a number of calculators that you can use to put in all the risk factors and they'll give you back an estimate.
Q. Any calculator you regard as reliable and authoritative or you can point my attention to?
A. These days, so the APACHE calculators and the APACHE II, those are -- again, tend to be largely for trauma, but -- but you can use them, they're modified calculators, for a number of risk stratifications.
Q. Let's take the pancreatitis out of it. Let's just talk about this gentleman's obesity.

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Do you have an opinion based on your education and training of what his mortality rate was or percentage of mortality given his obesity?
A. From -- from what process?
Q. From being obese.
A. From -- from life?
Q. Yes, sir.
A. Yeah. Yeah, he -- yeah, he has -- someone with his degree of obesity a life expectancy greater than 20 years less than -- than someone who is not obese.
Q. At this point in time, you know, beginning roughly around November 2014 and again setting aside the pancreatitis, but looking at his obesity, do you have an opinion of what his percentage of mortality was based on his obesity? I know you said he had a reduced life expectancy.
A. Yes.
Q. But are you able to say -- would you agree his mortality given his obesity was greater than 50 percent?
A. From -- from what?
Q. Obesity.
A. Oh, you mean obesity-related cause of death at some point in his life?

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Q. At that point in his life.
A. Oh, so you're saying -- so I'm just trying to understand the question. So you're saying that -- that half of 19-year-olds with his weight will die?
Q. More than half.
A. More than half. No, it's not that high.
Q. Does super morbid obesity carry with it a high mortality rate?
A. Yes.
Q. And what is the mortality rate?
A. Again, it depends on a number of risk factors. It depends on your age. You know, it's -- it's good to be a teenager.
You know, he hasn't -- he has yet to develop the diabetes, though it's coming. He has, you know, yet to develop the arthrosclerosis, though it's coming.
So it's -- he still has the benefit of youth and time on his side, but, yes, the older you get, the higher your mortality rate gets.
Q. And, again, is there some sort of literature, guidelines, calculators, something that you can turn my attention to -- o learn more about that?

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A. Oh, yeah. I can't -- I can't tell you some -- a specific one, but -- but we've all -- we've all seen the -- as bariatric surgeons the graph of -- of your relative overall mortality from any disease process as your BMI increases.
And -- and usually as you approach a BMI of 40, we say that your overall mortality rate is about four times that of the general population.
Q. What about if your BMI's in the 70's?
A. It -- it just gets higher. I can't -- I can't give you the specific numbers, but it gets higher and higher.
Q. Is it your understanding that when Dr. -- Dr. Ugbarugba was initially consulted, do you understand that he was not consulted for an ERCP?
A. I -- I believe so. I believe he was consulted for -- I think to weigh in on the gastroenteritis, if I -- or the pancreatitis, pardon me, if I remember correctly.
Q. You told me your one criticism of Dr. Ugbarugba was that he did not perform an ERCP on Mr. Zeigler, correct?
A. Correct.
Q. When during this admission do you believe Dr. Zeigler -- Dr. Ugbarugba should have performed

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an ERCP on Mr. Zeigler?
A. You know, I think knowing everything we know now, I think the -- the best time for it would be the day he walked in -- for the second admission, the day he walked in the door and was consulted.
You know, I think we -- we know it's going to carry with it increasing risks, but we also know that not treating a potentially stenosed bile duct or obstructed bile duct also carries risks.
And then I think, you know, certainly he recovered from that. Other windows opened where he could have done the procedure, but I think it may have -- it may have saved a more prolonged hospitalization had he done it as early as possible, and it would have been high risk.
Q. On December the 19th at the time of the original consult, what are you basing your opinion on that he had a stenosed or obstructed bile duct at that time?
A. At that time, again, some of this is -- has the benefit of retrospect, but I believe it's within the first 48 to 72 hours that his liver function tests began to climb, so, you know, I think -- I think at that point what you can hang your hat on is that he was recently admitted with

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gallstone pancreatitis. He's back again with the same thing. Again, different people having different opinions, I think that you could say let's do the same thing. Let's wait for the pancreatitis to cool off, but he -- he certainly needs to get one that admission.
Again, I think knowing in retrospect that likely he had a stricture that was causing all this, then -- or -- or an ascending cholangitis picture which became more -- sorry -- or an ascending cholangitis picture that became more clear within the first few days of admission, that it should have been done then. Earlier rather than later.
MS. NOLAN: And I'll respectfully object as nonresponsive to that response.
BY MS. NOLAN
Q. When in your opinion do you believe the standard of care required Dr. Ugbarugba to perform an ERCP?
A. I'd have to look at my report for the exact timing, but when his liver function tests began to climb, that's when I think it had to be performed.
Q. Today's my only day to talk to you, so --
A. Okay.

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Q. -- I'll need to know.
A. I'll take a look.
(Reviewing document.)
A. Yeah, according to my report, he came in with elevated liver function tests, so -- so the information was there on December 19th.
Q. Any other basis in the medical records on December the 19th other than elevated liver function tests that you believe made an ERCP indicated at that time?
A. Liver function tests and a recent known diagnosis of gallstone pancreatitis, as well as a rising blood count in a septic picture.
Q. You understand he had an ultrasound on December the 18th, the day before Dr. Ugbarugba saw him?
A. I don't -- I don't recall, but I -- I believe it.
Q. Do you know whether or not that ultrasound showed any evidence of a stricture?
A. I don't recall.
Q. I'll represent to you that the ultrasound showed a common bile duct of 5 millimeters. Would you agree with me that that is not indicative of a stricture?

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A. It depends on where they sampled it, but in general, no. Someone of -- of his age, 5 millimeters is the normal size for a common bile duct.
Q. Do you agree with me or are you able to say that an ERCP should not be performed until the common bile duct is greater than 8 millimeters?
A. No, I don't agree.
Q. And what is your basis?
A. In someone again like him with elevated liver function tests, a septic-type picture, known gallstone pancreatitis, the diagnosis is leaning a little more towards cholangitis. Sometimes -- sometimes the bile duct just doesn't dilate or it's difficult to tell on ultrasound.
Q. You say the clinical picture became evident for ascending cholangitis. When do you think that became evident based on your review?
A. Again, I think the pieces of it were there on December 19th when he re-presented with sepsis of -- of unknown origin or some type of sepsis and then he had elevated liver function tests.
Q. You understand his liver function tests improved after his admission without ERCP?
A. Yes.

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Q. Would you agree with me that by January the 5th of 2015, his clinical picture was no longer indicative of either a stricture or ascending cholangitis?
A. His clinical picture, I would say not indicative of ascending cholangitis. You can't necessarily tell whether there's a stricture or not.
Q. So I'm trying to understand your opinion. When in your opinion do you believe if an ERCP had been performed, it would have changed the outcome in this case? December 19th?
A. Potentially, yes.
Q. Are you able to say within a reasonable degree of medical probability a specific time in which had an ERCP been performed, it would have changed the outcome?
A. For the second admission or in general?
Q. Second admission.
A. Yeah, I would say within the first two weeks of admission.
Q. What's your basis for that opinion?
A. Oh, he just -- at that point, the longer he waited he was becoming more and more decompensated. I mean, he was not a healthy gentleman. He was super morbidly obese. He was

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having a prolonged intensive care course. He was mechanically ventilated. He ultimately ended up getting a tracheostomy. You know, he wasn't moving. He was becoming progressively more deconditioned.
You know, the longer you wait on this, the more and more you're setting it up for -- setting him up for hospital-acquired infections and all the complications of prolonged care and immobilization.
(Pause.)
Q. So it's your opinion that an ERCP, had it been performed by January the 1st would have changed the outcome?
A. Again, that's -- that's sort of a -- that's a guess as to the date. That's -- I just think the longer you waited, the worse his outcome was going to be, so, yeah, that date's a bit arbitrary, but -- but, yes.
Q. I need a date within a reasonable degree of medical probability based on your review of the medical records.
A. I can't give you a specific date.
Q. Are you able to give me a date at which whether an ERCP had been performed or not, it didn't make a difference?
MR. ENGELHARDT: Objection. Form.

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A. Yeah, again, I have a hard time saying. You know, it's a bit like looking into a crystal ball. I have a hard time saying, you know, what -- what would have been the point of no return.
It's just certainly one of these things that the longer you wait, the worse it's going to be, the longer he's going to be incapacitated.
Q. So you're unable to say within a reasonable degree of medical probability a point of no return at which an ERCP would have made a difference?
A. Yes.
MR. ENGELHARDT: Objection. Form.
Q. Do you intend to tell the ladies and gentlemen of the jury in this case that Dr. Ugbarugba should have performed an ERCP on Mr. Zeigler at Cy-Fair despite the risks for complications, inability to handle those complications, lack of a higher level of care?
MR. ENGELHARDT: Objection. Form.
A. Yes, if no other options were available.
(Pause.)
Q. Can TPN cause an increase in liver function tests?
A. Yes.

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Q. How does it do that?
A. Again, the -- you can have increased inflammation, fatty infiltration of the liver and that can cause elevation of your LFT's.
Q. We've talked about on January, the 21st Dr. Ugbarugba's recommendation at that time for ERCP. You're familiar with that?
A. I remember I was talking about it, yeah. I don't -- again, I don't recall anything in the chart.
Q. Do you have an understanding from your review of the medical records when it was that Dr. Ugbarugba started making efforts for ERCP to be performed by Dr. Raijmann at St. Luke's?
A. No. Again, most of -- most of what I recall are the critical care doctor's notes in terms of the transfer.
Q. Do you intend to offer an opinion to the ladies and gentlemen of the jury of this case that the timing of Dr. Raijmann's ERCP had any impact on the outcome?
A. How do you mean?
MR. ENGELHARDT: Do you understand the question?
THE WITNESS: No.

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Q. You understand that several days went by between Dr. Ugbarugba's efforts to get transferred to St. Luke's for a high-level, high-risk ERCP with Dr. Raijmann?
A. Yes.
Q. You understand -- or do you have an understanding when those dates were from your review of the records?
A. I don't remember. I mean, it wasn't the day he got transferred over, but it was very shortly after, if I remember correctly. I can check in my report.
(Reviewing document.)
A. No, I didn't comment, but I had that he was transferred over on 20 -- on January 26th, and I said there he underwent an ERCP.
Q. And do you have an opinion with respect to from -- well, let me -- let me back up. You understand that Dr. Ugbarugba was reconsulted on January the 21st for Mr. Zeigler?
A. I -- I didn't know that he was -- ever stopped consulting.
Q. You don't remember from your review of the records?
MR. ENGELHARDT: Objection. Form.

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A. No.
Q. I'll represent to you Dr. Ugbarugba was reconsulted on January the 21st.
A. Okay.
Q. Dr. Raijmann performed an ERCP on January the 27th.
A. Okay.
Q. Do you have an opinion whether or not the time lapse from the 21st to the 27th for the ERCP, whether that had any impact on the outcome?
A. Again, I'll go back to my -- my earlier answer where I think, you know, every day that went by represented an increasing risk for him. Every day he went by without some type of intervention.
So -- so, yes, I think later in January he started to have, again, another biliary obstructive-type picture; whether that was a stone, whether that was a stricture, you know, uncertain at that time, but -- but here he was with his, you know, now third episode.
Q. Are you able to say within a reasonable degree of medical probability whether those six days from the 21st to the 27th, whether that made a difference in the outcome?
A. Unable to say.

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Q. Based on your review of Dr. Raijmann's ERCP report, did he identify a stone in the biliary system?
A. No. I believe he just identified a stricture.
Q. Do you remember what type of stricture he identified?
A. I think it was a stricture in the distal common bile duct, if I remember correctly.
Q. Do you have an opinion what was causing that?
A. That was likely a pancreatitis-related stricture.
Q. How does that happen?
A. As the pancreas becomes more inflamed and edematous, it can even develop some fibrosis. The common bile duct actually passes through the pancreas, so as the pancreas becomes more inflamed, it can squeeze and narrow a segment of that common bile duct.
Q. So it's a mechanical obstruction?
A. Mechanical and inflammatory. Almost like a fibrosis, yes.
Q. External? An external obstruction --
A. Yes.

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Q. -- it's known as?
A. Yes. Extrinsic compression.
(Pause.)
Q. The cholecystostomy that was performed, do you have any criticisms of their performing that procedure?
A. No.
Q. Is it your understanding from your review of the medical records that the cholecystostomy was effective in draining the bile from the gallbladder?
A. It seems like it, yes.
Q. That's all the questions I have at this time. Have you understood my questions?
A. Yes.
MS. NOLAN: I'll pass you on.
(Pause.)
CROSS-EXAMINATION BY MR. HUGHES:
Q. Dr. Carmine, how are you?
A. Hello.
Q. I'm Matthew Hughes, and I represent Dr. Patel in this case. You're aware that Dr. Patel had no role whatsoever in the first admission in November, right?
A. I'm aware, yes.
Q. Okay. So you certainly aren't critical of

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anything that he did or failed to do at that time?
A. No.
Q. Do you have an opinion in this case about whether Mr. Zeigler was more likely or not to pass away as a result of the care or lack of care that he got as of the November admission?
A. I'm -- I'm sorry. I don't understand the question.
Q. I'm trying to get a sense that -- you've offered criticisms today of the care that the patient received both in November and also in December, right?
A. Yes.
Q. Okay. Is it your opinion in this case that the care that Mr. Zeigler received in November was in your opinion insufficient enough that that was the cause of his death?
MR. SERPE: Objection. Form.
A. Yes. It was a contributing cause.
Q. Okay. I'm trying to break that up, though. But I'm saying, what do you mean by a "contributing cause"?
A. So I think if he had had a cholecystectomy at that time, likely he would have never come back to the hospital again for the second admission.

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Q. Okay. But going forward, though, is it your opinion that he should have had a cholecystectomy during the December admission?
A. I think he never really had a safe window to do a cholecystectomy at that second admission. I -- I think he just never really got there. He never had his bile duct dealt with.
Q. Okay. All right. Is it your opinion in this case then that the standard of care did not require Dr. Patel to do a cholecystectomy during the December hospital admission?
A. A cholecystectomy, yes.
Q. Okay. And I assume it's your opinion that no other physicians any later than December were required by the standard of care to perform a cholecystectomy, fair?
A. I think fair enough. At that point he'd been deconditioned and his bile duct had been evaluated in other ways.
Q. Okay. Dr. Patel did attempt to order the patient having a CT scan, right?
A. Yeah, I believe so, yes. He was one of -- one of many.
Q. And they were unable to obtain that because the fact is the patient broke the table,

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right?
A. That, I don't know. I could never find a good explanation as to what happened.
Q. Is it fair to say you don't know why they weren't able to -- to do the test?
A. No. I saw a couple reports saying it was broken, a couple of reports saying he was too big for it, so I never -- I never got a straight answer, but both -- both are plausible.
Q. Do you think that in order to offer an opinion in this case about whether the patient should have been transferred, that as an expert witness you should -- you should understand the process as to how patients are actually received by other hospitals?
A. Yes.
Q. So what I'm getting at is that in order to evaluate whether the physicians met the standard of care or not in attempting to transfer a patient, don't you think that as an expert witness you should understand the process in Texas of how hospitals actually receive patients on transfer?
A. No.
Q. Okay. Have you read the testimony of either Dr. Patel or anyone else about efforts that

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were made to transfer this patient?
A. Nothing by Dr. Patel, but -- but, yes, I -- as we talked about earlier, there have been multiple times in the chart mentioned where we have attempted to get him transferred with no success.
Q. Okay. In order to transfer a patient, you do actually need to have a hospital receive the patient.
A. Yeah.
Q. They actually have to take the patient from one facility and another facility has to agree to take him in, right?
A. Yes.
Q. Okay. In this particular case, in order to criticize any of the physicians who treated Mr. Zeigler at Cy-Fair on the question of transfer, wouldn't you have to know that there was another facility that would actually take him at that time, right?
A. Ask the question again.
Q. What I'm getting at if you -- if you -- if you can't show that another facility would actually take him, how can you criticize the physicians for not getting him transferred out?
MR. ENGELHARDT: Hold on. Objection

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to form.
Q. You can answer the question.
A. Oh, again, I'm not -- I have never been critical of their attempts. I've been critical of their response when the other places wouldn't take him.
Q. Okay. Well, in this particular case, I want to make sure I understand. What is -- what is then your criticism of Dr. Patel?
A. You know, I actually -- I would say of all the providers, you know, he didn't really have much of a window to do a cholecystectomy on him.
I think he arguably could have done it during that brief time when the pancreatitis seemingly cooled off in early January.
You know, I think that he -- and I'm not certain what his skill set is, but with no imaging modalities and no gastroenterologist, you know, able to perform an ERCP, I think he certainly had other surgical modalities he could have employed to -- to help make diagnoses and treat.
Q. Okay. But you're not -- it doesn't sound to me like you're saying that he breached the standard of care by not performing this surgery in January?

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A. Again, it's difficult to say because I don't know his -- I don't know his rationale. I couldn't really find much in the chart from him.
Q. Okay. But if there's an absence of information, in fairness, you would say you don't have enough information to offer that opinion, right? Whether he breached the standard of care or not.
A. Yeah, again, I think more -- not perform a cholecystectomy, yes, but I still couldn't really find much of a surgical opinion rendered in the chart that second time.
Q. Okay. But what I'm getting at is if you acknowledge that by the time that Dr. Patel became involved in this case that he may not have been able to do surgery on this patient, you're really not critical of him for breaching the standard of care, right?
A. Correct. Certainly -- certainly during those first two weeks.
Q. Okay. And there may have been things that you might have done differently, but it doesn't rise to the level of saying that he breached the standard of care for a general surgeon or bariatric surgeon?
A. Yeah, I'd agree.

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Q. Okay. Considering the -- the challenges that all of the physicians had in this case, you -- you would agree that it's not just the size of the patient, the problems actually getting a facility with higher -- with greater facilities able to take this patient, that Mr. Zeigler represented kind of a unique problem for these doctors, right?
A. I wish it were a unique problem, but it's -- it's not.
Q. Okay. Individual doctors can't make a hospital accept a patient, right?
MR. ENGELHARDT: Objection. Form. That's not --
Q. Okay. Do you understand that they have something called a transfer center?
A. No.
Q. Okay.
A. You mean like a -- probably have different names.
Q. Yeah.
A. So we call it, you know, bed facilitator, bed coordinator.
Q. Okay.
A. But, yes, if that's what you're referring to, I'm aware of that.

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Q. And it's reasonable for physicians to operate and to use that, right?
A. Yes.
Q. Okay. And if a hospital will not actually accept a patient, that does tie the hands of the physicians, doesn't it?
A. Yes.
Q. Okay. Do you know -- have any opinion in this case as to what Mr. Zeigler's life expectancy would be based upon the -- his super super super morbid obesity at such a young age?
A. Yes.
Q. What is your opinion?
A. Likely his life expectancy is probably between 55 to 60.
Q. Okay. And what is that based on?
A. Oh, that's, again, just based on the survival charts of -- of patients with certain BMIs.
Q. And they have a large number of people who are 580 pounds at a young age that they've been able to extrapolate that data on?
A. Yeah. Yeah, unfortunately.
Q. And where does that data come from?
A. Oh, again, that's just -- well, we don't have it from the young age, but we have at that BMI

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at any age, so it's -- again, it's just -- it's essentially databases. You know, you can audit charts. It's pretty easy to do a -- you know, a chart review of patients with certain weights and -- and -- and death dates.

Q. Okay. You understood the questions that the lawyer for Dr. Singh asked you?

A. Yes.

Q. Right? And you gave truthful answers to his questions?

A. Yes.

Q. You understood the questions that the -- the lawyer for Dr. Ugbarugba asked you, right? And you gave truthful answers to her?

A. Yes.

Q. And you've understood the questions I've asked you today, --

A. Yes.

Q. -- right? You understand as an expert witness your job is to give truthful testimony?

A. Yes.

Q. Is to give your objective opinions on the case, right?

A. Yes.

Q. It is not to try to align the opinions

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based on the plaintiff's lawyer wants to ask?

A. Correct.

Q. Okay. So if you've given truthful answers to all -- all the lawyers in this case, there will probably be a chance for you to be asked questions by the Plaintiff's lawyer in this case, right?

A. Yes.

Q. After we finish. If you're objective, your answers really shouldn't change based on who's asking you questions, right?

A. Yes.

Q. Okay. So you have told me the limited extent of what your -- your criticisms are of Dr. Patel. You are not going to have a bunch of new criticisms just because somebody new is asking you questions?

A. Correct.

Q. I mean, you did review the -- the records in sufficient depth in order to give your testimony today, right?

A. Yes.

Q. And you feel before you started your deposition today that you had a chance to review the records and get an adequate understanding of them, right?

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A. Yes.

Q. You had a chance to review Dr. Patel's deposition before today?

A. Yes.

Q. And as well as the depositions of Dr. Singh and Dr. Ugbarugba?

A. Yes.

Q. Okay. And -- and based upon that review, you had the sufficient data of the case in order to offer opinions, right?

A. Yes.

Q. You also had sufficient time to prepare yourself for this deposition and to understand the facts of this case, right?

A. Yes.

Q. Okay. So if -- if -- as an expert witness, you understand that you're not supposed to be aligned with either -- either side in the case, --

A. Yes.

Q. -- right? And what you're supposed to do is help the jury understand the medicine of the case and also help understand the facts of the case, --

A. Yes.

Q. -- right? And that should not change

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based upon whoever's questioning you?

A. Yes.

MR. HUGHES: All right. I want to thank you, sir, for answering my questions.

THE WITNESS: Okay.

MR. ENGELHARDT: I have a few questions I want to ask you.

CROSS-EXAMINATION BY MR. ENGELHARDT:

Q. Okay. When you answered and responded to the last counsel's questions about Dr. Patel --

A. Yes.

Q. -- and you told him in the first couple of weeks, what did you mean?

A. The first couple of weeks after his second admission I think he was too ill to tolerate a cholecystectomy or a surgical procedure.

Q. All right. Do you recall how long Dr. -- do you recall how long Mr. Zeigler was in the -- in the hospital for the second admission?

A. A little over one month.

Q. And do you have any criticisms of Dr. Patel after the first couple of weeks of admission by -- for Dr. -- for Mr. Zeigler?

A. You know, unfortunately, my criticisms aren't really specific to Dr. Patel but, rather,

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almost the -- the treatment team as a whole, which is that nobody was evaluating his bile duct and both Drs. Patel and Dr. Ugbarugba had the ability to do that and really that was my main concern.
Q. Do you recall preparing a report that you provided to counsel?
A. Yes.
Q. And did you also make comments about Dr. Patel in the report?
A. Yes.
Q. Okay. Do you recall what those comments were?
A. Yeah, that he could have provided -- provided a cholecystectomy at that same admission.
Q. Did you also -- were you also critical of Dr. Patel in your report about the fact that he had failed to identify him with specificity any of the communications that he had had with the other doctors or his opinions as to why he could not operate on -- on Mr. Zeigler while he was there at the hospital for the second stay?
A. Yes. And that was, again, my chief criticism, is that I -- I just couldn't find a surgical opinion cogently rendered.
Q. And that --

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(Pause.)
Q. Do you believe that -- that Dr. Patel's actions or inactions was below the standard of care --
MR. HUGHES: Objection. Form.
Q. -- as it relates to failure to document what the issues were to treating Mr. Zeigler in the last two weeks of his stay at the second hospital visit?
A. Yes. I agree that the failure of documentation fell below the standard of care.
Q. All right. And so are you critical of any of these doctors' conduct being below the standard of care at the Cy-Fair Hospital in Texas?
A. Yes.
MS. NOLAN: Objection. Form.
Q. All right. What is -- what was their -- identify or describe their conduct for me, please, which you believe was below the standard of care.
A. I mean, it -- you know, it -- it boils down to I think people were so focused on the transfer, getting him somewhere else, getting him to this place where things couldn't be taken care of -- where things could definitely be taken care of by people who do this a little more frequently,

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that, you know, just time went by. He did not get the care that he should have gotten back in November and -- and because of this inaction, more -- more likely than not this is what led to his death.
You know, again, we can go back to our trauma analogy where you have somebody who comes in shot during a snowstorm and you can't get them anywhere other than there.
You know, a surgeon can't throw up their hands and say, well, I can't deal with this. I'm not comfortable dealing with this. I'd rather somebody else do this. You know, your -- your -- your hands are tied. You're -- you're the only game in town.
Q. Did you think --
MR. SERPE: I'm sorry. Objection. Nonresponsive.
BY MR. ENGELHARDT
Q. Well, I asked you specifically, was any of their conduct a proximate cause of Aaron Zeigler's death?
A. Yes.
MS. NOLAN: Join the last objection. Sorry to interrupt you.
A. Yeah. Yes.

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Q. Okay. Would you describe to the jury what actions were done by these doctors that was below the standard of care that was a proximate cause of his death?
A. So the first admission, failure to either get a temporizing ERCP or perform a cholecystectomy.
Q. And whose responsibility was that?
A. That was Dr. Singh as the surgical consultant.
Q. All right. What about Dr. Patel? He wasn't even involved in the -- in the first admission, but what about Dr. --
A. Correct.
Q. For clarity purposes, what about Dr. Patel in the second admittance?
A. So Dr. Patel, you know, inherited this mess, but, again, once -- it came to the same thing. Once you had somebody who was not willing to better delineate Mr. Zeigler's pathology anatomy, I think the -- the ball falls to -- to the surgeon.
And this is one of these cases where, you know, the surgeons may be pointing to the gastroenterologist. The gastroenterologist may be pointing to the surgeon, but neither of them correctly identified Mr. Zeigler's anatomy.

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Q. And you --
MR. SERPE: Objection to the nonresponsive portion.
MR. HUGHES: Join.
MR. ENGELHARDT: Which part?
MR. SERPE: The very beginning about inheriting the mess.
THE WITNESS: Okay. Sorry.
BY MR. ENGELHARDT
Q. I'll ask you again because of their objection. You have to clarify your response. Okay?
A. Okay.
Q. As the conduct you've described to these doctors, was any of their conduct below the standard of care at Cy-Fair medical hospital?
A. Yes.
Q. And was it a proximate cause of Mr. Zeigler's death?
A. Yes.
Q. Would you describe them for me as it relates to first Dr. Singh?
A. Okay.
Q. Please.
A. Dr. Singh, failure to perform a

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cholecystectomy at the index admission in November.
Q. All right. Anything else?
A. Failure to recommend an ERCP, failure to provide follow-up or arrange follow-up.
Q. All right. Now, Dr. Patel was involved in the second admission, correct?
A. Yes.
Q. All right. What was his actions that were below the standard of care?
A. So failure of documentation, failure to provide -- again, I'm trying to figure out the best way to phrase it, but failure to aid in the surgical treatment and evaluation of Mr. Zeigler's biliary system.
Q. And was this conduct a proximate cause of his death?
A. Yes.
Q. And you already responded as it relates to Dr. Ugbarugba, isn't that correct?
A. Yes.
Q. Is there anything you want to add as it relates to Dr. Ugbarugba as you've previously testified to?
A. No.
Q. All right. Were any of these doctors'

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actions in conscious disregard to Aaron Zeigler?
MS. NOLAN: Objection. Form.
MR. SERPE: Join.
MR. ENGELHARDT: You can answer.
MR. HUGHES: Join.
A. Yes.
Q. Were they in conscious disregard to his rights as a patient at Cy-Fair medical hospital?
MS. NOLAN: Objection to form.
MR. HUGHES: Objection to form.
MR. SERPE: Join.
Q. You can answer it.
A. I'd say yes.
Q. Okay. Do you have any additional criticisms of Dr. Singh or Dr. Patel or Dr. Ugbarugba as it relates to going beyond a failure to meet the standard of care in treating Mr. Zeigler?
MR. SERPE: Form.
A. Yeah, I don't understand the question.
Q. Okay. Well, you've been critical of these doctors' treatment of Aaron Zeigler not meeting the standard of care, correct?
A. Yes.
Q. Were any of these doctors' actions in

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conscious disregard to his position as a patient in that hospital?
MS. NOLAN: Objection to form.
MR. HUGHES: Objection to form.
MR. SERPE: Join.
MR. ENGELHARDT: You can answer it.
A. I would say yes.
Q. Okay. And what is the basis for your answer?
A. You know, I think the -- the most egregious was probably Dr. Singh at the first admission.
Q. All right. Was what egregious about Dr. Singh's conduct at the first admission of Aaron Zeigler?
MR. SERPE: Objection. Form.
A. It -- it seemed that he -- especially from reading his deposition that he knew what the appropriate treatment was and that the timing of that and that that procedure likely would not be able to be done by anybody other than him and still did not do it.
Q. And what was egregious about -- if anything, about Dr. Patel's treatment of Aaron Zeigler on the second at admission?

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MR. HUGHES: Objection.
A. I don't think there was anything egregious about Dr. Patel.
Q. All right. And what about Dr. Ugbarugba as it relates to his treatment of Aaron Zeigler?
MS. NOLAN: Objection. Form.
Q. What did you find egregious about his -- his behavior --
MS. NOLAN: Same objection.
Q. -- and the treatment of Aaron Zeigler?
MS. NOLAN: Objection. Form.
A. Again, sort of the same thing. Sort of the pattern of, you know, following him for -- off and on for several weeks, still not doing the ERCP and in somebody with a presumed biliary obstruction, possible cholangitis for such a prolonged period of time.
(Pause.)
Q. I have one other question. The fact that Dr. Raijmann performed a ERCP on January of -- 27th of 2015, the fact that there was a issue with Zeigler's weight, did that have anything to do with the actual ERCP procedure?
A. Well, you know, I've been thinking about how this question's been asked to me a couple times

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in terms of technical considerations, so -- so, no, in terms of passing the scope and visualization, that doesn't matter in terms of your weight.
You do need to change your equipment to be able to do it, but it's equipment that's readily available at any hospital that does surgery.
MR. ENGELHARDT: Pass the witness.
MR. SERPE: I'll come back.
(Pause.)
REDIRECT EXAMINATION BY MR. SERPE:
Q. Dr. Carmine, have you ever had a super morbidly obese patient die that you've been taking care of?
A. No.
Q. Also morbidly obese, super morbidly obese patients?
A. Well, no. I mean, I've been operating for so long now, some of them have died of other things, but -- but, yeah, not -- not from my care.
Q. Do they die from their super morbid obesity?
A. Well, again, usually by the time that I am done operating with them they're not super morbidly obese anymore, but I've had patients, for instance, who I've operated on so they could get a kidney

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transplant and, you know, they die of complications of renal failure down the line before they can get their transplant.
I've had been with years of arthrosclerosis and heart disease who ended up dying of heart attack, you know, months to years after the operation.
Q. All right. Well, Mr. Zeigler wasn't there to get bariatric surgery, correct?
A. Correct.
Q. Dr. Singh, you're not implying that he somehow should have done something to make him go from 580 pounds to 200 pounds?
A. Certainly not.
Q. All right.
A. I don't know if he would have been a good candidate for that at all.
Q. Why not?
A. A lot of -- I'm sorry. A lot of what was documented in the chart in terms of his, you know, failure to comply, what may have likely been a binge eating disorder, all of these are contraindications to weight-loss surgery.
Q. Okay. And, certainly, you'd agree Mr. Zeigler bears some responsibility for all the

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problem -- medical problems he had?
A. Yeah.
Q. I mean, in other words, Dr. Singh didn't tell him to go out and spend 80 bucks at McDonald's to go eat in one sitting, correct?
A. Correct.
Q. I mean, in some ways, to use kind of a different analogy, it's almost as if Mr. Zeigler almost kind of ate himself to death. That's a -- that's a fair to way to look at this case, --
MR. ENGELHARDT: Objection.
Q. -- is it not, sir?
MR. ENGELHARDT: Objection to form.
A. No.
Q. No?
A. No.
Q. When you're 19 years old and you weigh 580 pounds, that's not someone who's extremely self-destructive in terms of their personal habits?
MR. ENGELHARDT: Objection. Form.
A. I mean, again, it depends what we're talking about. I mean, he didn't -- he died of presumably gallstone pancreatitis. That could happen to him at any weight. More likely that at his weight that he was.

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Q. Right. In other words, you don't think he would have died of gallstone pancreatitis if he had been at 200 pounds?
A. Well, it sounds like they would have been more likely to do an operation if he was a lower weight.
Q. Sure. For that matter, how many 19-year-olds get gallbladder pancreatitis if they're not super morbidly obese?
A. A few.
Q. Okay.
A. It's not -- it's -- it's uncommon but not rare.
Q. All right. But you would agree with me that his super super super morbid obesity was a contributing factor to his death?
A. Yes.
Q. All right. And that the only person that you can fairly assign responsibility for his super super super morbid obesity is Mr. Zeigler?
A. Yes.
Q. All right.
A. As -- as best I can tell.
Q. Now, I want to get back because you just gave some questions about Dr. Singh's motivations,

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and I thought we'd established earlier that you were okay with Dr. Singh saying, look, this guy's extreme morbid obesity is outside my technical experience level and that you were okay with him saying I am not going to perform the surgery.
A. No. I was okay with him saying he wasn't comfortable.
Q. Okay.
A. Yeah.
Q. Well, and -- and do you think it's because -- I mean, you'd agree with me it's because Dr. Singh would legitimately be worried I've never operated on anybody close to this weight and there are lots of things that can go wrong and this patient would be better off in a situation where he's dealing with a -- a surgeon who would take care of this patient?
A. Yes.
Q. With experience?
A. Yes.
Q. In other words, -- and me ask you this: If -- next time Dr. Singh sees a 580-pound patient in his office, can he call you and we send the guy up to Boston to get treated?
MR. ENGELHARDT: Hold on. Objection.

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Form.
A. Yes.
Q. Okay. So to -- to break it down, you're okay with Dr. Singh saying I'm not -- I don't feel like the -- the benefits of doing the surgery outweigh the risks with me doing it based on my experience in terms of dealing with somebody with 580 pounds. You're okay with that decision by him?
A. I never saw that thought process. That the -- that the benefits outweighed the risks. I just saw that he wasn't comfortable doing it. I don't think the benefits outweighed the risks or, you know, we wouldn't be here.
I think that -- I think that the -- that ideally, again, we can talk to the hypothetical snowstorm in a trauma patient. I think ideally, yes, it should have been done by somebody who had more experience.
Nobody was taking him, and -- and the clock was ticking, so I think at that point with no other options, I think that he was obligated to -- to operate on the patient at that time.
Q. Well, the sequence of events at the time of his initial discharge from Cy-Fair and the plan which we covered with Dr. Nguyen's note was that

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Mr. Zeigler was going to go lose weight, which you'd be fine with, correct?
A. Yeah.
Q. All right. And he was going to get a second opinion in a medical center hospital that has more experience in dealing with super morbidly obese patients, correct?
A. Yes. That was in Dr. Nguyen's note, yes.
Q. Okay. Do you disbelieve Dr. Nguyen's note?
A. No. I believe it.
Q. Okay. And -- and also that Mr. Zeigler said I'm going to work to get insurance. That was the three things which are referenced in Dr. Nguyen's note, correct?
A. Yes.
Q. All right. And you don't see any evidence that Mr. Zeigler came back to Dr. Singh and said, hey, I can't find anybody, nobody will take me. You don't see any evidence of that whatsoever, do you?
A. No.
Q. Okay. And certainly, it's a two-way street with your patient. If you tell your patient I recommend you do something or the patient says I'm going to do something, if the patient can't get it

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done for any reason, you're not a mind-reader. They've got to call you and tell you that, right?
A. It -- again, it -- yeah, but it depends on what I'm asking them to do.
Q. Okay.
A. I -- you know, I think -- I think that he had probably two unrealistic goals set for him, which were just go get insurance and -- and then lose weight.
You know, that's -- those are two things that are hard for people to do, you know, either financially or simply, you know, through motivation and ability.
Q. Yeah, but the third part is go get a second opinion.
A. Well, I think that -- doesn't that -- that -- my understanding is that that hinged on the first part, which was get insurance.
Q. Well, you don't know that, right?
A. I don't know that.
Q. Okay.
A. But that was my understanding as to why nobody would see him.
Q. Okay. But that's documented all in the second hospitalization at Cy-Fair; not the first

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one?
A. Yes.
Q. Okay. And -- and when you talk about Dr. Singh's motivation and say that he was indifferent to Mr. Zeigler, you've got no real basis to say that, that that's what was going on in Dr. Singh's mind, do you?
A. No. It's just speculation.
Q. Okay. Because you'd agree with me that if Dr. Singh sat in his office and talked to Mr. Zeigler and said, look, Mr. Zeigler, I think you'd be better off seeing a doctor with more experience at a facility that is more used to handling people in -- of your weight, that that's a -- that's a reasonable thing for him to suggest?
A. That is absolutely a reasonable thing for him toe suggest.
MR. SERPE: Okay. All right. I'll pass the witness.
(Pause.)
RECROSS-EXAMINATION BY MS. NOLAN:
Q. Dr. Carmine, I have some follow-up questions for you. Did you have an understanding that when Mr. Zeigler was readmitted to Cy-Fair on December the 19th of 2014, that his attending

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physician again was Dr. Nguyen?
A. I was not sure about that because I know he spent most of his time in critical care.
Q. At the time of the initial presentation.
A. Yes.
Q. Prior to the transfer to ICU.
A. I -- I believe so. Again, I wasn't quite sure of the timing of when -- when he went to the ICU, whether he was in the emergency department, went from the emergency department to the ICU. I had a hard time seeing the time course there.
Q. Do you remember your review of Dr. Nguyen's history and physical for admission for Mr. Zeigler when he came back for the second admission?
A. Yes.
Q. Do you have an understanding at that time that Dr. Nguyen had requested a surgical consult with Dr. Patel?
A. Yes. I recall that -- that it seemed that multiple parties wanted somebody else to see him.
Q. Was it your understanding that they were seeking consult with Dr. Patel in terms of whether or not in his opinion Mr. Zeigler was a surgical candidate?

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A. Yes.
Q. Do you have an understanding from Dr. Ugbarugba's deposition testimony that he was deferring to Dr. Patel and his education, training and experience into whether -- as to whether or not Mr. Zeigler was a surgical candidate?
A. I don't recall that specific wording, but it's...
Q. Would that be an appropriate thing for Dr. Ugbarugba and the other healthcare providers to do?
A. Yes.
Q. Within the standard of care?
A. Yes.
Q. With respect to other consults, once Mr. Zeigler gets into the ICU, did you have an understanding that he had pulmonary critical care physicians who were now overseeing his care?
A. Yeah, I believe that that was what I saw, that the critical care doctor was a pulmonologist.
Q. And would you expect those physicians within their medical judgment to seek whatever additional consults may be needed for Mr. Zeigler?
A. Yes.
Q. Do you remember seeing Dr. Ugbarugba's

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deposition testimony where he was asked a question about why he didn't get a renal consult?
A. I don't recall that specifically.
Q. Did you -- do you have an expectation that that's something Dr. Ugbarugba would do?
A. No. That's a -- that's under the purview of critical care.
Q. You would agree with me that it would be appropriate for Dr. Ugbarugba to defer to either Dr. Nguyen if he's the attending at that point or the pulmonary critical care team once he get into the ICU, once he gets into the ICU in terms of whether or not a renal consult is indicated?
A. Yes.
Q. That's within the standard of care?
A. Yes.
Q. I want to ask you this: On December the 19th when Dr. Ugbarugba did his initial consultation, do you know what time of day that was -- that was performed?
A. I do not recall.
Q. I'll represent to you it was in the evening.
A. Okay.
Q. Do you know if the facilities would have

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been available for an ERCP to have been performed within that time frame? You understand it's just a few hours went by before Mr. Zeigler was then transferred into the ICU?
A. Yes. He decompensated quickly.
Q. Is it your opinion that an ERCP could have been performed on Mr. Zeigler at Cy-Fair before that decompensation?
A. Again, I'm not sure what their call schedule or facilities are like, but there's no hospital that has a -- that I'm aware of that has an inhouse endoscopy team at night but usually they have a call team.
(Pause.)
Q. On December the 19th, what therapeutic indication do you believe there was for the performance of an ERCP?
A. Relief of cholangitis.
Q. Do you have an opinion of what specific therapeutic intervention would have been indicated with the ERCP to relieve the cholangitis?
A. It -- it depends on what they found on the ERCP, so certainly if it was from obstructing stone, it could have been a withdrawal of the stone. If it was a stricture, which it -- in retrospect it may or

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may not have been. It could have been stenting of the stricture and either one likely would have come with a sphincterotomy.
Q. Are you able to say within a reasonable degree of medical probability what would have been found if an ERCP had been performed on December the 19th?
A. Not within a degree of probability. It would either have been stones or stricture would have been my guess.
Q. And if I've understood your opinion today, your basis for there being either a stone or a stricture and cholangitis is elevated liver function tests, elevated white blood cell count. Anything else?
A. Abdominal pain and hypotension.
Q. Hypotension?
A. Well, signs of shock. I actually don't recall what his blood pressure was.
(Pause.)
Q. If an ERCP had been performed earlier during the second admission, --
A. Yes.
Q. -- are you able to say within a reasonable degree of medical probability how much longer

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Mr. Zeigler would have remained in the hospital?
A. I suspect he likely would have improved by mid-January. I believe reviewing the chart that he had another episode of some type of biliary obstruction in mid- to late-January when his liver function tests began to rise again. I think it would have spared him that episode.
Q. Are you able to say within a reasonable degree of medical probability if an ERCP had been performed earlier in the admission before what you're calling this -- another episode of obstruction, whether or not -- let me back up.
Given your opinion that there was another episode of obstruction in mid-January, I take it you would agree that whatever obstruction, if any, that was present in what we're calling the first part of the admission completely resolved itself without an ERCP?
A. It's hard to say if it's completely resolved itself, but it was certainly more of a partial obstruction, if anything.
(Pause.)
Q. Say that last part again?
MR. ENGELHARDT: Read it back again.
MS. NOLAN: Yeah, that would be great.

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(Answer read back.)
MR. ENGELHARDT: Thank you.
BY MS. NOLAN
Q. And do you have an opinion within a reasonable degree of medical probability whether this partial obstruction was due to a stone in the duct, whether it was due to this sort of pancreatic swelling and was external?
A. I think at this point for that -- again, we're saying now the second episode at his second admission.
I think at that point it was likely a pancreatitis-related stricture because it was a matter of a week or two later that he had the ERCP at St. Luke's that showed that.
Q. We're mis-communicating.
A. Okay.
Q. I was talking with you about whatever this obstructive episode was at the time in your opinion that he re- presented.
A. Yeah.
Q. And you were saying -- you were acknowledging that it had pretty much resolved without an ERCP before this other episode of obstruction, correct?

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A. Yeah. Yes.
Q. You agree with that?
A. Yes.
(Pause.)
Q. And I kind of want to go back. Are you able to say within a reasonable degree of medical probability if he had had an ERCP at the outset of that second admission how much longer he would have been in the hospital?
A. An ERCP -- oh, again, I -- I don't know because I think he was -- he was likely going to end up progressing to ARDS, renal failure just because of how ill he was, so I -- I do wonder if he would have ended up having to go somewhere no matter what.
But I could take a guess that he would go to whatever facility he was going to go to by middle of January. That's a complete guess. Just it would have --
Q. But are you able to say within a reasonable degree of medical probability assuming he even went to another facility in the middle of January how much longer he would have been there?
A. Oh, I don't know.
Q. Are you able to say within a reasonable degree of medical probability even if he had gone to another facility in the middle of January whether -- January, whether he would have avoided some of the complications of confinement such as an MRSA infection like he ended up getting?
A. No, I can't say that.
(Pause.)
Q. Are you able to say within a reasonable degree of medical probability whether if he had had an ERCP at the outset of the second hospitalization before what we're calling the second episode, --
A. Yeah.
Q. -- are you able to say within a reasonable degree of medical probability whether or not he would have avoided post-ERC complications, including death?
A. No.
MS. NOLAN: That's all the questions I have. Thank you so much.
MR. SERPE: Are you done?
MR. HUGHES: Yes.
MS. NOLAN: I'll reserve until the time of trial.
MR. ENGELHARDT: We're done.
THE VIDEOGRAPHER: The time is 5:58 p.m. This is the end of the deposition. We're off the record.
(Whereupon, the deposition concluded at 5:58 p.m.)

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CASE: Zeigler v. Nguyen, et al.
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I have read the foregoing transcript of my deposition, and except for any corrections or changes noted above, I hereby subscribe to the transcript as an accurate record of the statements made by me.

Executed this ____ day of _____, 2017.

_____
BRIAN CARMINE, M.D.



COMMONWEALTH OF MASSACHUSETTS

I, SUSAN LOZZI, Registered Professional Reporter and Notary Public duly and qualified in and for the State of Massachusetts do hereby certify that the foregoing statement is a true and correct transcript of my original stenographic notes.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which this deposition is taken; and furthermore, that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my Notarial Seal this 5th day of March, 2018.

_____
SUSAN LOZZI
NOTARY PUBLIC

My Commission Expires: March 22, 2024.