IN THE CIRCUIT COURT, FOURTH JUDICIAL CIRCUIT
IN AND FOR DUVAL COUNTY, FLORIDA

CASE NO.: 16-2014-CA-004950
DIVISION: CV-G

DEBORAH ANN BISHARA, an incapacitated adult, by and through her attorney in fact, SHAWN W. BISHARA, and VICTORIA A. BISHARA,

Plaintiffs,

vs.

ST. VINCENT'S AMBULATORY CARE, INC., a Florida Corporation, doing business as ST. VINCENT'S CARDIOLOGY, MARIANO B. MIKULIC, M.D., BROOKE L. MCDUFFIE, A.R.N.P., JOSE M. GARMENDIA, M.D., and GARMENDIA MEDICAL ASSOCIATES, LLC, a Florida limited liability company,

Defendants.

1190 Northwest 95th Street
Suite 402
Miami, Florida 33150
9:25 a.m. - 12:17 p.m.
Monday, March 6, 2017

DEPOSITION OF KENNETH FISCHER, M.D., P.A.

Taken on behalf of the Defendants before Catherine L. Pflueger, Registered Professional Reporter, Certified LiveNote Reporter and Notary Public in and for the State of Florida at large, pursuant to Defendants' Notice of Taking Deposition in the above cause.

APPEARANCES:

On behalf of the Plaintiffs

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DEFENDANT'S EXHIBITS

THE COURT REPORTER: Please raise your right hand. Do you swear or affirm that the testimony you shall give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

(KENNETH FISCHER, M.D., P.A.)

DIRECT EXAMINATION

BY MR. KUNTZ:

Q. Dr. Fischer, my name is Bill Kuntz, and I represent St. Vincent's Ambulatory Care, and also known as St. Vincent's Cardiology, and Dr. Mikulic and Brook McDuffie.

Would you please state your full name for the record.

A. Yes, sir. My name is Dr. Kenneth Fischer.

Q. And where are we today here, Doctor? What's the address and what is this?

A. This is my medical office. The address is 1190 Northwest 95th Street, Suite 402, Miami, Florida 33150.

Q. And you are a practicing neurologist at this time, Doctor?

A. Yes, sir, I am.

Q. And you're board certified?

A. Yes, sir.

Q. Are you board certified in anything other than neurology?
A. Yes.
Q. What?
A. By the American Board of Quality Assurance and Utilization Review and credentialed by the American Academy of Pain Management.
Q. Okay. Have you ever done any residencies or fellowships in cardiology?
A. No, sir.
Q. Cardiac surgery?
A. No.
Q. You've never been a nurse, I assume?
A. No, I've not.
Q. And do you hold any teaching positions with nursing schools?
A. No.
Q. All right. In connection with this deposition, we provided a notice of taking deposition with a subpoena duces tecum attached, which has in turn attached Exhibit A, a list of records that are subpoenaed for your deposition.
Did you receive a copy of this through counsel?
A. I saw it this morning from the gentleman

here to my right. I had not seen that prior to today. But I think the only thing I have not complied with, and it's not been intentional, is my original record file I received back in 2013 was placed in storage because the records were old, so I don't have those. The more recent records I received this year are present as well as everything else.

Q. All right. And you've provided us with a current CV for yourself, correct?

A. Yes, sir.

(Photocopy of Fischer Composite Exhibit 1 was marked for identification.)

BY MR. KUNTZ:

Q. And that's marked as Exhibit 1 to this deposition.

Is there any literature or articles that you wrote that are referred to in your CV or otherwise that pertain to the topics you'll be discussing here today?

A. No, sir.

Q. Have you reviewed any literature of any kind with respect to your opinions here today?

A. I have not.

Q. I notice that the last publication that's

at least referenced in your CV is from 1976; is that correct?

A. That is correct.

Q. Since then you haven't done any scientific or medical writing, correct?

A. That is correct, sir.

Q. And you practice here in this office by yourself; is that correct?

A. I do.

Q. And your supporting staff, of course?

A. Certainly.

Q. And which hospital, if any, do you normally practice at?

A. North Shore Medical Center, and for my stroke rehabilitation patients St. Catherine's Rehabilitation Hospital. I also have privileges primarily for teaching at Jackson Memorial Hospital. I also have privileges primarily for teaching at Jackson Memorial Hospital and University of Miami Hospital.

Q. You have appointments there you said?

A. Yes.

Q. That is you can see patients there or admit patients there?

A. No. Not -- I gave those up. I'm an

honorary, but I can teach there and do teach there on a regular basis.

Q. At the University of Miami?

A. Yes.

Q. Do you get paid for that?

A. No, I do not.

Q. When's the last time you've taught there?

A. It will be December -- the last Wednesday in December. My next rotation is scheduled the first Wednesday in April.

Q. And what will that consist of?

A. The Wednesdays I spend there in the clinic at the University of Miami Jackson, instruct the residents in neurology.

Q. You went to -- did your internal medicine internship at University of Miami?

A. I did.

Q. And also your residency in neurology also University of Miami?

A. Yes, sir.

Q. You've been retained to testify on behalf of the plaintiffs in this case and against the defendants; is that correct?

A. Yes.

Q. And can you tell us when you were

retained?

A. I have a ledger that will tell me. I think you wanted that. Let me get that.

I can't seem to come up with that, but I know it was around July of 2013.

Q. Now, you indicated to me that you had a bunch of records that were provided to you back around that point in time but they're not here with you today, correct?

A. That is correct.

Q. And do you have a listing of what those records were?

A. Yes.

Q. Could you tell us?

A. The hospitalization of Ms. Bishara at St. Vincent's Medical Center beginning 12/7/12 and records of Brooks Rehabilitation Center beginning 12/15/12. And the other records I have are present, subsequent records, including those of Dr. Gama and Dr. Chabolla, C-h-a-b-o-l-l-a, and the X-rays which are present, which include -- may I borrow that for a second to --

(Photocopy of Fischer Exhibit 3 was marked for identification.)

BY MR. KUNTZ:

Q. Sure. I'll show you what's been marked as Exhibit 3, which is just going to be a copy of the disk that pertains some imaging.

A. Yes. This was the St. Vincent's imaging between 11/22/12 and 12/15/12, and the more recent Exhibit No. 4, which is Baptist South Imaging including CT head, 1/16/16; MRI brain, 1/7/16; MRA head, 1/9/16; MRI brain, 12/12/16.

Q. And these are the only imaging you've been provided?

A. Yes, sir.

Q. And you were just provided these recently?

A. Yes.

Q. When?

A. I'd say -- well, actually these came in Thursday late. I didn't look at them until late Friday.

Q. So what would that date be?

A. That would be March 3rd.

Q. 2017?

A. Yes, sir.

Q. Had you ever asked for any of the imaging before?

A. I don't recall. I might have. Typically

I like to look at imaging contemporaneous with my review. I just don't recall my discussions with Mr. Sowell back in 2013.

Q. These images that relate to the year 2016, in January of 2016 and December of 2016, do you know why they were taken?

A. No. I did ask for more updated records. I did receive some of Dr. Chabolla. I was informed she'd seen another neurologist and also Dr. Gama. I also was informed she saw another neurologist Dr. Boehm, B-o-e-h-m, but those records have not been received. That may have some explanation of why they were requested.

Q. So you're saying that you did receive records from Chabolla and Gama, but not from Dr. Boehm?

A. That is correct.

Q. You requested them?

A. I did. I had a conference with Mr. Sowell about ten days ago at which time I received these records from Chabolla and Gama. He told me the records from Boehm, I asked for them, but I have not received them.

Q. And with respect to all these images that you were provided, did you review them all?

A. Yes, sir.
Q. Not just the reports, but actual images?
A. I don't have the reports of this latter disk.
(Photocopy of Fischer Exhibit 4 was marked for identification.)
BY MR. KUNTZ:
Q. The Exhibit 4 from 2016?
A. Yes. Just the images themself.
Q. Can I see that Exhibit A again. I'll have the subpoena duces tecum to you today delivered to Mr. Sowell that was supposed to be delivered to you that you're saying really wasn't delivered to you until this morning, correct?
A. That is correct.
Q. And so you have the records that you described that you have here today. And when you were telling me which records you were provided back in 2013, what were you referring to? How do you know what you were provided?
A. I just remember -- looking at my report, I can remember what I had sort of stopped at the time of the discharge from Brooks Rehab.
(Photocopy of Fischer Composite Exhibit 2 was marked for identification.)

BY MR. KUNTZ:

Q. And when you refer to a report, are you referring to this report that we marked as Exhibit 2 dated February 22nd, 2017?

A. Yes, sir.

Q. Okay. Is that the only report that you have in this case?

A. It is.

Q. All right. And tell me what we've marked as Composite Exhibit 2 is?

A. This is my entirety of the chart. Since I saw Ms. Bishara in my office in patient circumstances, I did a regular patient chart on her. The entire contents of that chart are copied here for Exhibit No. 2.

Q. And was February 22nd the date that you saw her?

A. It was.

Q. Okay. And why did you see her?

A. To determine her neurological deficiency and relate that to her circumstances which occurred back in 2012.

Q. And was that done at the request of the plaintiffs' counsel?

A. It was.

Q. How long did you spend with her when you saw her?
A. Hour and 15 minutes.
Q. And obviously she came to your office?
A. Yes, she did.
Q. And who was she accompanied by?
A. Mr. Sowell.
Q. All right. Do you know how she traveled here?
A. Yes.
Q. How?
A. They drove from Jacksonville.
Q. And do you know if they drove back as well?
A. Yes, they did.
Q. Do you know why they drove as opposed to flew?
A. Yes. I asked, because to me it's a long drive. But Mr. Sowell said the connections weren't good. They just felt they might as well go ahead and drive.
Q. And what time of the day did you see her?
A. I think it was initially scheduled for the morning, but I had a conflict. So I think we did it in the midafternoon. If you would like, I could get

the exact time for you.

Q. Well, I take it, if you were scheduled in the morning, they must have driven at least the day before?

A. No. They came in -- no. Initially scheduled in the morning. I had to change their appointment to the afternoon because I had a conflict. So they came, as I recall, sometime around 1:00 o'clock, I believe.

Q. And do you know if they had driven that same morning all the way down?

A. Yes, they had.

Q. Okay. So they left early in the morning and got here about 1:00 o'clock?

A. Correct.

Q. And after your appointment was over, do you know if they went and drove back the same day?

A. Yes, they were.

Q. Just the two of them, no family members or anybody else?

A. No family members with Ms. Bishara, no.

Q. Now, we were provided expert disclosure with respect to your opinions prior to February 22nd, so I'm assuming that you had formed your opinions prior to that date?

A. Yes, that is correct, sir.
Q. And you then saw her on February 22nd. Did that change any of your opinions?
A. Well, no. But it really gave me a much better feeling for her, the specifics of her residual neurological deficiency currently.
Q. All right. But my question was: Did it change any of your opinions? And I think you said, no, it did not change?
A. It did not.
Q. Okay. But nice to see her in person and then be able to put the paperwork that you had seen previously and the imaging together with your actual visual examination?
A. Yes, that is correct.
Q. Okay. But you could have expressed essentially the same opinions that you had even without seeing her; is that correct?
MR. CHAKOUR: Objection.
THE WITNESS: In terms of causation, that is true. In terms of the specifics of her damages, I feel better fortified to discuss that having done a personal examination as opposed to relying on other people's examinations.

(Photocopy of Fischer Composite Exhibit 5 was marked for identification.)

BY MR. KUNTZ:

Q. Now, let's mark this as Exhibit 5.

Were you provided any depositions?

A. No, none.

Q. Did you ask for any?

A. I did not.

Q. When you did -- I take it you did some review in 2013. Had you done any review since then prior to this review you did in February of this year?

A. The initial records I alluded to earlier, the records of Dr. Chabolla, the records of Dr. Gama. Again, my report did not include any discussion of the X-rays because it was issued prior to receiving such.

Q. So I take it did the X-rays change any of your opinions, the imaging studies?

A. No, sir.

Q. With respect to Dr. Chabolla and Dr. Gama's records, I understood you just received those?

A. That was prior to February 22nd.

Q. When?

A. It was probably within a week prior to that.

Q. So it was within -- in February of 2017?

A. Yes.

Q. And were those something you requested or just something you were provided?

A. Way back in 2013 I had requested updated records of the patient's records. They had stopped after the Brooks Rehabilitation discharge, and some of those records were supplied to me in 2017, the ones I mentioned.

Q. I see some underlining or red markings and some stickers, are those things you put on here?

A. Yes, sir.

Q. Okay. With respect to Dr. Chabolla's records in here that's under Tab 1, it says "Office note of Dr. Chabolla, 2/12/13." Is that all you received from -- with respect to Dr. Chabolla?

A. Other than his involvement with her as an inpatient at St. Vincent's in 2012.

(Photocopy of Fischer Composite Exhibit 6 was marked for identification.)

BY MR. KUNTZ:

Q. In Dr. Chabolla's report, which I'll mark as Exhibit 6, you've highlighted it says, "She has

normal strength of the left upper extremity and both lower extremities."

Is that consistent with your observation?

A. No.

Q. Okay. How is your observation different from that of her treating neurologist Dr. Chabolla?

A. I found spastic weakness, which I graded 4+ over 5 in the right lower extremity. I did agree with him that Ms. Bishara exhibited normal strength on her left side.

Q. So it's confined to the right side, any weakness; is that correct?

A. Correct.

Q. And that indicates an injury to the brain of the left side; is that correct?

A. It does, sir.

Q. And indicates no injury to the right side of her brain, correct?

A. Well, at least the strength would not be indicative of that.

Q. Okay.

A. She has other things which are indicative of bilateral involvement.

Q. Are they outlined in the report that you just prepared?

A. Yes, sir.

Q. Okay. What are they?

A. Namely, her reflexes were excessive bilaterally, although asymmetrically to the right.

Q. What does that mean? Would you explain that?

A. Oh, sure. When a patient has their reflexes examined, the patient is seated on examining table and the doctor, neurologist typically, has a hammer and taps several reflexes both the arms and legs. And there is a grading system of zero to 4. Zero being absent, which is typically not normal; 4 being grossly excessive.

And the patient, Ms. Bishara, exhibited 3+ reflexes on the left and 4+ on the right, so both are abnormal although asymmetrically so to the right side, which means that she had bilateral cerebral dysfunction more pronounced in the left side of her brain.

Additionally, as part of the examination, the neurologist performs what are called cortical release signs. When a baby is born, the baby has rooting and sucking and snouting reflexes, which are primitive reflexes secondary to disinhibition of the frontal lobes. As a person ages, the frontal lobes

become more developed and those reflexes dissipate, typically by age three, and they should not return.

However, in senescence, they can return or with pathological conditions, conditions like stroke, brain tumor, multiple sclerosis, Lou Gehrig's Disease, Parkinson's and Alzheimer's.

Ms. Bishara is, when I examined her, 55 years of age. So a person of that age should not exhibit these reflexes, but she had the whole consortium of them, although, again, asymmetrically to the left side of her brain. She had specifically a snout, jaw jerk, glabella, and a right palmomental sign, which again were indicative of left-side dysfunction. And a right Hoffman sign again indicative of left cerebral dysfunction. So these reflexes are indicative of the patient having bilateral brain disease more pronounced on the more affected left side of her brain.

Q. Now --

A. Let me --

Q. I'm sorry. I thought you were finished.

A. There's just one other issue, her gait was a spastic ataxic gait bilaterally more pronounced on the right side. So, again, there's an asymmetry to the presentation exhibited by Ms. Bishara, but there

is involvement of both sides of her brain, again, the left side of her brain affecting the right side of the body having more pronounced defect.

Q. And is what you highlighted here from Dr. Chabolla, who I guess was her treating neurologist both in the hospital during the December 7th admission and at least up through February of 2013, he didn't find those same things at that point in time, correct?

A. May I borrow that back?

Q. Sure.

A. I'll see what he -- there is a difference between his exam and my exam to be sure.

Now, he did not do as intricate examination on 2/13/13 as I did on 2/22/17. So I can't compare them completely. But I found I had findings listed, but he did not discuss.

Q. Okay. And he did not -- also did multiple exams back in the hospitalization in connection with the December 7th, 2012, admission as well, correct?

A. He did.

Q. And he didn't find any of these things you found during those multiple exams either, did he?

A. Well, you said he didn't find them much for he looked for them. You see, I mean, the

documentation does not demonstrate the performance one way or the other. So he may not have sought them; therefore, he didn't document them. I don't know if he just didn't find them or whether he just didn't do those parts of the examination I did.

Q. A neurologist doing examinations of a patient like this should be doing those examinations, shouldn't they?

A. They should, but doesn't mean they necessarily do.

Q. All right. So -- but I just want to make sure. In all the examinations Dr. Chabolla did in 2012 and a year later in 2013, he did not find these things that you find existing in February of 2017; is that correct?

MR. CHAKOUR: Objection.

THE WITNESS: That's correct. But also take note that during the time of the earlier examination, the patient was poorly responsive, could not cooperate with the kind of testing I performed in 2017. She was not able to do that.

BY MR. KUNTZ:

Q. Well, she was in December of 2013, wasn't she, Doctor?

A. Yes.
Q. Okay. Because that was a year later.
A. Yes.
Q. Okay. So that doesn't explain any differences between 2012 and 2013 and now February 2017, does it?
MR. CHAKOUR: Objection.
THE WITNESS: Well, again, the differences may be that he didn't do the things. In other words, frankly, I do a very thorough examination of my patients, probably more than most people do.
And certainly I just had one chance to see this lady coming from 400 miles away. So I was going to take my time, do every little intricate thing, which may not be done in a routine follow-up visit, 15 minutes by a neurologist who's seeing a patient on a regular basis.
That may explain the difference between his examination and mine. The length of it was much more substantial in mine than his. I'm not criticizing him. He's seeing the patient for follow-up. Those little things don't make that much difference in terms of

what he's doing. It makes a difference in what I'm doing.

BY MR. KUNTZ:

Q. And what you're doing is examining so that you can testify in court against the defendants in this case, right?

MR. CHAKOUR: Objection.

THE WITNESS: I wouldn't put that. I'm examining so I have a good understanding of the patient so I can convey it appropriately to you or anybody else.

BY MR. KUNTZ:

Q. I understand, but you're not a treating physician of Ms. Bishara, are you?

A. You are correct, I am not.

Q. You're hired to be an expert and testify in the case against my clients, correct?

MR. CHAKOUR: Objection.

THE WITNESS: Yes, I am.

BY MR. KUNTZ:

Q. Okay. Now, would it be correct that you have not spoken to any of the treating physicians involved in this case?

A. That is correct, I have not.

Q. And, obviously, you've talked to

Mr. Sowell, the counsel for the family, correct?

A. Yes, sir.

Q. And he has another lawyer named Mr. Scott. Have you spoken with Mr. Scott?

A. No.

Q. And, of course, you've spoken with your lawyer here today?

A. He's not my lawyer, but I spoke with him, yes.

Q. Okay. How many times have you spent -- have you talked with these various attorneys prior to testifying here today?

A. Okay. I spoke with Mr. Sowell back in 2013 for a period of 15 minutes. I spoke with Mr. Sowell in 2017 for half an hour. Mr. Sowell was in attendance of my examination on February 22nd, 2017. I spoke with his associate here this morning briefly prior to our deposition. So I guess if you include all those things, it would be four times.

Q. You mean, during your medical examination of Mrs. Bishara, the lawyer was here for an hour and 15 minutes.

A. Yeah, yeah. I told you. I mentioned that earlier, yes.

Q. I didn't hear that.

A. Yes. He drove her here.
Q. That's pretty unusual to have a lawyer sitting in during a medical examination of a patient, isn't it?
MR. CHAKOUR: Objection.
THE WITNESS: Not at all.
BY MR. KUNTZ:
Q. It's common for you?
A. Most of the times I do CMEs and almost always the -- the plaintiff's lawyer is sitting in while I'm doing the CME. It happened Friday, as a matter of fact, so it's not unusual at all.
Q. These are all when you're involved in litigation, correct, not patient care?
A. That is correct.
Q. Did you speak with the lawyer during your examination?
A. He was a passive observer.
Q. No. My question is, did you speak with him during the examination?
A. I said hello, and he mentioned to me he had driven in, and he watched me examine her, but he didn't say anything otherwise.
Q. Do you have your billing in connection with this case? That was one of the things --

A. I did. But I can tell you exactly what it is point by point.

Q. Okay. Where is it?

A. I can get it for you. It's not that much, so I can tell you. There's a $1,000 charge for the initial record review. That was back in summer of 2013.

Q. Is that just a flat rate that you do initial records review for?

A. No. It was $500 an hour; it was two hours. It was $200 charge at the same time frame for a conference, 15 minutes with Mr. Sowell. There was a $400 charge for a conference, half an hour, I had with Mr. Sowell in February of this year. There was an $800 charge for the examination I conducted of Ms. Bishara on February 22nd, 2017. And there was a $625 charge, which is not in my records yet, but I can tell you I did over the weekend, included my review of the materials and the X-rays, which we discussed earlier.

Q. Okay. And that's what all your records would show?

A. Yes. Well, the records don't have this last $625 charge, but everything else I've discussed, they do.

Q. Understood. So it sounds like you charge $500 an hour for your review and you charge $800 an hour for other stuff; is that right?

A. Yes, sir, that is correct.

Q. So for the honor of me speaking to you today, what are you charging my clients?

A. $800 an hour.

Q. So if you're talking to the plaintiffs' counsel or to me, it's $800 an hour?

A. It is, sir.

Q. And if you come to trial, how much would that be?

A. Flat fee of $5,000.

Q. I have had the opportunity to see a lot of testimony you've given in other cases. And I gather from that that you have served as an expert in medical malpractice cases hundreds of times; is that correct?

A. I think that's fair.

Q. And that is probably in excess of 400 cases. Would that be fair?

A. I don't know that. I don't have the count, so I can't answer that question. It's in the hundreds. Whether it's 300 or 400, I do not know.

Q. And the bulk of your work is on behalf of

plaintiffs in cases?

A. In medical negligence cases, that is true. In other kinds of cases, it is not.

Q. Yes. I'm just asking you about medical negligence cases. You usually are testifying for plaintiffs against healthcare providers, correct?

A. That is true. At the current time, the last 10, 15 years, that is accurate.

Q. And, in fact, you've testified against healthcare providers throughout the state of Florida; is that correct?

A. Yes.

Q. That would include Tampa?

A. Sure.

Q. Lakeland?

A. Yes.

Q. Miami?

A. Oh, yes, many times.

Q. Ocala?

A. Yes.

Q. Jacksonville?

A. Yes.

Q. Hillsborough County, Tampa area?

A. Yes.

Q. And other parts of the state, right?

A. Yes, that is correct.
Q. And you testified against healthcare providers in the state of Texas many times, have you not?
A. Not recently. But I'd say overall I've been to Texas four -- I'd say five or six times over 30 years.
Q. You say "been there," that means you've been there to go to trial?
A. Yes.
Q. Okay. And in addition to that, you've reviewed and given depositions in many other cases besides the times that you went to trial?
A. Not many, but some, yes.
Q. All right. And many in Massachusetts as well?
A. Many in Massachusetts, yes.
Q. And many in the state of Ohio, correct?
A. Yes.
Q. And in New Hampshire?
A. Yes.
Q. And in North Carolina?
A. Yes.
Q. And in San Francisco, California?
A. No. One case in San Francisco, which was

a motor vehicle case. I gave a deposition, but I never went to trial there.

Q. All right. And in Georgia it was with respect to medical malpractice cases where you've testified against healthcare providers?

A. I have.

Q. And in Kentucky?

A. Both for and against in Kentucky.

Q. And in Michigan?

A. I've never been to Michigan, but I have testified in deposition in about five medical malpractice cases in Michigan.

Q. Against healthcare providers?

A. Yes.

Q. And in Maryland?

A. Yes.

Q. And in New York?

A. Yes.

Q. And in Illinois?

A. Yes.

Q. Including Chicago, Illinois?

A. Correct.

Q. And in South Carolina?

A. Illinois I also had one as a defense witness.

Q. One, okay. And in South Carolina?
A. By deposition only, not in trial.
Q. And West Virginia?
A. One case in deposition, not in trial.
Q. And Pennsylvania?
A. No. I had a -- I had one motor vehicle case, but not --
Q. Not a medical case?
A. No.
Q. All right. Except for the clarifications you've made, the rest of them were all medical malpractice cases, right?
A. Yes.
Q. And one of the things I asked you for in the subpoena are a list of cases?
A. That I have right away.
Q. All right.
A. This is a three-year list from 2014, 2015, 2016.
MR. KUNTZ: All right. Thank you. I'll have that marked as an exhibit.
BY MR. KUNTZ:
Q. Have you ever been hired by counsel in this case, plaintiffs' counsel in this case, for other cases against healthcare providers?

A. I have.
Q. How many times?
A. I'm guesstimating four or five times other than this case.
Q. Okay. And against healthcare providers, hospitals and others in the Jacksonville, Florida, area?
A. Yes. It was in Jacksonville or it's one of the St. Augustine county area, those two areas.
Q. Okay. And you have brought criticisms and testimony against the Baptist system hospitals up there, haven't you?
A. Yes, sir.
Q. And the St. Vincent's system of hospitals up there?
A. Yes.
Q. And Memorial Hospital up there?
A. Yes, sir.
Q. Any others?
A. Not that I recall, sir.
Q. All right. And down in St. Augustine, do you recall what healthcare providers or hospitals you were critical of there?
A. I do not know the name of the hospital.
Q. Would it have been Flagler?

A. Yes, I think so.
Q. Okay. Are there any up there that you haven't been critical of?
MR. CHAKOUR: Objection.
THE WITNESS: Any of the hospitals? I'm sure there are other hospitals in Jacksonville besides those, but those are the ones I recall being involved with.
BY MR. KUNTZ:
Q. How about the Shands Hospital or the UF hospital up there? It used to be called University Medical Center. It's had different names.
A. There was a case against Shands. I'm not sure it was the Shands in Gainesville or the Shands in Jacksonville, but it was not with Mr. Sowell. It was with a different attorney.
Q. Okay. Do you know how Mr. Sowell got linked up with you in these five or six cases that you've done with him?
A. No, sir, I do not.
Q. How many years have you been serving as an expert in the kind of cases we're talking about?
A. Since 1979.
Q. And what percentage, roughly, of your professional time do you devote to doing this work

as opposed to patient care?

A. You say "this work," you're talking about medical negligence or nonmedical activities?

Q. Well, let's say medical negligence.

A. Okay. I'd say 6 percent of my time is involved with medical negligence matters.

Q. And what percentage of your income is with respect to medical negligence?

A. The same percentage, more or less.

Q. Same percentage?

A. Yes, sir.

Q. That would suggest that you get $800 an hour for being a neurologist; is that right?

A. I earn pretty close to that doing the work that I do, yes.

Q. How many hours do you work?

A. I work every day about 16 hours.

Q. Sixteen hours every day?

A. Yes. Some days on Sundays I may take a little bit less. But Monday through Friday more or less 16 hours a day.

Q. Is that patient care except for the medical negligence work?

A. The whole composite of things. I'll be glad to discuss them if you'd like.

Q. Well, what percentage of other things do you do other than patient care?

A. Charity work, teaching. There's a company I run, which is unrelated to medical care, my late wife's company. I have certain responsibilities there I get involved with with Dade County.

Q. What kind of -- what's the general work of that company?

A. It's a social service concern. It evaluates social service products -- projects for the county.

Q. So of 100 percent of your business time, professional time, how much of it is devoted to patient care?

A. Overall 80 percent is patient care. I see a lot of patients.

Q. Okay. So the other 20 percent is other stuff?

A. Yes, sir.

Q. So 80 percent of 16-hour days would be 12 or 13 hours a day doing patient care, correct?

A. That's typical, yes, sir.

Q. And that's six days a week or maybe more?

A. No. That's Monday through Friday. I have no office hours on Saturday. So it would be fewer

number of hours on Saturday and Sunday, just hospital rounds.

Q. So just five days a week, not even counting the weekends, that's 60 hours of patient care a week or medical/legal work?

A. Sixty hours, yeah. Typically, I have 9:00 to 5:00 is outpatient, and I see patients typically 7:00 to 9:00 and then 5:00 to 6:30 or 7:00, so I'd say that's my patient care time allotment other than when I'm like with you today.

Q. You're not relying on any textbooks or any written materials, other than what we've talked about already; is that correct?

A. That is correct, sir.

Q. Do you have any transcripts of the testimony from the cases that are listed in Exhibit 6 here?

A. Only if it's gone to deposition, hasn't gone to trial, I retain them until such time it goes to trial, so I can't -- let's see. I'm looking at -- these are old ones. Actually, let's see.

Do you want me to go over each one? I can tell you most of these have settled and the stuff is shredded. I see one case which is still existing, which I was deposed on. I probably still have that

deposition.

Q. Well, that was just one of the things covered on the subpoena is transcripts of your prior testimony.

A. It would be very hard to access them because I would have to go each individual case.

Q. Okay. In any event, you did not bring any of those transcripts with you here today?

A. No, sir.

Q. Okay. And you didn't even know they were asked for until this morning, correct?

A. That is correct, sir.

Q. All right. Let's go ahead and move those aside. I want to go back to these records that you were provided recently. We've talked about Dr. Chabolla's, and then we have this list or a stack of documents. I think you said these are all Dr. Gama's records from what you understand --

A. Yes, sir.

Q. -- and you've reviewed all these?

A. Yes, sir.

Q. And there are lots of markings, red underlining of things. Is that all yours?

A. Yes, sir.

Q. All right. And then there's a -- I don't

know why there's a rubber band around part of them. Do you know?

A. I think it was separated out. I separated out from other records. I'm not sure.

Q. Okay.

A. I don't recall why.

Q. And there's some stickers on some of the pages. That's something you put on there as well?

A. It is, sir.

Q. Are you aware of whether or not Mrs. Bishara has suffered any further neurological problems separate and apart from those that she had in December of 2012 since December of 2012?

A. Well, she has the aftermath of that, which requires neurological care. I think you're suggesting that she had some new neurological problems.

Q. I'm asking if you are aware of any.

A. No.

Q. Okay.

A. I think she was evaluated for such, but I don't think they found any new structural neurological process.

Q. When do you think she was evaluated for those --

A. If I could borrow that, I could probably tell you exactly. Thank you, sir.

The answer is, I don't see any new neurological process described in these records of Dr. Chabolla we discussed before, nor Dr. Gama.

But something of note, which I'm not sure I like to comment on now, but of interest, in reports of Dr. Gama, he notes, similar to me, that the patient has bilateral hyperreflexia more pronounced on the right side.

Q. When was that?

A. Several occasions. For example, his visit of 1/24/17, which is not far removed from mine, there's only about four weeks' difference, he mentions the same exact findings I had documented.

Q. Okay. And when did Dr. Gamma's records start in terms of time earliest?

A. I see a visit here of 5/29/13. I think that's the earliest visit I have.

Q. At that time did he notice bilateral hyperreflexia that he noticed in January of 2017?

A. I will verify that in a second. He does note on that visit right-side weakness, arm greater in the face, greater in the leg. So he did indeed note right leg weakness on that visit.

And he also notes on that visit reflexes were increased in the upper and lower extremities, worse on the right, which is symmetrical with my visit, not consistent with Dr. Chabolla in a very similar time frame.

MR. KUNTZ: I believe I noted -- marked earlier Dr. Chabolla's records. Does anybody know if we did or didn't?

THE WITNESS: You did. That packet you did mark. It was one packet that had all Dr. Chabolla's and Dr. Gama's records.

MR. KUNTZ: All right, Doctor. I don't think I marked Dr. Chabolla's record that you had earlier with your red highlighting on it, so I'm going to mark that as Exhibit 7 now. And then these Dr. Gama's records that we were just talking about I'll mark as Exhibit 8.

THE WITNESS: Good enough.

(Photocopy of Fischer Composite Exhibit 7 and 8 were marked for identification.)

BY MR. KUNTZ:

Q. Let me show you an imaging report of a CT angio from Exhibit 8, Dr. Gama's records. The report is dated 8/20/2015 consisting of three pages.

You put a sticker on that. I want you to

tell me why that one was of interest to you.

A. Well, it was interval study after the studies she had at St. Vincent's in 2012. I was interested in seeing if there had been any changes in her status demonstrated on that study.

Q. And were there?

A. No. It was well consis- -- well, actually the only thing I can say is my recollection it had the same degree of stenosis on the left side and perhaps slightly increased degree of stenosis on the right as compared to the previous study. Other than that, no. But the degree of stenosis on the right was not critical; the one on the left was more significant.

Q. What were the degrees?

A. Sixty on the right, 70 on the left. Seventy is considered the cutoff from being clinically significant.

Q. And this is a stenosis or narrowing of what?

A. The carotid artery.

Q. Do you know why they did that study in August of 2015?

A. It says, "Rule out occlusive disease." Now, Ms. Bishara's an individual with factors

suggesting development of large vessel stenosis, and it's appropriate for a neurologist following her to determine if there's any increasing degree of disease, which would require any intervention.

So I'm surmising that is the reason why Dr. Gama requested those studies.

Q. The factors you referred to, would they be fairly characterized as risk factors for heart and other vascular diseases?

A. Yes, sir.

Q. What are they that she had?

A. Hypertension, dyslipidemia.

Q. What's that?

A. Dyslipidemia, high cholesterol of the lipids. Diabetes and family history of antecedent cardiovascular and cerebral vascular disease.

Q. Is that something you looked into, the family history?

A. Yes.

Q. What did you find?

A. Stroke and heart attack in her heritage.

Q. Where?

A. Mother -- let me see specifically. I think both sides of her family, as I recall.

Q. What about her siblings; did you take any

history with respect to the vascular diseases, if any, that her family suffered from?

A. Yes.

Q. Her brothers and sisters?

A. Yes. Hypertension and diabetes were often in them, and cardiac disease as well.

Q. Did she have all those risk factors before December -- well, in November of 2012 when she had her triple bypass surgery?

A. She did.

Q. And she, I assume, continues to have all those?

A. Yes. Now, one other risk factor she had was tobacco abuse. She no longer has that, but she did at the time of this incident.

Q. And up until the time that she had the triple bypass, do you know how long she was an abuser of tobacco?

A. Many years. I don't remember. I don't think she told me exactly the number of years, but it was a substantial number of years.

Q. Okay. And did she tell you the degree of -- I take it that's what you call a smoker, an abuser?

A. Yes.

Q. How many -- how much she smoked?
A. More than a pack a day.
Q. Is that substantial?
A. Yes.
Q. Maybe better question is, is it medically significant?
A. Yes.
Q. In what way?
A. Tobacco abuse increases the risk of cardiovascular and cerebrovascular disease. I can talk with some authority on cerebrovascular disease, it raises the risk of stroke by a factor of two.
Q. And prior to the time that she had the triple bypass in December of -- excuse me, November the 20th, I believe, of 2012, do you know if her disease caused her to need and receive any other interventional treatment?
A. Prior to -- I believe she had a stent put in before the events of winter of 2012.
Q. And when you say "stents," could you tell us what you're talking about?
A. Cardiac stents.
Q. So what are they for?
A. To avoid occlusion of the coronary arteries.

Q. Is that only done when there's a very large blockage in the coronary arteries?

A. Yes.

Q. Do you know what is the percentage of a coronary artery that exists before stents are place?

MR. CHAKOUR: Objection.

THE WITNESS: That would be getting beyond my capabilities as a neurologist. I understand, but I'm not speaking as an expert, so I'd rather not answer. I'd refer to a cardiologist in making that determination.

BY MR. KUNTZ:

Q. And I appreciate that and understand what you're saying. But based upon your understanding, and I understand you're a neurologist and not a cardiologist, but earlier you talked about what was significant with respect to carotid artery blockages, correct?

A. Yes, sir.

Q. So with respect to coronary artery blockages, what do you think is significant?

MR. CHAKOUR: Objection.

THE WITNESS: My understanding is 70 percent or greater is considered a level requiring intervention. But, again, I would

defer to a cardiologist in terms of exactly that determination.

BY MR. KUNTZ:

Q. I think you said smoking for a long period of time, to the degree at least that she smoked for a long period of time, would double a person's risk of stroke; is that right?

A. Yes.

Q. When you add in the other risk factors that you described that she has with the family history of -- on both sides, and her siblings and her high cholesterol and I think you said diabetes; is that right?

A. Yes.

Q. When you put all those together, how many multiples of a risk would she have for a stroke?

A. I would estimate that she had eight-fold increase of stroke compared to the average person with none of these risk factors.

Q. So for a similarly aged person back in 2012, she had 800 percent -- she was 800 percent more likely to have a stroke?

MR. CHAKOUR: Objection.

THE WITNESS: That would be my estimation. That being said, at the time of the incident,

she was only 50 years of age, so that still is a relatively small risk of stroke, but reticent person, most people her age are the reasons I expressed.

(Brief Interruption.)

BY MR. KUNTZ:

Q. Are you familiar with a Modified Rankin Scale?

A. Yes, sir, I am.

Q. What is it?

A. It's a scale used for research purposes and also for rehabilitation purposes to determine a patient's status neurologically after a neurological process, typically, stroke, although not exclusively stroke. It goes from zero to 5, zero being totally normal, 5 being basically wiped out, total care, bedbound and so forth.

Q. Well, would it be fair to put a Modified Rankin Scale on Ms. Bishara; in other words, would she be the kind of person you could apply that scale to?

A. Sure. She's a stroke victim or similar ischemic hypoxic encephalopathy victim, so, yes, it could be utilized in her.

Q. What would you rank her?

A. Okay. Let me look at my report and I can answer that question. I would assess her as a high 2, low 3.

Q. Okay. And I've got a description here, and I want you to tell me whether you agree with these descriptions. But a 2 would be a -- excuse me -- a 3 would be moderate disability requiring some help but able to walk without assistance?

A. That would be indicative of her. I don't think she had a cane with her. Let me look at that. Yes, that would be fair.

Q. And a 2, which you said she would be in your view a high 2 is -- would you agree with the description of slight disability, unable to carry out all previous activities, but able to look after her own affairs without assistance?

MR. CHAKOUR: Objection.

THE WITNESS: Yes.

BY MR. KUNTZ:

Q. Have you, in the course of your career, had other patients who had an event of some sort that left them in a condition similar to Ms. Bishara?

A. Many times.

Q. Hundreds?

A. Yes.
Q. Thousands?
A. Probably so.
Q. Okay. That you would rank, if you were asked, in the similar range of high 2, low 3 Modified Rankin score?
A. Yes, sir.
Q. None of those people require full-time attendant care, do they?
A. Some do; some don't, depends on their cognitive aspects.
Q. Of their what?
A. Cognitive aspects. In other words, Ms. Bishara can walk unassisted albeit with some abnormality. But her cognition is significantly impaired. In other words, her cognition is disproportionately affected compared to her motoric status. She's ambulatory, but significant reduction of cognition, which is concerning for her ability to be giving self-care.
Q. All right. Well, I've watched her for a couple of hours being questioned by lawyers. Did you have the benefit of looking at that deposition --
A. I've seen no depositions in this matter.

Q. Well, in the one that I saw, she was able to understand every question asked to her and give a response to --

MR. CHAKOUR: Objection.

BY MR. KUNTZ:

Q. Would that be consistent with what you saw?

MR. CHAKOUR: Objection.

THE WITNESS: No. She had some difficulty in carrying out some requests during the exam. She had some aphasia, some reduction of comprehension, some inability, some apraxic tendencies. So the answer is no.

BY MR. KUNTZ:

Q. Okay.

A. Superficially, other than her voice being very affected, she doesn't look that bad when you do formal testing on her. I don't know if she's had formal neuropsychological testing. But just doing a Mini-Mental Status score, she had a score between 22 and 24, which is a substantial reduction of one should have.

Q. What's the norm under that scoring system?

A. Normal, 30.

Q. Okay. And what do you call that?

A. It's the Folstein, F-o-l-s-t-e-i-n, Mini-Mental Status Examination.

Q. Is that a written or verbal?

A. It's in the packet that you have. What I do is I have a 30-question sheet. I asked her questions as we go.

Q. Oh, okay. I see, yeah.

A. Now, she had -- reason two, I could not score the last two numbers, so I gave her credit for it. In other words, she had a score of 24, but it's really only 22 out of 28. She didn't have two things because of her inability to write. She could not write a sentence, nor could she copy a figure.

Q. Is this your numbers that you put on the right there?

A. It is, sir.

Q. Okay. And the other writing on this --

A. That's all mine.

Q. -- page within Exhibit 2, that's all your handwritings?

A. It is, sir.

Q. All right. Did she write anything at all in connection with your visit?

A. No. She could not.

Q. With respect to the new-patient profile,

who filled that out?

A. I think she dictated to my assistant. She couldn't write.

Q. All right. Looks like she gave a signature on one of your consent forms, although it was I'll say shaky looking, for lack of a better description?

A. Yes, that's right.

Q. Was she pleasant during your interview and examination of her?

A. I'm sorry?

Q. Was she pleasant?

A. Oh, very pleasant, yes.

Q. Did you talk to her at all about the things that she enjoys doing?

A. Yes.

Q. And what did she tell you?

A. Well, she used to like to go out to dinner. She used to like to --

Q. No. I'm talking about now.

A. Now?

Q. Yes.

A. Now she feels very restricted. She can't drive. Her balance is impaired. She's afraid. Her vision is impaired. Her strength is impaired. She

feels clumsy. Afraid of falling. She feels uncertain about her thinking. She feels confused. Feels depressed. So she does not feel -- she's not a happy camper now, sir.

Q. Okay. So she doesn't enjoy anything?

A. No.

Q. Okay. Have you ever had any other cases of these, I think you estimated three or four -- you didn't know if it was 300 or 400 cases you've worked on that involved a patient who suffered a neurological injury that you related to having postop pericardial tamponade? Have you had any other cases like that?

A. The answer is I don't recall any such case.

Q. Have you had any other cases that you've been involved in, in the hundreds you've been involved in, where a patient had postop pleural effusion?

A. Maybe they had them, but was not part of the neurological issues. In other words, the answer is, no. In other words, I was not testifying in terms of any neurological ramifications of a pleural effusion.

Q. I take it you've taken care of many

patients who have had cardiac bypass surgeries?

A. Oh, sure.

Q. Okay. And do you know if any of those patients that you've taken care of that had cardiac bypass surgeries had pleural effusions or pericardial effusions after the surgery?

A. Yes.

Q. Would you agree that that's a very common thing to have after open heart cardiac bypass surgery?

A. You say very common. I don't know the answer to that question. I only see them if they have neurological ramifications, so I couldn't answer that question in an expert manner.

Q. Okay. So you've seen a number of patients after bypass surgery who have had effusions?

A. Yes.

Q. Okay. Either pericardial or pleural or both?

A. Yes.

Q. And do you know anything about what is the most common course with respect to postoperative pleural and pericardial effusions?

MR. CHAKOUR: Objection.

THE WITNESS: Most often they resolve

spontaneously. That's my understanding.
Again, we're getting beyond my expert abilities here. Just my personal exposure, whether that's reflective of the literature or not, I do not know.

BY MR. KUNTZ:

Q. Okay. Have you ever had a patient who a week or more after open heart surgery had a tamponade from an effusion of any kind?

A. I do not recall that specific occurrence, no, sir.

Q. Do you use -- make use of CT scanning in your practice and care of patients?

A. Of course.

Q. And the same for MR scanning of various types?

A. Yes, sir, I do utilize that technique.

Q. And would you agree that typically it takes six hours for a CT scan to demonstrate an acute stroke?

A. Usually, although not always, that is accurate, yes.

Q. Now, do you know whether or not a CT was done after -- well, let me back up.

What is your understanding of the time

that Mrs. Bishara on December the 7th of 2012 suffered any kind of event that resulted in lower than normal oxygenation for her?

A. That event was sustained approximately 1:00 p.m. on the date in question.

Q. And what do you base that on?

A. The documentation in the chart that she had a Code Blue.

Q. Okay. And is that the chart that you don't have with you anymore, it's the one from 20 -- that you were provided back in 2013?

A. Yes, sir.

Q. You just remember that from that chart or how do you --

A. I looked at it the other week. It was brought back to my office from storage. I reviewed it. My assistant dutifully put it back to storage, but shouldn't have done that, but I did review it just a few weeks ago.

Q. Okay. And is it your opinion that it is the time of that approximately 1:00 p.m. on December 7th, 2012, that caused Ms. Bishara to have any neurologic impairments that you believe she has today?

A. Yes, sir, it is.

Q. Okay. And if the start time was around 1:00 o'clock, and I take it you're referring -- I think there was a code sheet somewhere in that time zone. Is that what you're referring to?

A. Yes, sir.

Q. And you recall that after that or during the course of that, there was the pericardiocentesis done?

A. Yes.

Q. And that then sometime shortly after that she was taken for emergent surgery, open surgery?

A. Yes, sir.

Q. And I think that was called a pericardial window, if I'm using the term right?

A. Yes, you are.

Q. And that was somewhere in the 2:00 o'clock zone on that day?

A. Yes.

Q. Okay. Now, is it your opinion that whatever injury that Mrs. Bishara currently has, from a neurological perspective, is attributable to that time period from 1:00 to 2:00 p.m. on December 7th?

A. That is my opinion.

Q. Okay. And do you have any opinion as to

whether or not she had any neurological event that caused injury to her prior to that time that is 1:00 p.m. on December 7th?

MR. CHAKOUR: Objection.

THE WITNESS: I see no indication of that.

BY MR. KUNTZ:

Q. Okay. And do you have -- and is that an opinion you have within medical probability?

MR. CHAKOUR: Objection.

THE WITNESS: Yes, sir.

BY MR. KUNTZ:

Q. And with respect to the -- after, say, 2:00 o'clock p.m. on December 17, was there any neurological event or event of any kind that caused neurological injury to Mrs. Bishara in your opinion?

MR. CHAKOUR: Objection.

THE WITNESS: After the 2:00 o'clock time frame?

BY MR. KUNTZ:

Q. Yes.

A. No. It's my opinion that the majority, if not the entirety, of her neurological deficit is related to the events in the 1:00 to 2:00 p.m. time frame on 12/7/12.

Q. Okay. And you're not aware of any injury

after 2:00 o'clock p.m., any event that -- let me start over. That's such a poor question.

Is it your opinion, within a reasonable degree of medical probability, that she did not have any event after approximately 2:00 o'clock p.m. on December 7, 2012, that resulted in any neurological impairments that she has today?

A. I saw no such other events.

MR. CHAKOUR: Objection.

BY MR. KUNTZ:

Q. Okay. And so is that your opinion within a reasonable degree of medical probability?

A. Yes.

Q. Are you aware of whether or not she was hospitalized at any time after December of 2012 for a stroke or suspected stroke?

A. I do not have records of any hospitalizations, so the answer is I don't believe -- let me look at the records of Dr. Gama and specifically to see if he alludes to any such hospitalizations.

Q. All right. So I'm handing you back Exhibit 8.

A. Thank you, sir.

MR. KUNTZ: You're welcome to answer that,

Doctor.

THE WITNESS: I'm in the middle of a deposition. I'll speak to you later.

I'm sorry.

MR. KUNTZ: No problem.

THE WITNESS: Now, Dr. Gama alludes to, in his visits of 3/29/16, he says that she is post hospitalization in January, revisit secondary to dehydration, renal insufficiency with no evidence of recurrent strokes.

So apparently, she had a hospitalization and there was some change in her status, but Dr. Gama at least concluded there was no new stroke, but rather it was secondary to metabolic factors superimposed on her previous strokes. I do not have records of that hospitalization to discuss in more detail.

Otherwise, again, I don't have the entirety of her records of hospitalizations, and I've asked for other records from Dr. Boehm, who also has seen her, but I don't see any indication of a new stroke in a time frame after 2012 to the present.

BY MR. KUNTZ:

Q. Do you have any opinions as to the cause

of the -- of any neurological injuries that you believe she suffered between that 1:00 p.m. and 2:00 p.m. time on December 7th?

A. Yes. Ms. Bishara -- I'm sorry. I'll let you finish.

Q. What is your opinion?

A. During that interval, Ms. Bishara sustained a so-called hypoxic ischemic injury. She had a lowering of her blood pressure. She had insufficient cardiac output. She was in asystole for a significant period of time, which was measured by some observers as 14 minutes. And she had asymmetric bilateral cortical process develop. Asymmetric likely because she had antecedent disease particularly in the left internal carotid artery system which subjected her to greater potential insult in her dominant left hemisphere.

So the brunt of the deficiency was in the left middle cerebral artery circulation. But it was not a typical arteriosclerotic stroke, but rather one induced by reduction of blood flow because of her cardiac insult.

In other words, if a person has some stenotic disease of an important vessel as the carotid artery and one is subjected to hypotension,

reduced cardiac output, that particular area of the brain will have a greater propensity to be damaged. That explains the significant asymmetry in Mrs. Bishara's presentation then, and it's remained that way to the present.

Q. By significant asymmetry, you're saying substantially more injury to the left side of her brain resulting in more impairments on the right side of her body?

A. Yes. As well as cognitive, because her being a right-handed individual, her speech and cognitive function would be disproportionally affected on the left side of her brain, which was indeed the area of the brain that was involved most substantially.

Q. And you explain this substantial asymmetry with damage to the left side of the brain resulting in right-side deficits by reason of what you claim is a greater blockage or stenosis of the left internal carotid artery?

MR. CHAKOUR: Objection.

THE WITNESS: Yes, sir.

BY MR. KUNTZ:

Q. Okay. And what do you base that on?

A. They did testing just to measure the

patency of the left internal carotid artery and found it to be 50 to 70 percent stenotic.

In fact, her treating neurologist at that time, Dr. Chabolla, had a similar conclusion. He stated in his visit of 2/13/13, he discussed her findings and said she had, quote, a left middle cerebral artery territory ischemia after her cardiac decompensation with hypotension.

Q. All right. My question is more about, is -- what is -- let me start over.

What is your basis for the conclusion that there was a greater blockage of the left internal carotid artery as opposed to the right internal carotid artery?

A. She had carotid studies done at that time demonstrative of such.

Q. Okay. And is that one that you claim showed that she had a 50 to 70 percent, you call it a blockage or stenosis?

A. Yes.

Q. Stenosis, okay.

A. This was a carotid ultrasound of 12/11/12.

Q. Eleven --

A. I'm sorry. The blockage was on both sides. But for some reason it affected more

profoundly the left side and it occluded the left middle cerebral artery.

Q. Okay. So now you're saying that the blockage of the carotid artery was on both sides, the left and the right?

A. Yes. Now, subsequently, the more studies and basically it's -- the patency is about the same, 70 percent on the left, 60 percent on the right.

Q. And it was about the same prior to this event as well, wasn't it?

A. I suspect so.

Q. So there was no greater blockage on the left side than there was on the right side; is that correct?

MR. CHAKOUR: Objection.

THE WITNESS: Of the carotids, but the middle cerebral artery. Now, we don't know antecedent. There's no testing antecedent to this what disease she had in the middle cerebral artery.

BY MR. KUNTZ:

Q. Okay. So if I understand correctly, you can't explain the fact that she had a injury to the left middle cerebral artery by any claim that there was a greater stenosis on the left side of the

carotid artery than the right carotid artery; is that correct?

MR. CHAKOUR: Object to form.

THE WITNESS: Not quite, because, again, the more recent studies which may be -- I don't know the quality of the study in 2012; I did not see it. Subsequently it was a good study and it showed 70 percent on the left, 60 percent on the right. It's a minor difference, but there is a difference.

BY MR. KUNTZ:

Q. What studies showed 70 percent on the left and 60 percent on the right?

A. That was 2015.

Q. 2015. Is that in those Dr. Chabolla records that you refer to?

A. No. That's in Dr. Gama's records.

Q. All right. I'm going to give those back to you again and ask you to show me that.

A. Sure. This is a CTA angio of the neck with and without contrast performed 8/20/15.

Q. And you think this study from 2015 would explain the fact that her primary injury was to the left middle cerebral artery territory of the brain?

A. Well, this is -- well, the main study is

demonstrative of the MRI scans, CT scans done in 2012 and subsequently. They all show significant involvement of the left middle cerebral artery distribution.

Q. Correct. But I'm asking you about the carotid artery that you claim explains why the injury was on the left side.

A. Well, she had stenosis of that -- 70 percent stenosis of that artery, which is a significant amount then and now.

Now, could she have had bilateral disease? She could have had, but she's fortunate she didn't.

Q. With respect to the studies done at the time at or around December the 7th of 2012, either shortly before or shortly after, within a month or two either direction, was there any difference in the carotid artery stenosis between the left and the right?

A. No.

Q. Okay. So there being no difference at about the time that you say that she suffered the neurological impairments to the left middle cerebral artery territory, if there's no difference in the stenosis, what, if any, explanation do you have for that?

A. Well, the luck of the draw is one, and also I don't know specifically antecedently what disease she had specifically in the left middle cerebral artery versus the right middle cerebral artery. We know it was occluded after the stroke had occurred. Now, whether that's indicative that she had a higher degree of stenosis of that particular vessel before or not, we don't know. There's nothing we have to compare antecedent to this.

Q. Now, I take it you did look at the CT scan done on December the 8th, 2012, did you not?

A. Yes.

Q. And what impairments, if any, were there that were reflected by the December 8 CT scan?

A. Was it the 7th or 8th, sir?

Q. I believe it was December the 8th, sir. You tell me if you think differently.

A. I thought there was one -- I think you're correct. I'm sorry, you're, correct.

Q. All right. So when was that December 8th scan, Doctor?

A. The one I have is I think 4:33 p.m.

Q. 4:33 p.m. So that would be how many hours after the time period that you say that all of her

neurological injury occurred?

A. That would be 20 -- if I'm correct, it would 27 hours, something like that.

Q. All right. And what neurological injury to the middle -- left middle cerebral artery area, if any, is shown on that CT scan done 27 hours after the time you claim the injury occurred?

A. I don't think -- I don't recall seeing very much in that particular scan.

Q. You didn't see any, did you?

A. No.

Q. Okay. Now, earlier you testified under oath here that usually within six hours CT scan will show any acute infarct, correct?

A. No. When you asked me the question, if you look at the tape, I'm sure it will -- the CT scan will be off normal in six hours, it will be. It may show something earlier, usually it does not. You may not see abnormalities in the CT scan for a period of 24 hours or more. You may see some, but you don't have to see any.

Q. All right. Let me ask you this one more time to make sure I have it correct, sir. Typically it takes six hours for a CT scan to demonstrate an acute stroke, correct?

A. Yes. You will not see it earlier than that, but you may not see it at that time frame.

Q. Okay. Well, you have testified earlier today and in other cases that within six hours, a CT will show an acute stroke, haven't you, sir?

MR. CHAKOUR: Objection.

THE WITNESS: No, it may. You may see some sluka (phonetic) edema, things of that sort within six hours. You don't have to.

BY MR. KUNTZ:

Q. Typically, you see it, don't you, sir?

A. Tremendous variability. No, I would not say that.

Q. Okay.

A. Often you do, but not necessarily.

Q. Okay. And if you don't see -- so you see it often at the six-hour mark or before, correct?

A. Often you do.

Q. All right. And if in those less often cases where you don't, you would see it within 12 hours, wouldn't you, sir?

MR. CHAKOUR: Object to the form.

THE WITNESS: The farther you go, the more likely you'll see it.

BY MR. KUNTZ:

Q. Okay. So within 12 hours, in the vast majority of cases, if there was an acute infarct injury to the brain, you would see it within 12 hours, would you not, sir?

MR. CHAKOUR: Object to form.

THE WITNESS: Of an acute ischemic infarct. No, this was not the typical acute ischemic infarct. This was an hypoxic hypoperfusion type of insult, which is less often seen early, so that's compatible with the clinical course sustained by Ms. Bishara.

BY MR. KUNTZ:

Q. So you're saying she didn't have an acute infarct. Is that what you're saying now?

MR. CHAKOUR: Object to form.

THE WITNESS: No, she did not have a classic thrombotic infarct. People like Ms. Bishara have a tendency to have those. They can have an acute blockage of an artery second to atherosclerosis. That is not what happened to Ms. Bishara.

Ms. Bishara had antecedent disease of her carotid system to be sure. She was subjected to an abrupt reduction of her blood pressure

and blood flow because of the cardiac arrest, and that induced an asymmetrical hypoxic ischemic injury more pronounced in the left hemisphere. And people who have that kind of insult, the scan may not be demonstrative of a stroke as early as an typical ischemic infarct, which is not what Ms. Bishara had.

BY MR. KUNTZ:

Q. So she didn't have it at six hours, she didn't have it at 12 hours, she didn't have it at 18 hours and she didn't have it at 24 hours?

A. Radiographically that is correct.

Q. Okay. And she didn't have it at 27 hours either, did she?

A. Radiographically that is correct.

Q. And since the stenosis of the carotid arteries was roughly the same both in the left and the right, stenosis of the carotid arteries cannot explain the left-sided infarct as opposed to the right, can it?

MR. CHAKOUR: Objection.

THE WITNESS: Well, the reason why she had the left cannot be explained by that.

BY MR. KUNTZ:

Q. Okay. You cannot explain --

A. Let me finish my answer.
Q. Okay.
A. Bear in mind carotid ultrasound is not as exacting a technique as CTA angiography. She did not have contemporaneously a CTA angiogram. Subsequently when she had CTA angiography, there was an asymmetry of a slight degree, but that test was not done contemporaneous to her stroke. The carotid ultrasound was read fairly symmetrical. It is more or a screening technique; it is not a -- as profoundly an accurate technique as CTA would be.
Q. Were you provided the CT angiogram that was done on her because of a suspected stroke in July of 2014?
A. 2014, I don't recall that, sir. No, I don't recall that.
Q. Okay. Would you agree that if a CT angiogram done on or about that day in July of 2014 showed a mixed hard/soft plaque resulting in 66 percent stenosis of the proximal left internal carotid artery and 65 percent stenosis of the proximal right internal carotid artery, that means that they are essentially identical?
A. Yes, I would agree with that.
Q. And, again, that kind of difference in

stenosis of the carotid arteries would not in any way explain the fact that there was a middle cerebral artery infarct that showed up in Mrs. Bishara's imaging study, the MRI study done in December of 2012, would it?

MR. CHAKOUR: Objection.

THE WITNESS: Well, it wouldn't explain the asymmetry, but there's enough stenosis there that that stenosis coupled with ischemic hypoxic insult could cause a stroke on either side.

BY MR. KUNTZ:

Q. I'm asking you about the asymmetry. Why is it on the left middle cerebral artery if you're saying it's due to hypoperfusion?

A. Yes.

Q. And you have no explanation for that; is that correct?

MR. CHAKOUR: Objection.

THE WITNESS: I have no explanation for the substantial asymmetry in her problem. She's not pristine on the right, but she's much worse on the left than the right. Just based on the carotid studies, that does not explain the asymmetry.

BY MR. KUNTZ:

Q. Is there any other study that explains it?

A. No.

Q. Okay. So as you sit here today, you have no explanation for why her primary injury is in the left middle cerebral artery territory, correct?

MR. CHAKOUR: Objection.

THE WITNESS: Well, I would -- I have suspicions, but I can't prove them, because tests weren't done simultaneously.

BY MR. KUNTZ:

Q. Now, the one thing that would explain a left middle cerebral artery infarct that did not show up 27 hours after her arrest between 1:00 and 2:00 p.m. on December 7th would be a blood clot that went -- either formed or went to her left middle cerebral artery territory; isn't that correct?

MR. CHAKOUR: Objection.

THE WITNESS: Could that happen, sure.

BY MR. KUNTZ:

Q. Yes. And that would explain that finding, would it not?

A. A blood clot, yes. If she had an embolism either from the carotid artery going rostrally or from the heart going distally, that could explain

such an insult, yes.

Q. Okay. And if that occurred sometime after the 1:00 to 2:00 o'clock p.m., that could also explain why nothing, no irregularity showed up on the CT scan 27 hours after the time you claimed the injury occurred, wouldn't it?

MR. CHAKOUR: Objection.

THE WITNESS: Well --

BY MR. KUNTZ:

Q. Wouldn't it, Doctor?

A. Bear in mind -- yes, that's true.

Q. Okay.

A. Let's assume for a second she had clots in her carotid artery, clots in her heart, the profound hypotension that she sustained and the asystole could promote the propagation of those clots. So either way the events of 12/7/12 are the proximate cause of her neurological ischemic insult.

Q. That isn't your opinion of what happened at all, is it? You just came up with that right now, correct?

MR. CHAKOUR: Objection.

THE WITNESS: No. You asked me a question about could she have a clot. I said, yes, a possibility. But such clot more likely than

not would be propagated by the same event that she had.

BY MR. KUNTZ:

Q. So you just came up with that explanation because that advances the side that you're on in this case, right?

MR. CHAKOUR: Objection.

THE WITNESS: No, sir.

BY MR. KUNTZ:

Q. You never came up with that in your report, did you, sir?

A. No. The most likely cause of this was the substantial hypoxia she sustained during the episode itself. Now, you asked me a question, let me answer it.

Q. Sure.

A. You asked me a question, could she have a clot. Yes, that's a possibility. I'm not saying it's medically probable. If that clot had occurred, the same mechanism that produced that clot as produced the -- as my postulation of her deficit.

Q. Okay. The patient's -- I think you've said you've had -- let me strike that.

Is it correct that you have cared for many patients similar to Mrs. Bishara in the sense of the

kind of risk factors and the kind of status she currently has?

A. Many, yes.

Q. And is it true that within the degree of probability, the combination of those factors produces a reduced life expectancy?

MR. CHAKOUR: Objection.

THE WITNESS: Yes.

BY MR. KUNTZ:

Q. And roughly what would you -- what degree of reduction of life expectancy occurs?

MR. CHAKOUR: Objection.

THE WITNESS: Let me make sure I understand your question so I answer it appropriately. Let's assume Ms. Bishara did not have the events of December 2012, that she had -- she was back to the way she was prior to this, what would be her life expectancy. Is that your question, sir?

BY MR. KUNTZ:

Q. That's a good one, yeah, I want to ask that one.

A. Okay. She was 51 years of age then. A Caucasian of 51 years of age based on the life tables -- most recent life tables we have are 2014

by the U.S. Public Health Service, 51-year-old Caucasian woman typically would have a 32-year life expectancy. That would be reduced in Ms. Bishara because of her premorbid issues, diabetes, the hypertension, the cardiac disease, the smoking. I would say her life expectancy would probably be reduced from 31 years to about 23 years.

Q. So maybe eight years, maybe something like that?

A. Yes.

Q. So nothing like -- nothing -- none of the December 7th events occurred, and then you would have estimated at that time she had 23 years life expectancy?

A. Yes.

Q. Within a reasonable degree probability?

A. Yes.

Q. And taking into account the events of December 7th, as you understand them to have occurred, as you've described here today, what do you believe would have been her life expectancy at that point in time in say December 8th or the end of December of 2012? What do you think her life expectancy would be?

MR. CHAKOUR: Objection.

THE WITNESS: After this event?

BY MR. KUNTZ:

Q. Yes. After this event, the way you understand this event occurred and what happened with this event.

A. Okay. Well, I think, again, I'll try to paraphrase your question, so I -- in other words, what effect would this event have in her life expectancy basically is what you're -- I think you're asking. Maybe I'm wrong.

Q. I think that's a fair way to say it, but let me try to do it better.

A. Thank you, sir.

Q. As of say December the 10th, 2012, given your understanding of what her status was on December 10th, 2012, what do you -- in your opinion, what was her life expectancy?

MR. CHAKOUR: Objection.

THE WITNESS: Just looking at that day, horrible. I mean, she looked like she was moribund. So I would have expected -- wouldn't have given her a year. I mean, she's very fortunate that she recovered to the degree she has based on the events of December 7th, 2012.

So just looking at the records

dispassionately not knowing what happened after that date, I would say this lady was going to be very severely impaired, not ambulatory aphasic, plegic and so forth. I'm surprised how she is today. She's not good, but she's much better than what was expected looking at the records of December 7th and December 10th of 2012.

BY MR. KUNTZ:

Q. All right. So that's fair. Now, let's take it out past December 10th to a point in time where she's stabilized.

A. Okay.

Q. From the event of December 7th. Okay?

A. You're talking about her now, for example.

Q. But I want to go back. At some point she sort of stabilized out from that December 7th event?

A. Yes. In other words, if you take the neurological events that she had, it's typically 18 months to two-year hiatus in which they can improve.

Q. Okay.

A. So she would be stabilized neurologically by December 2014, a little more than two years ago.

Q. All right. So December 2014. Then her life expectancy, according to the sort of the

calculation you did earlier, the opinion you expressed earlier, would be about another 21 years?

MR. CHAKOUR: Objection.

BY MR. KUNTZ:

Q. Without the event of December 7th, right, just based upon her other risk factors?

A. Yes.

Q. But now adding in the now stabilized December 2007 event, instead of 21 years, what in your opinion would be her reasonable life expectancy?

MR. CHAKOUR: Objection.

THE WITNESS: So going back 2014.

BY MR. KUNTZ:

Q. Yes.

A. Okay. So 2014 she would have been a 53-year-old Caucasian woman with the same risk factors, plus a stroke, minus her smoking. In other words, the smoking had stopped, the stroke could happen.

We'll call it stroke, this neurologic episode. Now, that episode would not curtail her life expectancy very much, while it might curtail, reduce the quality of her life, the life expectancy would not be changed because she is ambulatory,

would not be subject to certain potential ramifications as deep vein thrombosis and aspiration pneumonia and decubiti.

So I don't think her life expectancy would be changed by this episode to a significant degree. It will be slightly improved by the cessation of the smoking, which was a negative in her. So I think she has probably about the same life expectancy in 2014 as she would have had in 2012.

Q. Okay. So that would be about 21 years?

A. Yes, I think that's a fair statement, sir.

Q. And if you move that up to today, March of 2017, three more years have passed by, so it would be about 18-year life expectancy from today?

A. Yes, sir, I think that's a fair statement.

Q. Versus the tables which would say what?

A. Let's see, now she's 55, the 55-year-old Caucasian, forgetting about her risk factors, would have like a 26-year life expectancy, 27-year life expectancy.

Q. All right. So about nine-year reduction of life expectancy?

A. Yes.

Q. You said 26 or 27?

A. Yes.

Q. So eight- or nine-year reduction?
A. Yes, sir.
Q. And, again, that's your opinion, within a reasonable degree of medical probability?
A. Yes, sir.
MR. KUNTZ: Why don't we take a short break. I'll try to see what else I got.
(Recess was taken.)
BY MR. KUNTZ:
Q. When you think about strokes, which you deal with frequently, do you fit strokes into different categories?
A. Yes.
Q. What categories do you use?
A. First ischemic versus hemorrhagic. Then localization, anterior circulation versus posterior circulation. And if it's for ischemic, I just look at thrombotic, embolic or other causes.
Q. And then you said interior or --
A. Anterior.
Q. Anterior or posterior?
A. Yes, sir. In other words, the chronic circulation versus the vertebral vascular circulation.
Q. Which category would you put

Mrs. Bishara's stroke in?

A. She is in the ischemic not the hemorrhagic side to be sure. And she's anterior as opposed to posterior circulation.

Now, in terms of the mechanism, which is the other area I alluded to, her mechanism would be hypoxic ischemic as opposed to thrombotic or embolic. And I can explain that further if you would like me to do so.

Q. Sure. That would be great.

A. A typical stroke I see, I say 70 or 80 percent of them, a person has in situ blockage of an artery secondary to antecedent risk factors for stroke: Hypertension, diabetes, dyslipidemia, smoking. And then as time progresses, with lack of attention to those, that a thrombus occurs, blocks a vessel and, of course, there's a stroke. That's the most common kind of stroke we see.

A certain percentage of strokes, probably 20 to 30 percent, are embolic, that's to say a person has atrial fibrillation or cardiac vascular disease or blockage of the large vessels in the neck subclavian of the carotids, and an embolism travels from the blockage upstream, catches in a small vessel, blocks it and causes a stroke.

Those are the two most common mechanisms of ischemic as opposed to hemorrhagic stroke. Again, hemorrhagic stroke has nothing to do at all with Ms. Bishara.

There are other mechanisms besides that. People with vasculitis or people with things like lupus or sudden surgeries and blood pressure and hypertensive encephalopathy or cocaine, and then people who have dissection, which is some trauma, some other causes inside part of the artery to sort of unravel and block up. That doesn't pertain to Ms. Bishara either.

And there are other people who have an abrupt reduction of blood flow through vessels through cardiac arrest, and that's the likely mechanism of the stroke which occurred in Ms. Bishara.

And, again, the asymmetry of this is not classic, but is not terribly unusual. It's mediated by the person antecedent to this may have had some blockages which were asymptomatic.

We know she had bilateral carotid artery disease. Likely she had middle cerebral artery disease. We don't know that for a fact. No testing was done to determine that. We know she had carotid

disease from the carotid studies we discussed before in detail.

Q. You said that she likely had middle cerebral artery disease?

A. Yes.

Q. And by that you mean a buildup of plaque?

A. Yes.

Q. Normally that would be on both sides, not just one side, right?

A. Sure. We just don't know the extent the one side versus the other. So a person like her would be more prone to have vessel disease than a person who had the same insult, but did not have these risk factors that she had.

Q. Have you ever seen strokes categorized as a large vessel territory stroke versus a small vessel territory stroke?

A. Yes. I was alluding to that. I didn't use that terminology. But the carotids and the vertebral vascular arteries are considered large vessel, and you can have strokes emanating from them by one or two mechanisms. One is the degree of stenosis becomes so profound, typically 90 percent, where no blood gets through and you have a stroke.

The other mechanism is, there's stenosis

and the stenosis causes sludging of the blood developing an emboli, and emboli stem from the carotid arteries or the vertebral vascular system to small tributaries, clog them and cause a stroke.

Q. And I think you said carotid and something else. Did you say --

A. Carotid and vertebral vascular, vertebral arteries, the two vertebral arteries join become the vascular artery and then small vessels branch out from the vascular artery.

Q. And would you describe -- would you fit Mrs. Bishara's stroke into a large vessel territory stroke?

A. Well, if you consider the middle -- the answer is the middle cerebral artery is the next biggest artery after the carotids. So, yes, she had a middle cerebral artery stroke. It's not the biggest vessel, but it's the second greatest vessel of the anterior circulation.

Q. So if it fits into the large vessel territory stroke, it would not fit into the small vessel territory stroke category; is that correct?

A. Yes, sir.

Q. And then a third category might be a watershed distribution stroke?

A. Yes. I was alluding to that. That's typically one sees with reduction of blood flow from an event like this, strokes all over the place bilaterally.

Q. So usually when there's a hypoperfusion event, sort of by definition, that covers the whole brain not the middle cerebral, left middle cerebral artery territory?

A. That's true.

Q. Okay.

A. Again, if a patient has certain antecedent anatomical disfigurement, it may be more in the realm of that particular vessel as opposed to global.

Q. But she doesn't have that, correct?

MR. CHAKOUR: Objection.

THE WITNESS: I'm sorry?

BY MR. KUNTZ:

Q. Well, she didn't have one side versus the other side stenosis --

MR. CHAKOUR: Objection.

BY MR. KUNTZ:

Q. -- greater than the other -- one side greater --

A. We don't know the middle cerebral artery.

We just don't know that.

Q. Oh, okay, sure. Okay. I was talking about the carotid artery.

A. Yes, we agreed to that before.

Q. Okay. So most commonly, if there were a hypoperfusion event, which is what you're postulating occurred between 1:00 and 2:00 o'clock p.m. on December 7 which result in a watershed distribution of injury, correct?

MR. CHAKOUR: Objection.

THE WITNESS: That's the most common thing. Bear in mind, let me amplify a little bit here. She does have clinically and radiographically bilateral disease. In other words, it's not symmetric. It's very asymmetric, but it's not unilateral. In other words, the examinations I conducted and Dr. Gama also show bilateral disease.

BY MR. KUNTZ:

Q. Well, do you have the December 8th CT scan that we talked about earlier?

A. Do I have it, not with me now. No, sir, I don't.

Q. All right. Let's see if I can find it.

A. Thank you.

Q. So I'll show you the 12/8/2012, 1633 hours CT scan. I think that's the one we talked about earlier and about 27 hours after the time of injury as you have testified here, correct?

A. Yes, sir.

Q. And if you take a look at the report, I understand you've looked at the image as well, correct?

A. Yes, I do recall this. I did look at this, yes.

Q. And that's a completely normal report?

MR. CHAKOUR: Can I take a look at it?

THE WITNESS: Sure.

BY MR. KUNTZ:

Q. And when you looked at the image, the image was no different, correct?

A. I didn't see anything on that image.

Q. Okay. I'll mark that as the next number exhibit, which would be --

THE COURT REPORTER: It'll be 9.

(Photocopy of Fischer Exhibit 9 was marked for identification.)

MR. CHAKOUR: Is this the entire report, Bill, or is there a page missing?

MR. KUNTZ: It says page 1 of 1, so I'm

thinking this is it.

MR. CHAKOUR: That's the entirety.

MR. KUNTZ: But you tell me if you think there's something else.

MR. CHAKOUR: No, I'm just asking.

THE WITNESS: I don't recall anything besides that one page.

BY MR. KUNTZ:

Q. All right. Now, then we talked about the MRI done, which was 12/10. I'm not sure the exact time.

A. I think that scan was done 11:13 a.m. from my recollection.

Q. And you looked at this image as well, correct?

A. Yes.

Q. And did you make any notation as to your interpretation of that image that is in any way different from this file report?

A. I recall the report, so may I borrow the report?

Q. You may.

(Photocopy of Fischer Exhibit 10 was marked for identification.)

BY MR. KUNTZ:

Q. Let me mark this report MRI from December 10th, which is the first one after the arrest event that we've discussed as No. 10.

A. Yes, I do recall this report. I do recall reviewing the films. I had no discrepancy of my interpretation versus this of Dr. Dunn.

Q. Now, in terms of showing neurological injury to the brain, would it be generally true that the MR study is considered more revealing than a CT?

A. Yes.

Q. Okay. Is that -- did I describe it in a fair way? Or medically how would you describe it the difference between an MRI, what it should show, the sensitivity of it for showing --

A. That's the key word "sensitivity." Sensitivity of MRI is much greater than a CT.

Q. Okay. And what did the much greater sensitive MRI study of December 10th show with respect to brain injury for Mrs. Bishara?

A. The description is left temporal lobe gyral, g-y-r-a-l, edema.

Q. Okay. Is that it?

A. That's the only thing that's noted here.

Q. Okay. And did you notice anything besides

that?

A. I did not.

Q. And what does it show with respect --

A. The answer is I found -- I saw some areas bilaterally of old ischemia, not significant, nothing to do with the current state.

Q. You saw some findings of old ischemic brain injury?

A. Correct.

Q. By old you mean well prior to December of 2012?

A. Yes.

Q. And what would have explained old ischemic; that is, low blood flow injuries prior to December 2012 for Mrs. Bishara?

A. Many people with hypertension, diabetes, dyslipidemia have such changes, so-called silent stroke.

Q. Okay. So she had silent stroke or strokes prior to December of 2012?

A. Yes.

Q. Based upon your review of this December 10th, 2012, MRI?

A. Yes.

Q. How many?

A. I'm sorry?
Q. How many?
A. I don't recall that. They were not significant. They were small.
Q. Okay. So what right-sided hypoxic injury did this much more sensitive MRI from December 10th, 2012, show?
A. I didn't see anything on this particular scan.
Q. Have you seen any imaging studies that show right-sided injury apart from these old silent strokes that you were referring to?
A. Here's the issue. I've seen more recent studies, including we have the copy -- you have the report -- the exact dates in the -- thank you. These studies of 2016 January and December, they show bilateral findings. They show the same left temporal insult but maturing; in other words, this was -- this study was early, showed some edema. Now you see a drop out in the left temporal lobe of an old looking infarct.
There are some similar but much less profound changes on the right, particularly in the right parietal region. But I don't know when they occurred. They're old looking in 2016/2017. I

don't have interval studies demonstrative of them, so I don't know when they occurred.

Q. So they could have occurred 2013?

A. I don't know.

Q. Could it have occurred 2014?

MR. CHAKOUR: Objection.

THE WITNESS: Yes, sir.

BY MR. KUNTZ:

Q. Could have occurred 2015?

MR. CHAKOUR: Objection.

THE WITNESS: Yes, sir.

BY MR. KUNTZ:

Q. Could have occurred 2016 prior to the studies themselves?

MR. CHAKOUR: Objection.

THE WITNESS: Well, it was older -- the first study here is January 9, 2016. It was older than a week or so. But the answer is it could it have occurred mid-2015 or earlier. I can't age it.

BY MR. KUNTZ:

Q. Okay. So and you looked at these particular images closely, right?

A. Yes.

Q. Do you remember where they were taken?

A. Where? What facility?
Q. Yes.
A. Let's see if it says that. Baptist South.
Q. Okay. And you're saying they showed something on the right side of the brain?
A. As well as the left. Again, I'll stress to you the more significant lesion was in the left hemisphere.
Q. The same one that showed up in the December 10th MRI that we've talked about, Exhibit 10?
A. Well, it looked different, but it was the same area of involvement. In other words, I think that's the maturation of what you see in December 2012. The 2016 and 2017 images are reflective of that lesion.
Q. Not reflective of a new event in your opinion?
A. That is correct.
Q. And I may have asked you this before, but I've just forgotten. Why were these studies done?
A. Well, some of them, as I recall, Dr. Gama's indicated there was some question about a new neurological event in which she had some increasing confusion. She was hospitalized. There

was dehydration and some electrolyte imbalance. He felt there was no new stroke, but maybe to be on the safe side, he wanted studies to see if there's something new imaging-wise.

Q. There was something new, at least compared to the December 10th, 2012, correct?

MR. CHAKOUR: Objection.

THE WITNESS: Oh, yes, but these were not acute findings relative to that hospitalization.

BY MR. KUNTZ:

Q. But there was something new after December 10th, 2012?

MR. CHAKOUR: Objection.

THE WITNESS: Yes, that is correct.

BY MR. KUNTZ:

Q. Some new neurological event, correct, after December 10, 2012?

MR. CHAKOUR: Objection.

THE WITNESS: Not necessarily. In other words, you can have silent strokes, as I said, which are not reflected by any clinical situation. The one on the left was not new. That was just a maturation of the one in 2012. And then saw something on the right, which was

much smaller. I'm not sure what it is reflective.

BY MR. KUNTZ:

Q. Whether they were silent or not, they were something that did not show up on December 10th, 2012, but did show up in these images referred to on Exhibit 4 here from 2016?

MR. CHAKOUR: Objection.

THE WITNESS: Yes.

BY MR. KUNTZ:

Q. Now, the event that occurred and caused the damage between 1:00 and 2:00 p.m. on December 7th, and you have already said this, but what was it that you believe caused the arrest that caused the hypoperfusion injury?

A. Cardiac tamponade.

Q. Okay. Now, and you saw I think that there was a sort of an emergent pericardiocentesis done during the time of that arrest?

A. There was.

Q. By the emergency room doctor I think, and it removed some amount of fluid?

A. Yes. Dr. Garmendia.

Q. No, it wasn't Dr. Garmendia. He was there, I think, but it was Dr. Dietrich I believe?

A. I'm sorry. I stand corrected. Dr. Dietrich was the one.

Q. He was an emergency room physician there with Dr. Garmendia?

A. Yes.

Q. All right. And you know that emergent pericardiocentesis was done at that time?

A. That is correct.

Q. And removed some amount of fluid from around the heart?

A. That is correct.

Q. And there was a return of blood pressure and color at that time, correct?

A. Yes.

Q. Now, when that occurred, recognizing that she was then taken to the OR and they did a so-called pericardial window, but do you believe that the return of blood pressure and color that occurred before she got up to the OR signified an end of any hypoperfusion injury?

MR. CHAKOUR: Objection.

THE WITNESS: No. Because she still had asystole subsequent to that. In other words, they took the fluid out. At 1:23 she still had a significant abnormal rhythm.

So the answer is eventually she did recover from the asystole, and I'm sure the removal of fluid was instrumental in that, but it wasn't an immediate response, because six minutes after Dr. Dietrich's intervention, she still was in asystole according to the code sheets.

BY MR. KUNTZ:

Q. Okay. I understand what you're saying there.

It looks like, did you look -- were you provided, I assume, the anesthesia record from the pericardial window that was done?

A. Yes, sir.

Q. And the records showed that anesthesia started there at about 1350, about 1:50?

A. That comports with my recollection, yes.

Q. So that's between that 1:00 and 2:00 o'clock time frame that we talked about earlier?

A. Yes, it is.

Q. And from my looking at this, it looks like the blood pressures at the beginning of that sometime around that 1350 I guess time zone were about maybe 120/80. Is that how you would interpret that?

A. Yes, sir.
Q. And then you see that they jumped up higher than that?
A. Let's go back. It was about 120/60 is what I see here.
Q. 120/60. Did I say something else?
A. You said 80.
Q. I meant 60.
A. They came up after that to a higher level.
Q. Okay.
A. A higher level -- excuse me, a higher level systolic, but the diastolic remained in the level of 40 to 50. So the -- this did not improve -- improve the systolic pressure to a certain adequate degree, but did not improve the diastolic pressure.
Q. Okay. So prior to this time reflected on this anesthesia record from December 7th for the pericardial window, the blood pressure had been lower than the 120 over it looks like 70 to me. Does that look like 70 if you go to the top of the arrow?
A. Yeah. The little triangle used is the triangle is as low as 57 and as high as 70, so in that vicinity. Look at the very first one's below

the 60 level and the other one just nudges just right to the 70 level.

Q. Okay. So between 60 and 70 is what you're saying for the three ones that were recorded there?

A. Yes, sir.

Q. Now, prior to this point in time, 1350 or so, the blood pressures had been much lower than that?

A. They had been.

Q. Okay. And it's that period of time when they were much lower than 120/65 or 70 that you believe the hypoperfusion occurred that caused the damage; is that correct?

A. Yes, sir.

Q. Okay. So once the pressures got back up to over 100 in terms of systolic, there's probably no more hypoperfusion injury at that point?

MR. CHAKOUR: Objection.

BY MR. KUNTZ:

Q. Is that correct?

A. Yeah, I would not attribute her damage to those blood pressures you just cited.

Q. Right. It was prior to that?

A. Yes, sir.

Q. Okay. Now, and the thing that caused them

to go from the much lower level that you would attribute her damage to to these levels shown here of roughly 120/60 or 70 was due, at least in part, to the emergent pericardiocentesis done by Dr. Dietrich somewhere in the 1:30 or so time frame?

A. Yes, sir.

MR. CHAKOUR: Objection.

BY MR. KUNTZ:

Q. Okay. And then she also received some medications too, of course, in connection with --

A. Yes.

Q. So a combination of those things caused the blood pressure to go back up to a level where she was no longer being hypoperfused?

MR. CHAKOUR: Objection.

THE WITNESS: Yes, sir.

BY MR. KUNTZ:

Q. Okay. That's your opinion within a reasonable degree of medical probability?

A. Yes, sir.

Q. Okay. And prior to the 1:00 o'clock period when you say the hypoperfusion injury started, you know she got to the emergency room around 7:00 in the morning?

A. That is correct.

Q. And so at that point in time, had she say had a pericardiocentesis done, presumably could have avoided the whole arrest?

MR. CHAKOUR: Objection.

THE WITNESS: Now we're getting into areas of expertise beyond my capability. I think that is correct, but I'm not testifying as a cardiologist here, so I would defer to cardiology. So the answer -- I think the answer is correct, but I'm not giving you expert opinions in that regard.

BY MR. KUNTZ:

Q. Okay. Well, you did give us the opinion that in your opinion it was a tamponade that caused the arrest that caused the hypoperfusion that caused the brain injury, correct?

A. Yes, sir.

Q. Okay. And the tamponade is due to a buildup of fluid around the heart, correct?

A. Yes, sir.

Q. Okay. So whatever buildup there was, it didn't evidence itself in an arrest and hypoperfusion until around 1:00 o'clock, correct?

A. That is correct, sir.

Q. So normally a tamponade could be corrected

by pericardiocentesis, correct?

A. It can be.

Q. Okay. And so if that was done at 7:00 o'clock or 8:00 o'clock or 9:00 o'clock, that should have prevented what you say caused the neurological injury, shouldn't it?

MR. CHAKOUR: Objection.

THE WITNESS: I would think so, but I'm not imparting how bad the tamponade was or what kind of procedure should have been utilized. That's beyond my expertise. If there were similar degree of fluid at 7:00 o'clock as there were at 1:00 o'clock, the answer is yes to your question.

I don't have opinions as far as how severe the pericardial infusion was or how severe the tamponade was at those different time frames. All I can say is what happened neurologically to her and how it coincided with the vital signs and what was going on with her between 12:00 and 1:00.

BY MR. KUNTZ:

Q. 1:00 and 2:00 you mean?

A. 1:00 and 2:00, excuse me, sir. Thank you.

Q. Okay. Now, I understand what you just

said. But what I want to make sure of is, regardless of how bad it was, if it had been relieved; that is, the amount of fluid had been relieved by a pericardiocentesis at 7:00 or 8:00 or 9:00 or 10:00 or 11:00, then the amount of tamponade would have never progressed to the point where there was an arrest, correct?

MR. CHAKOUR: Objection.

THE WITNESS: I think that is correct.

BY MR. KUNTZ:

Q. Now, I take it that you do not intend to express any opinions in this case as to the standard of care exercised by anybody?

A. You're correct, I will not express any such opinions.

Q. Now, you commonly do express opinions about standard of care when it's within your area of neurology, do you not?

A. Yes, sir.

Q. Okay. So the reason you're not is because whatever the other physicians did of any category other than neurology, you don't -- you're not qualified to express opinions about them; is that correct?

A. That is correct, I am not.

Q. With respect to this report that you gave me -- and I'm sorry, I didn't have time -- I mean, I wish I had seen it earlier. It could have saved me some time or you some time here today -- this was based upon your consultation with her, what you learned from that, plus all the medical records and imaging studies you had been provided; is that correct?

A. Yes. The last imaging batch is not incorporated into this report because I had only received that on Thursday or Friday.

Q. That's the 2016 imaging?

A. Yes.

Q. But you had been provided what's been marked as Exhibit 3, the 11/22, the 12/15/2012 images?

A. Yes.

Q. You've previously been provided those?

A. Yes.

Q. So all of that together is what went into this consultation?

A. Yes, sir.

Q. Okay. Do you have any other opinions that you intend to express in this case beyond what we've talked about here today?

A. Only to say that the neurological deficits expressed by Ms. Bishara when I saw her are permanent in nature, they will not improve by any treatment, but she does require substantial supportive care as a result of these deficits.

Q. So no matter what treatment she gets, it's not like her speech impairment or her right-sided impairment or the other impairments that you believe exist, they will not get any better?

A. That is correct, sir.

Q. Okay.

A. In fact, that's mentioned specifically in my report in the last paragraph.

Q. Where it says "impression"?

A. Yes, sir.

Q. Now, did you talk to her about what her current abilities are in terms of her ability to eat, for example?

A. Yes. She can swallow. She had some difficulty utilizing typical instruments in her right hand. She's clumsy. She can eat on her own.

Q. Can or can't?

A. Can eat on her own.

Q. All right.

A. She can dress herself. She can bathe

herself, but she has uncertainty of her balance. She falls easily.

MR. CHAKOUR: Excuse me. Matt just texted me. They got cut off, so we may need to call them again.

(Brief Interruption.)

BY MR. KUNTZ:

Q. Okay, Doctor, I think you were just starting to tell us Mrs. Bishara can swallow?

A. She can swallow. Let's see. She does have -- let's see, let me just check something. She had reduction of swallowing, but she was able to swallow.

Q. Okay. She can eat herself?

A. Yes.

Q. She didn't have to be fed by anybody?

A. No, she does not.

Q. She can dress herself?

A. Correct.

MR. CHAKOUR: Objection.

BY MR. KUNTZ:

Q. She can bathe herself?

A. She can bathe herself, but there's some -- a little bit problem here because her balance is poor and she gets -- like stepping into a bathtub,

for example, or in the shower with the water in her eyes, she has a tendency she could fall, so she might need some supervision for some of these activities.

Q. Okay. Do you know that at one point in time she actually got in her car and drove to the doctor's office and back?

A. I understand that. I think that would be a -- let me just check something here. Yeah, that would be a precarious --

Q. Now, I'm not asking you if you think it's precarious.

A. The answer is she could do it physically, but she should be prohibited from that because she has a field defect and it would be unsafe for her to drive.

Q. Okay. And my question is pretty simple. Are you aware that she got in her own car, she started it, she drove to the doctor's office and she drove home again?

MR. CHAKOUR: Objection.

THE WITNESS: I'm aware of that, yes.

BY MR. KUNTZ:

Q. She did not have any accidents?

A. Fortunately.

Q. Okay. And it's her family that told her not to drive, not some legal authority that told her not to drive, correct?

MR. CHAKOUR: Objection.

THE WITNESS: Yes.

BY MR. KUNTZ:

Q. And are you aware that she can put her food in the microwave if she wants to heat it up?

A. Yes.

Q. And she can use her left hand to pick up objects?

MR. CHAKOUR: Objection.

THE WITNESS: She can.

BY MR. KUNTZ:

Q. And she was right-handed, so she has more difficulty doing things with her left hand, for example, writing, but she can write to some degree with her left hand?

MR. CHAKOUR: Objection.

THE WITNESS: To a very minimal degree.

We see the signature that she issued.

BY MR. KUNTZ:

Q. I understand.

A. I tried to have her write a sentence for me. She was unable to do that. I had her draw

something for me. She was unable to do that. So her writing is substantially limited.

Q. All the things you said she can do about, not all of them, but, for example, eating, she does with her left hand, right?

A. Yes.

MR. CHAKOUR: Objection.

BY MR. KUNTZ:

Q. And dressing, to the extent she dresses, she can do that with her left hand?

MR. CHAKOUR: Objection.

THE WITNESS: Yes.

BY MR. KUNTZ:

Q. And with respect to bathing herself, again, that's her left hand that she uses to bathe herself, correct?

A. Yes.

Q. She can move her right arm and right hand. It's just not functional, I guess, for real useful purposes?

A. That's a fair statement, sir, yes.

MR. KUNTZ: Okay. Doctor, I think I've hopefully covered what I needed to cover. I appreciate your courtesy here today.

THE WITNESS: Thank you, sir. I

appreciate your courtesy.

CROSS-EXAMINATION

BY MR. CHAKOUR:

Q. I just have a few follow-up questions.

Doctor, you just said that Ms. Bishara can eat, but given the deficit that she has in her right arm and right hand, can she use a knife to cut her food?

MR. KUNTZ: Objection.

THE WITNESS: She can --

MR. KUNTZ: Form.

THE WITNESS: -- use her left hand -- the answer is it would be very difficult for her to cut food because the right hand is poorly functional. She would have to hold something down, use the left hand to cut. It would be difficult to do it.

BY MR. CHAKOUR:

Q. Okay. And we were talking about Ms. Bishara's driving. Do you think Ms. Bishara can ever drive again?

A. Absolutely she should not drive for several reasons: Her cognitive function is impaired. Her right-sided strength and coordination and sensation are impaired. And she has a field

cut; in other words, she can't see things to the right properly. So she would be prone to have accidents. She would move to the right and not see a car behind her. So the answer is she's not had a formal driving (cough). I'm quite certain she'd fail if she submitted to that.

Q. In your opinion, can Ms. Bishara ever work again?

A. No. She's totally and permanently disabled from any and all useful work.

Q. And in your opinion, will Ms. Bishara now need 24-hour assistance and supervision?

MR. KUNTZ: Object to the form.

THE WITNESS: Yes.

BY MR. CHAKOUR:

Q. And is that to make her life safer?

MR. KUNTZ: Object to the form.

THE WITNESS: Yes. Because of her deficits, her weakness, coordinative, sensitive, sensory, gait and capacities and her cognitive dysfunction, her speech dysfunction, she would be subjected to falls, other things, untoward things that she needs supervision.

BY MR. CHAKOUR:

Q. Okay. The activities that she may need

supervision with that you were talking about, do they include taking her medications?

MR. KUNTZ: Objection. Leading.

THE WITNESS: Yes. Any cognitive issues. In other words, her memory is impaired, recent memory particularly. Her executive function is impaired. Her planning organization impaired. So that she would not be capable of remembering her medications properly, and she requires a whole slew of them for her various conditions.

BY MR. CHAKOUR:

Q. And the 24-hour supervision and assistance, is that also -- would that also make her life safer?

MR. KUNTZ: Object to the form.

THE WITNESS: In other words, as I mentioned before, she has all these coordinative sensory, motor, visual, cognitive speech difficulties. She's prone to having falls and accidents. Having such supervision would prevent those from happening.

BY MR. CHAKOUR:

Q. Okay. Do you also think that having such supervision will help her exercise daily?

MR. KUNTZ: Object to the form.

THE WITNESS: In other words, she does not do that on her own accord. She needs that, needs to be constantly reminding, reminding of medications, reminding of carrying on normal function. She does not do that when prompted.

BY MR. CHAKOUR:

Q. Okay. And we were talking about risk factors that affects or affected Ms. Bishara's life expectancy.

If she has the care and supervision that she needs to take her medications timely and exercise and eat healthy, don't you think that will reduce the risk factors that impact her life expectancy?

MR. KUNTZ: Object to the form. Leading again.

THE WITNESS: The patient has endogenous factors which are negative. These -- to some extent, these can be supervened by proper attention. In other words, if the blood pressure is controlled, her diabetes is controlled, her lipids are controlled, her activity and dietary considerations are well maintained, this will reduce the effects of these comorbidities and enhance her life

expectancy.

But because of her incapacities intellectually, cognitively, she needs constant supervision to insure this compliance.

BY MR. CHAKOUR:

Q. Okay. Now, we've touched a little bit upon her speech defect now, how would that affect her life let's say in terms of calling 911 if she's in a medical emergency?

MR. KUNTZ: Object to form.

THE WITNESS: Let's take that possibility. Something happens to her and she calls 911. Her speech is very slurred and dysarthric. She also has what's called a nonfluid aphasia. She can't get the words out. If someone says who is this, she might say ur, ur, ur, some guttural manner. What's your location, she might not be able to express it. They may be able to tell by Caller ID where she is and so forth, but she will not be able to convey quickly and appropriately the circumstances of her distress.

BY MR. CHAKOUR:

Q. Okay. And if there's somebody there 24/7,

they could take care of that emergency or that phone call and relay that information accurately, correct?

MR. KUNTZ: Object to the form.

THE WITNESS: It's one of the reasons I've indicated she needs 24/7 supervisory care.

BY MR. CHAKOUR:

Q. Now, when you did the neurological exam on Ms. Bishara very recently, you did that neurological exam on her just like you would on any one of your patients, regular patients, correct?

MR. KUNTZ: Object to the form.

THE WITNESS: That is correct. But I spent -- because I've only seen her one time, she's not going to come back from Jacksonville tomorrow, I spent substantial time going over things in great detail.

And she was a new patient. So the answer I do the same exam on all new patients, but it was painstaking my time with her in order to get every detail possible in her situation.

MR. CHAKOUR: Okay. I may have finished, I'm just going to take a quick look at my notes, Bill.

TELEPHONIC MALE SPEAKER: Fadi, check your e-mail, please.

MR. CHAKOUR: Okay.

BY MR. CHAKOUR:

Q. Now, Doctor, let me ask you this. Are all the neurological deficits you noticed when you examined Ms. Bishara related to the left middle cerebral artery infarct?

MR. KUNTZ: Object to the form.

THE WITNESS: No. As I mentioned to your colleague, you know, about two hours ago, she has bilateral dysfunction asymmetric to be sure, worse in the left hemisphere, but she has abnormal reflexes in left and both sides. It's worse on the right than the left, which means the left hemisphere is worse than the right, but the right hemisphere is involved.

She also had these cortical release signs, which are clearly indicative of bilateral cortical dysfunction and indicative of more global as opposed to a simple hemispheric process.

MR. CHAKOUR: Okay. I believe I have no further questions.

THE WITNESS: Thank you, sir.

REDIRECT EXAMINATION

BY MR. KUNTZ:

Q. I have a couple follow-up, Doctor.

A. Sure.

Q. You said this is just like any other exam that you did on Ms. Bishara just like any of your other patients, right? Is that more complete?

A. Yeah. The only difference is different people come for different things. If I see a person that comes in with back pain, I'm not going to spend substantial time with mental status, unless I see something strange, or checking intricacies with a facial sensation. Any new stroke patient gets a similar kind of exam as Ms. Bishara did.

Q. Okay. So my question to you was, sir, you're saying your testimony is that the exam that you did of this lady, Ms. Bishara, was just like the exam you do of any other neurological patient that you see in your office. Is that your testimony?

MR. CHAKOUR: Object.

THE WITNESS: New patient.

BY MR. KUNTZ:

Q. Okay. Now, when's the last time you had a new patient who had a lawyer sit here with you for an hour and 15 minutes or for any period of time

while you examined her?

MR. CHAKOUR: Objection.

THE WITNESS: I wasn't here. It was Friday.

BY MR. KUNTZ:

Q. When's the last time you had a regular patient --

A. Not regular patients.

Q. Okay. I'm not talking about legal/medical work that you do. I'm talking about just like your other patients.

MR. CHAKOUR: Objection.

THE WITNESS: I had a patient --

BY MR. KUNTZ:

Q. She's not your patient, is she?

MR. CHAKOUR: Objection.

THE WITNESS: I rendered treatment. I've given you opinions. I would make recommendations for future care, yes. In other words, if she called me tomorrow or someone called me from her family on her behalf tomorrow, I could intelligently give recommendations in her care.

BY MR. KUNTZ:

Q. What treatment did you provide

Ms. Bishara, Doctor?

MR. CHAKOUR: Objection.

THE WITNESS: Nothing in terms of medication.

BY MR. KUNTZ:

Q. Well, you just said you provided her treatment. What treatment did you give her?

MR. CHAKOUR: Objection.

THE WITNESS: I didn't give prescriptions, sir, but giving treatment is more than that. I made recommendations for future care. That's a treatment.

BY MR. KUNTZ:

Q. Okay. So when's the last time a regular patient, not one of these patients where you're getting paid $800 an hour or $500 an hour to talk to lawyers and testify against other healthcare providers, when's the last time you had a lawyer sit in and during your initial examination?

MR. CHAKOUR: Objection.

THE WITNESS: Well, a lawyer, regular patients, lawyers don't sit in.

BY MR. KUNTZ:

Q. Doctor, it's a simple question. When is the last time you had a lawyer sit in on your

initial examination for a regular patient, not a medical/legal?

MR. CHAKOUR: Object to form.

THE WITNESS: I guess it would be a lawyer spouse. In other words --

BY MR. KUNTZ:

Q. Oh, so there was a spouse involved, not a lawyer, correct?

A. No, no, no. I mean, you're asking me what a --

Q. When's the last time a practicing lawyer who's not a spouse sat in during your initial neurological examination of a new patient?

MR. CHAKOUR: Objection.

THE WITNESS: If this is not a legal case, they wouldn't be there.

BY MR. KUNTZ:

Q. So is the answer never, Doctor, it never happened?

A. Well, I've had cases like this. No. I've had cases like this where lawyers sit in on their clients or the opposing lawyer sits in on a client.

Q. I said not on medical/legal cases.

MR. CHAKOUR: Objection. Asked and answered.

BY MR. KUNTZ:

Q. I'm asking about a regular, new patient.

MR. CHAKOUR: Objection.

THE WITNESS: I can think of a time where, again, it was sort of like a legal case. A person's competency was involved, and somebody sat in to watch me doing the examination in terms of competency. I was not a retained expert or anything.

BY MR. KUNTZ:

Q. Okay. Again, I'm not asking you about legal cases. I'm asking you about a regular medical patient. When's the last time you had a lawyer sit in for an hour and 15 minutes for any initial exam?

MR. CHAKOUR: Objection.

THE WITNESS: That's unusual. I can't recall that.

BY MR. KUNTZ:

Q. Never, is that the answer?

A. Not in nonlegal cases.

MR. CHAKOUR: Objection.

BY MR. KUNTZ:

Q. Okay. Now, you also said that she has a speech deficiency that the implication was, if she calls 911, she's not going to get help from a

emergency rescue team?

A. That's not what I said, sir.

MR. CHAKOUR: Objection.

BY MR. KUNTZ:

Q. Isn't that the implication of what you were talking about, Doctor, that she can't call 911 and get help?

MR. CHAKOUR: Objection.

THE WITNESS: I didn't say that at all, sir. I did not say that.

BY MR. KUNTZ:

Q. You didn't say that because you know that if she calls 911 and she has garbled speech, she will get attention from 911?

MR. CHAKOUR: Objection.

THE WITNESS: I mentioned that, sir.

BY MR. KUNTZ:

Q. All right. And you know that since 2012 she hasn't had 24-hour-a-day attendant care, has she, Doctor?

MR. CHAKOUR: Objection.

THE WITNESS: I do not know the role of her family in her current care. That's what she requires, however. She's fortunate nothing has happened untowardly.

MR. KUNTZ: All right. I have nothing else. Thanks again.

THE WITNESS: Thank you, sir. I'd like to read if I may.

(Thereupon, the deposition was concluded at 12:17 p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA

COUNTY OF MIAMI-DADE

I, the undersigned authority, certify that KENNETH FISCHER, M.D., P.A., personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 6th day of March 2017.

_____

Catherine L. Pflueger, RPR, CLR
Notary Public - State of Florida
My Commission No. CC906758
Expires: March 19, 2020

STATE OF FLORIDA

COUNTY OF MIAMI-DADE

I, CATHERINE L. PFLUEGER, Registered Professional Reporter, Certified LiveNote Reporter certify that I was authorized to and did stenographically report the foregoing deposition of KENNETH FISCHER, M.D., P.A.; that a review of the transcript was requested; and that the pages 1 through 134, inclusive, are a true and complete record of my stenographic notes.

I further certify that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

Dated this 13th day of March, 2017.

_____

CATHERINE L. PFLUEGER, RPR, CLR

DEPOSITION ERRATA SHEET

Assignment No. 33274

Case Caption: DEBORAH ANN BISHARA, et al.

vs. ST. VINCENT'S AMBULATORY CARE, INC., et al.

Witness: KENNETH FISCHER, M.D., P.A. - March 6, 2017

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me, and the same is true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

Signed on the _____ day of

_____, 20___.

_____

KENNETH FISCHER, M.D., P.A.

Sworn to and subscribed before me this _____ day of _____, 20__.

_____

Notary Public

My commission expires_____

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KENNETH FISCHER, M.D., P.A.