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

CASE NO. 16-2010-CA-008527

PAULA LUKE, individually, and as
natural parent and guardian of
GRAYSON LUKE, her minor child,

Plaintiffs,

vs.

MANUEL B. PORTALATIN, M.D., and
BAPTIST PRIMARY CARE, INC., d/b/a
BAPTIST PRIMARY CARE, and
CITY OF JACKSONVILLE,

Defendants.
_____/

Kenneth C. Fischer, M.D.
1190 Northwest 95th Street,
Suite 402,
Miami, Florida
Monday, December 3, 2012
2:10 p.m.

DEPOSITION OF KENNETH C. FISCHER, M.D.

Taken before Debra Petracca, Notary Public, in and for the State of Florida, at Large, pursuant to Notice of taking Deposition.

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APPEARANCES

ON BEHALF OF THE PLAINTIFF:

MILTON, LEACH, WHITMAN, D'ANDREA & ESLINGER, P.A.,
By: JOSHUA A. WHITMAN, ESQUIRE,
815 South Main Street, Suite 200,
Jacksonville, Florida 32207

ON BEHALF OF THE DEFENDANT:

SAALFIELD, SHAD, STOKES, INCLAN,
STOUDEMIRE & STONE, P.A.,
By: JOHN B. SAALFIELD, ESQUIRE,
245 Riverside Avenue, Suite 400,
Jacksonville, Florida 32202

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THEREUPON:

KENNETH C. FISCHER

was called as a witness and having been first duly sworn was examined, testified, and stated as follows:

DIRECT EXAMINATION

BY MR. SAALFIELD:

Q. Your full name, sir.

A. Kenneth C. Fischer.

Q. And we're in your office today?

A. Yes, sir.

Q. Do you have a curriculum vitae that's current?

A. Yes. This is as of January. It hasn't changed since then, but it's the most current one.

Q. January this year?

A. Yes, sir.

MR. SAALFIELD: We'll mark this as No. 1, composite, Ms. Reporter.

(Whereupon, Defendants' Composite Exhibit No. 1 was marked for identification by the Court Reporter.)

BY MR. SAALFIELD:

Q. My understanding is you requested payment in advance. Is that true?

A. Yes, sir.

Q. And how much for the two hours we have set aside?

A. $1,600.

Q. Okay. So you charge "X" amount an hour?

A. $800 per hour for depositions.

Q. And then as far as review of materials?

A. $500 per hour.

Q. If you were to appear at trial in Jacksonville, what would the charge be?

A. It would be a $5,000 fee for the appearance, plus actual expenses like airfare and lodging.

Q. All right. If you had to go up the day before the trial and return the evening of the trial, would there be any fee expense other than the 5,000?

A. No, there would not be.

Q. When were you first contacted relative to this matter?

A. I believe it was early in 2010, maybe March of 2010.

Q. By whom?

A. Mr. Whitman.

Q. Did you know him before he contacted you in this matter?

A. I did not.

Q. This is the only case you've reviewed for him or someone in his firm?

A. That's correct.

Q. Do you know how he happened to locate you when he did?

A. If he told me, I don't recall the conversation.

Q. What did he ask you to do?

A. To review the matter of a patient, a young woman who had a stroke.

Q. Any more than that?

A. No, he did not.

Q. Have you brought with you and have before you on this table any and all materials you've been provided in this case?

A. Except there were some depositions I reviewed I had over the last couple of years. I reviewed them, and my employees mislaid them last week after I had given them back to them.

So what I have here is a list I've prepared which encompassed everything I've reviewed. Most of the things are here, except a

few of the depositions I reviewed are not, but thus far which ones.

Q. You've listed about 12 or 13 deposition transcripts all of which you've reviewed?

A. That's correct.

Q. Did you mark in any manner those depositions?

A. I don't believe so, no.

Q. And where they presently are we don't know?

A. Excuse me, sir?

Q. Where they presently are we don't know?

A. Some of them are here. Some of them I gave them to my employees to file back after I looked at them last week in preparation for this, and I asked them to pull out Friday. They couldn't find them Friday nor could they find them today.

MR. SAALFIELD: We'll mark this as 2, Ms. Reporter, the materials he's reviewed including the depositions.

(Whereupon, Defendants' Exhibit No. 2 was marked for identification by the Court Reporter.)

BY MR. SAALFIELD:

Q. What deposition transcripts do you have

before you?

A. I have Paula Luke, Manuel Portalatin. I believe this is the first one. There's a second one also, I believe, more recently.

Q. You have both transcripts or the first one?

A. I have the first one. The second one I've reviewed, but I don't have currently. And Suzanne Godwin, M.D. Those are the ones I have.

Q. After being contacted initially in the spring of 2010, you were provided materials via mail and/or disk?

A. Yes.

Q. CD?

A. Yes.

Q. And what materials were you provided after that initial phone contact?

A. Records of Baptist -- well, let's see. Some records of Baptist Primary Care, not all of them; Jackson EMS records; statements of Mr. Tom Quinn and Ms. Maria White; and records of Baptist Medical Center South admission of 4/17/08.

Q. Can you recall what records at Baptist Primary Care but not all you were provided?

A. Yes. I reviewed records stemming from

2006 to 2008. Records of Dr. Godwin, Dr. Tan, Dr. Portalatin; and some notations on the chart after the admission to Baptist in April.

Q. I thought I understood you didn't receive a complete copy of all the Baptist Primary Care records?

A. Actually, I received that. I received again sometime later, with Dr. Godwin's deposition, I received the records again. I believe maybe it was the same records over again. In other words, I received it twice, let's put it that way.

Q. Well, all right. I was wondering whether you thought there were any records missing from the copies you were initially provided from Baptist Primary?

A. To my knowledge, no.

Q. Then, at some time later, did you receive additional records than those you've just identified?

A. Yes. I received the records that came in with -- again, it was another copy of the Baptist Primary Care; records from CVS pharmacy; records from Walgreen's pharmacy; records of Dr. V-A-D-I-M, first name; M-A-D-F-I-S, M.D.; and a life care plan of Ms. Luke prepared by Ms. Willard.

Q. Did those records you just identified come in at the same time?

A. No, sir, they did not.

Q. Can you tell me chronologically when they came in?

A. Well, I have letters here, for example, a letter 3/29/11 from Mr. Whitman, which included the CVS and Walgreen's records; records from St. Johns County fire-rescue; selected City of Jacksonville Fire and Rescue Department protocols.

I have a letter of 6/17/2010 with records of Dr. M-A-D-F-I-S. I have a letter dated 11 -- 10/11/11, which included a brain CT scan of Ms. Luke. That scan was on -- I'm not sure of the time. All the scans are put together, so I'm not sure when that was.

Q. On disks?

A. Yes, sir.

Q. Is that the first time you received an imaging scan of any kind?

A. No, it was not.

Q. Or a study?

A. No. I received scans back at the time of the initial submission.

Q. The brain CT you referred to

October 11, '11, enclosure letter was that of what date?

A. I missed the last thing you said?

Q. The brain CT, what date was that that you received in October of '11?

A. I don't know that because I put all the CDs together, so I'm not sure which one that was.

Q. Can you tell me what the record of receipt was of imaging studies?

A. I couldn't tell you because I put all -- I've got these things. Well, here's something. Here's a letter dated 11/11/12, which included brain CT scans of July 2010, April 2011, May 2011, and March 2012.

Q. What are the significance of those scans as far as you're concerned?

A. Just showing the persistence of the brainstem infarcts that Ms. Luke had sustained.

Q. Initially, in the materials that were sent after you were first contacted by Mr. Whitman at or about March 2010, did you receive imaging studies?

A. Well, the ones I just indicated, plus I received scans at the time of the initial records.

Q. Okay. That's better. That's what I

meant. You did receive scans when you received initial records?

A. Yes.

Q. What scans did you receive with the initial records?

A. They were scans of April 2010. April 2008 -- excuse me -- in Baptist Hospital.

Q. All scans that were taken at Baptist Medical Center South for the April 17, '08, admission?

A. Yes, sir.

Q. Are there any other scans that we haven't identified which you have received?

A. No, sir.

Q. Are there any other documents you've received we have not identified?

A. I received -- there's a letter here. I just saw that, on 9/26/11, which just accompanied the deposition of Dr. Portalatin, which I think I mentioned to you.

There was another letter dated 9/10/12, which gave -- I'll show you the letter. In these depositions, which are included in the list I gave you initially.

MR. SAALFIELD: Not now, but later,

Ms. Reporter, after the deposition, please attach as a composite the respective enclosure letters from Mr. Whitman beginning with the initial one through the last one.

BY MR. SAALFIELD:

Q. Is the last letter you received from Mr. Whitman September 10, 2012?

A. To my knowledge, yes.

Q. 2012, rather?

A. Yes, sir, to my knowledge. This might help you. This is a list of some scans that I received. That being said, I didn't look at the non-neurological ones, shoulder, things like that. It's beyond my purview.

MR. SAALFIELD: We'll mark this as Exhibit 4. The composite we just identified of enclosure letters will be 3.

(Whereupon, Defendants' Exhibit Nos. 3 and 4 were marked for identification by the Court Reporter.)

BY MR. SAALFIELD:

Q. Any imaging studies, disks, films or medical records and depositions we haven't identified?

A. There's a disk somewhere in here.

Maybe it's not of a -- I think it was a disk. I got a second deposition of Dr. Portalatin, a very brief one.

Q. What does that deposition add as far as context to his first deposition, if anything, as far as you're concerned?

A. Not much.

Q. Anything in particular?

A. No, sir.

Q. You're a neurologist?

A. Yes, sir.

Q. And are you a vascular neurologist?

A. Well, that's -- there is a special board certification of vascular neurology. I never sat for that because that was not available when I was a resident.

However, a good part of my practice is involved with vascular neurology. The most common issue I deal with both in the hospital and my office is stroke. So, in actuality, I do vascular neurology, even though I don't have a board certification in that. It's a special qualification.

Q. Special or added qualifications?

A. Yes.

Q. When did that added qualification board recognition first begin?

A. 2006.

Q. Are you qualified to sit for the boards for added qualification as in vascular neurology?

A. I don't think that -- I'm not sure if it requires a fellowship or not. I don't know the answer to that question.

Q. As far as your practice is concerned, let's say over the last ten years, has there been any essential change in the type of patient or conditions you assess, diagnosis and treat?

A. The only change is that since the latter part of 2008 when I was a named the director on the stroke center of this hospital, I've had a little bit more involvement than previously with stroke.

Q. When you say "this hospital."

A. North Shore Medical Center.

Q. How many bed facility is that?

A. 304.

Q. You were named director of the stroke center at the hospital in 2008?

A. Yes, sir.

Q. When in '08?

A. October.

Q. Do you remain?

A. Yes.

Q. Expect to continue to do so indefinitely?

A. Well, nothing's indefinite. I do -- they did give me renewal, asked me to renew it through at least December of 2013. So at least through that period of time I'll be doing that, barring anything happening to me.

Q. Do you break down your practice in the office as well as at the hospital as far as time?

A. Yes, sir. I think I spend maybe 70 percent of the time in the office, 30 percent in the hospital.

Q. And in the office, do you see patients on referral?

A. Yes, sir.

Q. The majority of the patients you see in the office are on referral?

A. Yes, sir.

Q. And referral from primarily physicians on staff at North Shore?

A. Not necessarily. It could be from other parts of the other hospitals in North Dade

particularly.

Q. How many of your patients are referred who you initially see in the office would you estimate?

A. I would say 90 percent.

Q. Typically what are they referred for, what kind of conditions?

A. Migraine, neck and back pain, epilepsy, Parkinson's disease, multiple sclerosis, dementia, stroke. Those are the main issues.

Q. Those are conditions often treated by general neurologists?

A. Yes, sir, they are.

Q. And of those conditions, can you select one or two which is the most prevalent referral?

A. Stroke encompasses about 25 percent. I'd say it's migraine about 20 percent. I think stroke the most common outpatient diagnosis I have and probably migraine is number two.

Q. What's usually -- give me examples of the medical condition of the patient who's referred to you in whom you diagnosis a stroke.

A. Typically --

Q. Initial office visit.

A. Oh, what medical condition they might

have concomitantly, was that what you're asking for?

Q. Yeah.

A. Most people with stroke have underlying medical problems, most common of which are hypertension, diabetes, cardiac disease, peripheral vascular disease, dyslipidemia.

Q. And what's the average age of those patients who are referred in the office?

A. For stroke, I would say most of them are in the upper 60s or 70s.

Q. Is that because often the underlying disease such as you've identified are more associated with the elderly than the younger?

A. Yes, sir, that's correct.

Q. And patients you see in the hospital which would comprise about 25, 30 percent of your practice?

A. Yes, sir.

Q. You're seeing primarily in consultation?

A. Yes, sir.

Q. And in consultation for the same conditions you've just told me about in the office?

A. It's a different breakdown.

Q. Tell me what the breakdown in the hospital patient consultation is.

A. Half of them are stroke patients. The other half would be epilepsy, encephalopathy, acute spinal cord problems.

Q. And of those patients who you are consulted in the hospital for stroke, are most of them diagnosed with signs and symptoms of a stroke?

A. Yes, sir.

Q. And have most of those patients been diagnosed as suffering a stroke for whom you're consulted initially in the hospital?

A. Yes. It's thought to be a stroke. That's why I'm called. Not necessarily. They may come in with some other confusional states, and I find indications under examination or imaging or both of having a stroke.

But usually someone, either an ER physician or a primary physician, has considered a stroke, and that's why I'm called. Typically I'm called very early in the game, because in the stroke center, we try to get the neurologist involved very early in the care of the patients.

Q. Have you generated any handwritten notes relative to your review of these materials?

A. Just on the margins of the records. Not every record, but many records. There are like stickies like this, sir, and underlines.

Q. May I?

A. Sure.

Q. The sticky is colored?

A. Yes, sir.

Q. Is that color of any significance?

A. No. Random.

Q. Red, green, yellow, blue?

A. No.

Q. And you haven't handwritten any formulated opinions in reviewing any of these records?

A. No, sir.

Q. Nor generated handwritten notes that itemize your opinions?

A. No, sir.

Q. Or generated any computer entries consistent with your opinions?

A. The only thing is, at some point in time, I did provide for Mr. Whitman an affidavit in this matter. That was back in 2008 -- 2010, excuse me.

Q. Presuit?

A. Yes.

MR. SAALFIELD: Josh, that was presuit?

MR. WHITMAN: Yes, sir.

BY MR. SAALFIELD:

Q. Other than that, you have not generated any computer-generated documented -- document of your opinions?

A. No, sir.

Q. Now, in these cases in which, for instance, this is Baptist Medical Center South admission copy where you have underlined on the pages that are tabbed, what is the general purpose for having done so?

A. Well, you see, when I review these things later on, I don't need to review every sheet of paper again. I just go right to my tabs to get a good idea of the gestalt of the case, and it reminds me of what was significant. These are tests or entries which I felt were important in describing the patient's condition at various times.

Q. Now, with respect to depositions, have you tabbed or underlined certain pages at times?

A. I don't believe in this case I have. Sometimes I do that. In this particular matter, I

don't believe I did.

Q. You say you don't believe you did. Do you know whether --

A. The ones I received in September, the ones which are missing, I've quite certain I did not do that.

Q. Okay. Look at Dr. Portalatin's, for instance, deposition transcript and see if you've marked or tabbed in any manner a page or more.

A. Sure. I tabbed his name and the dates. I think that's it. No, I'm sorry, excuse me, sir. I stand corrected. I did underline some things. You are welcome to look at it.

Q. In general, that which you underlined in red to Dr. Portalatin's deposition, and I'm looking at the June 27, 2011, transcript, you did so for what reason?

A. I thought it was more important than other parts of the transcript.

Q. It looks as though all you did was underline rather than write in the transcript; is that correct?

A. Yes, sir.

MR. SAALFIELD: I would like copies of only those pages that are underlined from

Dr. Portalatin's deposition, Ms. Reporter.

(Whereupon, Defendants' Exhibit No. 5 was marked for identification by the Court Reporter.)

BY MR. SAALFIELD:

Q. Did you do the same to the second transcript of Dr. Portalatin?

A. I don't believe there was much in there, so the answer, I think, is no.

Q. I asked the same question before. You were somewhat equivocal. I'd ask you to check to be sure.

A. I'll check the other ones. Let's see. I do have some underlines in Dr. Godwin's deposition. I'll hand that to you.

MR. SAALFIELD: With respect to Dr. Godwin's deposition, Ms. Reporter, let's do the same as we did for Mr. Portalatin's, please.

(Whereupon, Defendants' Exhibit No. 6 was marked for identification by the Court Reporter.)

BY MR. SAALFIELD:

Q. What did the substance of Dr. Godwin's deposition add to any formulated opinions you may

have in this case?

A. Only it confirmed the records that Ms. Luke did not have any major predisposing illnesses suggestive of stroke between the 2006 and 2008 period of time she had been treated in that group practice.

Q. As far as the treatment provided, were you critical for any reason?

A. Which treatment specifically, sir?

Q. At the respective visits to Baptist Primary Care?

A. Yes, sir, of the 4/7/08 visit.

Q. Only that one?

A. Yes, sir.

Q. Now, specifically, were you asked to do anything upon review of these records or review them for any specific purpose?

A. No. I received the material. Mr. Whitman spoke with me. He was very terse. He said: I have a young woman with a stroke. I would like you to look at the records and discuss it with me. Then I reviewed them and I called him and had a conference with him.

Q. Have you met with Mr. Whitman prior to this deposition in person?

A. No.

Q. You have it --

A. Wait. Wait. I'm trying to think of way back in 2010, we did. I did not meet with him this year. I did have a phone conversation with him last week for half an hour. But I know I had other phone conversations with him in the past, and I think I met with him in 2010 in person.

Q. Do you recall any information he provided to you at any time by phone or in person with respect to what you understood or facts and circumstances about the case in addition to that which you read in the respective records and depositions?

A. I don't recall any additional information, no, sir.

Q. You've not removed or discarded any materials you've been provided?

A. No. Other than depositions that are missing, not that I removed them, but they're somewhere circulating around.

Q. Do you know who any other identified forensic expert witnesses are on behalf of the plaintiff in this case than --

A. No.

Q. -- you?

A. I do not know that, sir.

Q. Do you know Harold Miller, who's a primary care physician?

A. I do not know him.

Q. Or Joel Meyer, who's a neuroradiologist?

A. I don't know him either.

Q. I take it, therefore, you've not been involved in cases in which they have as well, on the same case?

A. To my knowledge, I have not seen those individuals, nor involved in cases involving them.

Q. Have you seen any pleadings in this case?

A. No.

Q. The complaint or interrogatory answers or disclosure of expected testimony from expert witnesses?

A. No.

Q. What is the scope, before we get into your opinions, of your opinions in this case based on review of the records?

A. I have opinions on the standard of care of Dr. Portalatin in his visit with Ms. Luke of

April 7, 2008 and the causation of that vascular (sic) care deviation and the propagation of the stroke sustained by Ms. Luke and the resultant damages that she has.

Now, I believe I've submitted records, more recent records, which demonstrate that she has other neurological problems which have evolved secondary to the stroke. For example, she developed a lumbar problem requiring surgery. I would have opinions that the stroke and the resultant abnormal gait was a factor in her developing, as a young individual, lumbar problems requiring surgery.

Q. Have you seen the surgical records?

A. No, I've not seen the surgical records.

Q. Do you recall when the surgery was?

A. I believe it was -- she had a couple of surgeries. She had one surgery, and then it was compounded. She had a motor vehicle accident, then she had a second surgery after that. I think the last surgery was 2011.

Q. When you say the second -- or the vehicle accident compounded the surgery, what do you mean?

A. She had surgery. She was stable and

had a rear-end motor vehicle accident and had additional back pain requiring further surgery. I don't have the records of that. It's alluded to in the deposition of Dr. Harris her treating physiatrist.

Q. Did you understand that the surgical intervention initially for her back was successfully accomplished?

A. That's my understanding.

Q. Did you understand that she was recovering as expected from that surgery?

A. That was my understanding.

Q. Do you know whether she reached MMI before the rear-end automobile accident?

A. I don't know that. I don't have the records to discuss that.

Q. Do you know what disruption, if any, the motor vehicle accident had to her surgery that preceded the accident?

A. I do not have the specific records of that, so I could not answer that question.

Now, mind you being used in that vein, but I did receive deposition testimony which discussed it, but Mr. Whitman has not specifically said if he wants me to comment on that or not.

Q. You haven't formulated opinions on that as we speak?

A. Only that the initial surgery, within reasonable medical probability, had a substantial influence from her significant gait disturbance and asymmetry, which often aggravates a lumbar condition.

More than that, I'm not -- at this point in time, I'm not prepared to opine.

Q. Maybe I didn't understand. You said her original surgery, within reasonable medical probability, had a significant influence on her gait disturbance?

A. No, no. The stroke influenced her gait disturbance, which in turn propagated the need for the initial surgery.

Q. Do you know what her prognosis would have been, assuming recovery from the first surgery?

A. From what I understand -- again, I've not seen records, just in deposition testimony -- but she was proceeding well after the first surgery.

Q. Do you have an opinion, within a reasonable medical probability, as to whether she

would have required additional surgery but for the motor vehicle accident?

A. I'm not prepared to render an opinion in that manner at this point in time, unless I'm provided additional records.

Q. You have not seen or met with Ms. Luke, have you?

A. Correct, I have not.

Q. Now --

A. Excuse me. I want to complete another aspect of my answer. That based on the fact this stroke transpired in April 2008 and we're now more than four-and-a-half years from that time, whatever neurological deficits Ms. Luke sustained from that stroke is permanent and she will not have any spontaneous improvement.

Q. The stroke affected what area of the brain?

A. The bilateral brainstem and the cerebellum.

Q. Is the cerebellum essentially the same level as the brainstem?

A. It's close to it. I mean, the brainstem is just below the cerebellum. They are controlled or subserved by the same arterial

circulation, the vertebral vascular system.

Q. What level relatively, typically, is the brainstem if we consider the cervical spine?

A. Around C2.

Q. The -- are you able to estimate how much of the cerebellum was affected by the stroke?

A. Well, let's see --

Q. As far as territory I'm talking about or area --

A. Okay.

Q. -- of the total cerebellum.

A. 20 percent. That's in terms of side. Interestingly, the cerebellum is an area which often you can have clinical restitution of function. In other words, you may have an ischemic area, even a fairly large cerebellar stroke which you can get good restitution of function. So even though it may be 20 percent were involved radiographically, it might have a lesser degree of involvement ultimately clinically.

Q. As we speak today, based on subsequent images you've seen, is it approximately 20 percent of the cerebellum that's affected?

A. Yes, sir.

Q. As you would say, it's a permanent

stroke?

A. Oh, yes, it is.

Q. Or infarction is what you're seeing?

A. Yes, sir.

Q. With respect to the brainstem --

A. At least -- let's go back. I'm sorry, sir. I didn't mean to interrupt you.

At least radiographically. If you look at the evolution of these films, the cerebellar stroke, at least in part, occurred, within reasonable medical probability, at the time of her or shortly before her visit to Baptist Primary Care on April the 7th, 2008.

She may have had aggravation of that stroke. But the subsequent more major stroke that she suffered 4/16 and 4/17/08, when she had -- certainly had the bilateral brainstem infarct came about and probably was aggravation of the cerebellar stroke at that juncture.

Q. With respect to the brainstem, bilateral brainstem stroke, as you refer to it, and that excludes the cerebellum?

A. Yes, sir.

Q. The pons are affected?

A. Yes, sir.

Q. One side more than the other?

A. Yes. It's the left side more than the right.

Q. And, again, generally speaking, the pons itself, relative to the cerebellum, is it essentially the same size in area or smaller?

A. The pons is a smaller structure than the cerebellum.

Q. How much smaller?

A. 80 percent smaller.

Q. And with respect to the pons left, which you say is more affected or infarcted than the right, how much of the left pons is involved?

A. Probably 40, 50 percent.

Q. And the right pons how much?

A. 20 percent. These are gross numbers --

Q. I understand.

A. -- but they're approximations.

Q. Okay. The cerebellum stroke, in your opinion, occurred on or about April 7th?

A. Yes, sir.

Q. What's your basis for that opinion?

A. Symptomatology expressed by Ms. Luke at that time, and it was also voiced in the deposition of her father who took her to the doctor's office

on that occasion.

Also that -- actually the documentation of Dr. Portalatin demonstrated that she was having symptoms which are consistent with a cerebellar stroke.

Q. And what documentation did Dr. Portalatin indicate consistent with signs and symptoms of a stroke?

A. She was dizzy, nauseous, having vomiting, having a positive Romberg maneuver.

Q. What was positive about the Romberg as you understand?

A. He described it as that she worsened with closure of her eyes. If one had a peripheral process; in other words, if a physician is evaluating a patient, if the symptoms that she expressed, the dizziness, the nausea, the vomiting, trouble with balance, differential includes a peripheral process as nystagmulopathy (sic), positional vertigo, Meniere's disease, labyrinthitis versus central process, which could be a tumor, a stroke, hemorrhage, things of that sort.

Sometimes it's hard to tell just in examination what you're dealing with. That's why

we typically obtain imaging to do that.

And a Romberg test sometimes tells you if it's a peripheral process or a central process. And a positive Romberg test, which means that there was a change with loss of visual input, would be more suggestive of a central process as opposed to a peripheral process, but usually it's the same both ways.

So that might have clued Dr. Portalatin, in addition to symptomatology she otherwise demonstrated, that this was central process requiring urgent neurological evaluation and imaging at that time.

Q. When you say it's usually the "same both ways," you say with the eyes opened or closed?

A. Yes, sir. With a peripheral process, if you have a vestibulopathy, a positional vertigo, closing the eyes doesn't modify the symptomatology. It doesn't make the examination worse.

If you have proprioceptive problem or a central problem, the loss of visual stimuli often worsens the patient's symptomatology, which was apparently what was transpiring here based on his deposition testimony.

Q. What symptoms were exaggerated with

closing the eyes as you understood?

A. Her balance.

Q. Balance as determined by seeing what when the eyes were closed?

A. The swaying of the patient in front of the examiner.

Q. So you understood that, with the feet together and the patient in front of the examiner, there was swaying --

A. Yes.

Q. -- by Ms. Luke?

A. Yes.

Q. "Swaying" meaning what?

A. Moving from side to side. Not being able to maintain her balance.

Q. I envision what you're telling me is that looking at the patient, she would move to her left and then to her right?

A. It's not described, I don't think, in detail in his deposition. That certainly could happen, or lurch to one side or the other or both. Again, I don't know exactly what transpired in the examining room.

Q. Well, didn't Dr. Portalatin testify in his deposition she did not lose her balance with

her eyes closed?

MR. WHITMAN: Object to the form.

THE WITNESS: Well, I think he said her balance was impaired, and it was worse with the eyes closed.

BY MR. SAALFIELD:

Q. So, if balance is impaired and worse with eyes closed, that's possibly a central condition?

MR. WHITMAN: Object to form.

THE WITNESS: Possibly.

BY MR. SAALFIELD:

Q. What else about examination by Dr. Portalatin was significant to you as far as the conduct of the Romberg than what you deduced was that there was impaired balance and worse with the eyes closed?

A. I'm a little bit unclear of your question. What else in his examination besides that?

Q. Yeah. Just the Romberg. What other findings in the Romberg?

A. Oh, that's all. That's all.

Q. Okay. And then, when the eyes were open, there was loss of balance, but it wasn't as

much as when the eyes were closed?

A. Yes, sir.

Q. And the loss of balance with the eyes open, as you recall or understand, was the patient would seem to move from left to right?

A. That's my understanding.

Q. Any other movement of any kind that you're aware with eyes closed or open when Romberg was conducted?

A. Unaware of any other movements.

Q. Okay. And loss of balance, as we've just discussed it and you understand, moving from side to side, may indicate a peripheral or a central problem?

A. Yes, sir, it can.

Q. In your experience, when that is involved, loss of balance, what percentage of the time does it turn out to be a central condition rather than a peripheral condition in patients who present with dizziness or vertigo-type complaint?

MR. WHITMAN: Object to the form.

THE WITNESS: Of course, I see a selected group because I'm a neurologist. So people who are sent to me someone typically suspects a neurological problem. They may

have come from a general practitioner or internist or ENT physician who thinks it may be central as opposed to peripheral.

So I may see skewed amount. So the number I see may be 30, 40 percent central. Whereas someone coming to a general practitioner or a family physician, it may be much lower amount, but I would suspect that would be the case.

BY MR. SAALFIELD:

Q. You understood that the day visiting Dr. Portalatin Ms. Luke was vomiting?

A. Yes.

Q. And how long had she been experiencing that condition?

A. I don't know exactly the amount of time.

Q. Is it important or significant the amount of time?

A. No.

Q. And she was nauseous the visit 4/7?

A. Yes.

Q. For what amount of time?

A. I don't recall that either.

Q. Not significant?

A. No, sir.

Q. What else -- what other symptoms or history were significant to you that visit, if any?

A. She had no -- well, she was a person who did not have any major risk factors for cerebral vascular disease except she had long-standing migraine. And she was on certain medications, vasoconstrictive medicine, Zomig and sumatriptan.

Q. Spell that, please, sir.

A. Zomig, Z-O-M-I-G; and sumatriptan, S-U-M-A-T-R-I-P-T- A-N.

Q. Has that got another name?

A. Yes, Imitrex, I-M-I-T-R-E-X.

Q. What's that typically prescribed for?

A. Migraine.

Q. And Zomig as well?

A. Yes. She also was on gabapentin, but that wouldn't have any impact on cerebral vascular disease, whereas the other two are vasoconstrictive agents and they can sometimes precipitate stroke in migraine patients.

Q. What's the likelihood of stroke statistically, if you know without speculating, from any studies?

A. In what?

Q. With regard to a 32-year-old female.

A. One in a thousand.

Q. If we add to that a 32-year-old female who has a history of migraine headaches, what is the statistical likelihood?

A. Increased two- or threefold.

Q. So, maybe three to four in a thousand?

A. Yes, sir.

Q. And for those numbers you've just related, what is your reference or source?

A. I've seen that in the literature. I can't point to a particular thing. At least I've seen that in my reading.

Q. And in that regard, as far as the literature is concerned, would I assume correctly you've not specifically gone to any literature to corroborate, support or enforce any of the formulated opinions you have developed in this case?

A. You're correct.

Q. Would I assume correctly you don't know what the deposition testimony in part or whole is from Dr. Miller?

A. I have no idea. I didn't know of his

existence until you mentioned it a little bit ago.

Q. Is the same true for Dr. Joel Meyer?

A. It is.

Q. What is your basis for assuming that Ms. Luke was on Zomig and Imitrex?

A. That was in the notes of the Baptist Primary Care office.

Q. Specifically where, sir? The flow sheet?

A. Yes. Zomig, I don't see -- I don't see the sumatriptan.

Q. While you are looking through those, I see you have underlined in red.

A. Yes, sir.

MR. SAALFIELD: Ms. Reporter, the next composite exhibit will be those respective pages from the office chart, Baptist Primary Care, in which he has underlined in red. Thank you.

(Whereupon, Defendants' Composite Exhibit No. 7 was marked for identification by the Court Reporter.)

THE WITNESS: I may have to remove the sumatriptan. I see Zomig listed several times, but I don't see sumatriptan. They're

very similar medications actually.

BY MR. SAALFIELD:

Q. Either one have a greater proclivity to -- or is either more of a vasoconstrictor than the other?

A. No. They're almost identical chemically actually.

Q. How long was she taking Zomig, if you know?

A. Probably since 2000 -- well, let's see, she was in 2006. I have to look at the previous doctor's records to see if it was before then. I'll find that somewhere else.

Q. We don't need to know specifically. But do you have a gestalt as to how long she may have been taking --

A. Maybe three or four years.

Q. Do you know when she was first diagnosed with migraine headaches?

A. I don't because I don't have records before 2004.

Q. Do you know the etiology for her migraine headaches were, why she's having them?

A. Well, it's a cryptogenic process. We don't know the etiology of migraines.

Q. What does "cryptogenic" mean?

A. Unknown cause.

Q. Was she relatively functional with her migraine headaches as far as activities of daily living and employment?

A. Yes.

Q. How often would she suffer a migraine headache when she did so on a monthly basis let's say in '07/'08?

A. It wasn't that common. She was taking a preventive medication, gabapentin, and using the Zomig for breakthrough headaches. It's not specified exactly how often she was utilizing them.

Q. Spell that preventive medication.

A. Zomig. I'm sorry. Oh, the gabapentin. G-A-B-A-P-E-N-T-I-N. It's also referred in the chart as Neurontin, N-E-U-R-O-N-T-I-N.

Q. Any particular vasculature that was involved with her migraine headaches?

A. No.

Q. In other words, can't say it's the vertebral artery?

A. No, I could not say that.

Q. Or the basilar artery?

A. I could not say that.

Q. Don't know?

A. Don't know.

Q. So if I understand what you're saying for the reasons you expressed, migraine headache history was a very slight risk factor to stroke --

MR. WHITMAN: Object to the form.

BY MR. SAALFIELD:

Q. -- in a 32-year-old female?

A. Well, it increases it. It's still, even with the migraine, she still had a low-risk profile for stroke being her young age and lack of hypertension, diabetes, cardiac disease, smoking.

Q. Very low-risk factor?

A. Yes.

Q. Any other risk factors at all that she had other than the migraine?

A. Minor. There was some family history of stroke. It was not a first degree relative. It was a grandparent or grandparents.

Q. If we look at the one out of a thousand in a 32-year-old, what does that family history elevate the statistical likelihood, if any?

A. Slightly only.

Q. Pardon me?

A. Slightly only.

Q. We don't know what that relative's stroke was; i.e., hemorrhagic, ischemic, thrombotic?

A. I don't know that.

Q. Nor the age?

A. I don't know that either.

Q. And it was a grandparent?

A. Yes.

Q. Any other factors at all that would in any way maybe increase your risk factors for stroke?

A. None of which I'm aware.

Q. Did she have coagulopathy abnormality?

A. We know she didn't because she was worked up for that subsequently and it was not found.

Q. Not found?

A. Not found.

Q. So, as far as you're aware, she did not have a coagulopathy problem?

A. She did not.

Q. Did that workup include a Factor 5 Leiden?

A. I believe it did.

Q. And PT/INR?

A. Platelet count, yes.

Q. I looked. I didn't see a Factor V, but you believe you saw it?

A. I believe I saw it in the Baptist records.

Q. What other coagulopathy testing would be done, other than those we just mentioned?

A. Platelet adhesion studies.

Q. Was that done?

A. No. They would do, you know, looking for lupus, arilatex (sic), other forms of tissue disease.

Q. None of which were indicated under the circumstances?

A. They did the testing. It was not borne out. She didn't have those.

Q. She didn't have those things?

A. That's right.

Q. So, from what you saw, complete coagulopathy profile and testing was conducted?

A. As far as I can tell, yes.

Q. And that was at Baptist Medical Center South?

A. Yes, sir.

Q. We were talking about her symptoms 4/7

and history. Anything else of significance we haven't talked about?

A. No, sir.

Q. And you indicated that the Romberg testing, when performed, demonstrated what you recall swaying to the left and right.

Were there any other examinations conducted and findings that you thought were significant and may suggest the possibility of stroke?

A. Oh, to the contrary, actually. I mean, the limited examination that was conducted by Dr. Portalatin didn't show any -- did not demonstrate any focal findings. In other words, he didn't document a full neurological examination.

Whatever he did document was not demonstrative of any focal or focality. He didn't show any facial asymmetry or paralysis or focal sensory loss or anything of that sort. That being said, it was not a full neurological examination.

Q. There wasn't weakness or reflex dysfunction?

A. No, there was not.

Q. No paresthesia?

A. Paresthesia is a symptom, but he didn't

mention that.

Q. Do you feel she had that symptom?

A. I don't know that.

Q. Was the -- I mean, you don't -- was his examination, under the circumstances for a PCP, within recognized parameters?

A. Yes, I think. I don't quarrel with the examination per se, sir.

Q. What you quarrel with is his not entertaining the differential that the Romberg, because of the swaying back and forth, might indicate the possibility of a central problem?

A. Well, that coupled with the symptomatology expressed by the patient. When you're a young woman, although young, who has nausea, vomiting, falling to the side, that differential is a central problem be it vascular or neoplastic or a peripheral problem. Again, it's very hard on the examination itself to distinguish.

And the way one distinguishes either is order an MRI scan or, alternatively, have a neurologist see the patient. And either one of those would be a satisfactory response to her presentation. I criticize Dr. Portalatin for not doing one of those two things, either getting a

neurologist involved immediately, or sending her for an MRI scan of the brain, which would be the best test to demonstrate the posterior fossa structural process.

Q. You say that he should have entertained the differential possibility that she was having a posterior fossa dysfunction?

A. Yes, sir.

Q. And posterior fossa is what?

A. The brainstem.

Q. In your opinion, a stat neurologic consult was necessary the same day?

A. Either the same day or -- sometimes it's hard to get it the same day. He could have done several things. He could have sent her to the emergency room at Baptist South, if that was close by, and asked them to do an MRI scan or get a neurologist and call to see her, or talk to a neurological colleague he deals with, look, and say, I have this patient here in my office, she's having these symptoms, I'd like you to see her today or tomorrow. If he had done one of those things, I would be satisfied with his behavior.

Q. Now, is it your opinion that Mrs. Luke suffered a stroke on April 7?

A. Yes, sir.

Q. And a stroke is defined?

A. As a -- well, actually it's an interesting question. I'll tell you why, because she got better. I mean, a stroke typically has a definable residual neurological defect. And there was no neurological examination conducted on her on the 7th until the 17th. I don't know whether a neurologist seeing her in that period of time before the 17th would have seen a focal neurological deficit.

However, we do have her scans done on the 17th, and the scans on the 17th which demonstrate the cerebellar and pontine infarcts indicate some chronicity in that cerebellar lesion. It looks like it was old. It could well date to the 7th. It certainly was not something that happened on the 17th.

Q. And how are you able to date the MR -- are you talking about the MRI on the 17th?

A. Yes, sir.

Q. And you've looked at that?

A. Yes, sir.

Q. How many times?

A. Let's see, at least -- probably twice.

Not recently, but I looked at it way back in the beginning, and I think I discussed that with Mr. Whitman sometime after my initial review.

Q. Have you looked at it in the company with any colleague who has special expertise in interpreting MRI?

A. No, I have not looked at it with anybody else.

Q. And you see in the MRI what, which, in your opinion, is consistent with a stroke that occurred about ten days earlier?

A. It looks old. It looks -- I see strokes every day. I look at all my patients who have stroke. I look at their imaging. I see a couple of strokes a day. And sometimes you can see an old stroke versus a new stroke.

I could not say specifically how old it is, but it looked older than -- in other words, she had an MRI the day that she was admitted on the 17th. This looked older than the 17th. Whether it was three days old, a week old, ten days old, I'm not equipped to tell you that.

Q. Well, that's what I'm asking you. Looking at the scan itself, are you able to see how many days old that stroke looks like?

A. No, sir. No, sir.

Q. And the stroke you're referring to is the one in the cerebellar?

A. Correct.

Q. Not in the pons?

A. Correct.

Q. The pons is more recent than that in the cerebellum?

A. Yes, sir.

Q. All right. So you would say it's older, the stroke in the cerebellum on the MRI, the 17th of April 2008. How many days, based only on the film, though, you can't tell me?

A. That's correct, sir.

Q. What is it you see that suggests to you that this is an older cerebellum stroke?

A. It looks more defined.

Q. And be more specific as to what you see that you characterize as more defined.

A. Some dropout of the cells. It's been there for some time.

Q. Again, for a layperson, "dropout of the cells," what does that mean?

A. Well, usually, see, when you see an acute stroke it's edematous. There's a loss of

socle demarcation. There's swelling. And then as the stroke evolves over several days to a week, that that swelling is reduced. It becomes fixed.

The pontine infarcts look acute, edematous. The cerebellum, one looks like it's been there -- like it's been there for some period of time. The acute swelling has dissipated.

Q. Based -- so if imaging was done on the 7th of April 2008, for purposes of discussions --

A. Yes.

Q. -- it would not have looked as defined as you saw it on the 17th?

A. That's correct, sir.

Q. What -- are you able to opine what it would look like if an MRI had been done on the 7th?

A. I'd be speculating.

Q. I don't want you to speculate. You would defer to a specialist?

A. A neuroradiologist, yes.

Q. If a CT scan had been done on the -- April 7, have you an opinion what it may have shown?

A. Yes. Probably normal.

Q. Why do you say that?

A. CT scans, number one, do not well

demarcate acute strokes. And, number two, they are specifically poor in delineating brainstem posterior fossa strokes. So whereas you might possibly see it, most of the time you don't.

Q. Why is it, sir, that CT scans typically and especially are not good at demonstrating brainstem posterior fossa?

A. The bones get in the way of the scan.

Q. If a CTA had been performed April 7, same answer?

A. No. It's a different answer.

Q. Okay.

A. CTA is good for the vasculature. And looking at the entirety of her records, the most likely process that was occurring with Ms. Luke was a vertebral artery dissection which was throwing off artery-to-artery embolization.

What likely transpired on April 7, 2008, that dissection gave off a clot which went into the -- and caused a cerebellar infarct. You would have seen, within a reasonable medical probability, on the CTA that dissection which was later visualized on the scan that was performed the 17th.

Q. Are often CT scans performed initially

in patients such as this who present with symptoms as she did on the 7th as you understand them?

A. That depends. In other words, if a person comes into the hospital and there's a consideration of stroke, the first thing you do is a CT scan to rule out hemorrhagic process. However, neurologists know, many internists and generalists know that CT scan is insufficient to rule out a posterior fossa process. So its being negative does not eliminate that diagnosis and you'd follow that with an MRI scan.

In this particular case, I would criticize no one to do a CT scan to rule out a hemorrhage. But, then, if you just did that as a stand-alone procedure, that would be insufficient. The sequence would be either directly to an MRI scan or a CT followed almost immediately by an MRI scan. And the MRI scan would have demonstrated a cerebellar infarct that would have been followed by either a CTA or MRA to delineate the vascular cause.

Q. You mention a dissection. That dissection was to the vertebral artery?

A. Yes. The right vertebral artery.

Q. Right vertebral artery.

When you say "dissection," what kind of dissection are you talking about to that artery?

A. Well, we don't know the etiology. In other words, there's no history of trauma in this patient. There's no history of an endogenous process which would cause dissection. About half of dissections we don't have a handle on why the people have them; they just occur spontaneously.

It seems that that's the way it was with Ms. Luke. I don't know why. I don't think anybody's defined why she had dissection in the first place.

Q. There's three layers to the artery?

A. Yes, sir.

Q. And the dissection affected what lining of the artery or layers?

A. Well, the intima was affected. I couldn't tell you all the layers just by the radiographs.

Q. And we don't know the etiology of the dissection in her case, if that's what she had?

A. That's correct, sir.

Q. We're not aware of trauma?

A. I am unaware of any trauma; that's correct.

Q. Not aware of any predisposition to dissection?

A. That's correct.

Q. For any reason. What often are predisposing factors?

A. Sickle cell disease; Marfan syndrome; Moya, M-O-Y-A, Moya syndrome; Ehlers, E-H-L-E-R-S, hyphen, Danlos, D-A-N-L-O-S, syndrome; systemic lupus; rheumatoid arthritis. There's a whole host of connective tissue and congenital illnesses which would cause that.

Q. So what did the dissection do physiologically when it occurred?

A. It causes a rent, a tearing of the intima of the artery. That causes the body to try to heal that rent by aggregation of platelets in that area of trauma -- or trauma of disturbance -- I wouldn't say trauma -- and that causes a clot to form.

Subsequently, these clots migrate cephalad and go into the smaller tributary from the vertebral to the vascular and the vascular branches.

Q. Cephalad meaning?

A. Forward, up.

Q. Superiorly?

A. Yes. And I think that is what happened with Ms. Luke, because many different arteries were involved.

Q. So the propagation went into different arteries?

A. Yes, sir.

Q. Of clotting?

A. Yes, sir.

Q. And once the dissection occurs, why does the clot propagate?

A. Well, clots initially fix to an artery and then they move. I mean clots can leave where they're situated and go up.

Q. You're talking about embolism?

A. Yes, sir.

Q. Okay. Where pieces of a clot break off?

A. Yes, sir. That's what happened.

Q. Okay. And I'm talking about you said from the dissection a clot developed?

A. Yes, sir.

Q. In the right vertebral artery?

A. Yes, sir.

Q. Did that clot, without embolizing,

propagate after developing?

A. Well, it probably didn't. It was probably smaller on the 7th. It was larger on the 17th, because it was a very -- when they had the vascular studies performed the 17th, it showed significant disease of the right vertebral and basilar artery.

Q. Right vertebral and vascular?

A. Basilar.

Q. Well, do you understand that there was propagation of clot emanating from the dissection in the right vertebral artery and continuous up into the basilar?

A. Yes, sir, that's correct.

Q. So we're talking about a distance of about approximately what in millimeters or centimeters?

A. Probably 2 or 3 centimeters.

Q. And then, from that, you're saying and are of the opinion that some pieces of that, embolic pieces broke off and went up into smaller arteries?

A. Yes, sir.

Q. And lodged in the pons as well as the -- as where?

A. Lodged in arteries serving the pons as well as the cerebellum.

Q. When did they -- when did the embolization occur to the cerebellum?

A. Well, I think the initial one was back on the 7th of April when she had that episode for which she came to Dr. Portalatin.

Q. So for the symptoms you associate with a stroke on the 7th are the consequence of embolic disease?

A. Yes, sir. Artery-to-artery embolization from the right vertebral artery through the basilar artery, and the clot lodged probably in one of the arteries serving the right cerebellum.

Q. Even though at that time -- well, what was the size of the clot would you estimate?

A. Much smaller because she totally recovered.

Q. When did she totally recover, as you understand, following the 7th as far as any symptoms?

A. In her deposition -- I have no records. But in her deposition she said she was better the next day or so. She felt back to normal and went

back to work.

Q. She was able to go back to work until late afternoon April 16?

A. Correct. I think at that point in time, she had another embolism form.

Q. Was she having any significant symptoms you're aware of two or three days after April 7 before April 16?

A. No.

Q. At work, did she have any symptoms that you would consider focalizing or consistent with a stroke?

A. Let me -- there's no medical documentation. She did not see a physician. I have letters from two co-workers which describe her symptoms. If I may, I'll pull them out.

Q. Yes, please do.

A. I'm talking Maria White and Tom Quinn.

Q. Yes, sir.

A. And first Maria White says, "Paula said the room was spinning." That is all she says, basically. Tom Quinn --

Q. You have not read her deposition?

A. No, sir.

Q. Okay.

A. "She said the room was spinning and everything was going to the right."

Q. This is White now?

A. No. This now is Tom Quinn.

Q. I'm sorry. Okay.

A. Not much else in Ms. White's statements.

Mr. Quinn is little more specific. He says, "everything was going to the right." So that suggests that the right cerebellum was involved here.

Let me see if anything else was said. "She was vomiting and threw up in the trash can." But, again, that's not localizing in answer to your question.

"She said her face was numb," but he didn't specify which side of the face was numb, so I don't -- localizing. Facial numbness typically suggests a pontine issue. But I can't say which side because he didn't specify. Let's see if he says anything else.

He mentions the room was spinning. And that's all. So I mean, the suggestion from these statements, these are nonmedical people, is something was involving the cerebellum and one side

of the pons, but I can't be more specific in localizing it just from these statements.

Q. We know that both sides of the -- both of the pons or the pons bilaterally was involved based on imaging on the 17th?

A. That's correct.

Q. Do you know whether afternoon of the 16th both sides of the pons were involved?

A. I don't know that.

Q. Is it probable that they were?

A. Yes.

Q. Did you see the rescue report?

A. Yes, I did. The Jacksonville EMS.

Q. What understanding do you have as to why rescue did not take this lady to the emergency room?

A. That's correct, they did not.

Q. Yeah, but what understanding do you have as to why they did not?

A. I think they assured her inappropriately, this was since the doctors had found nothing wrong, it would be a waste of her time and she would go in for no reason, and they sort of persuaded her not to go.

Q. Are you aware of stroke protocol for

EMS?

A. Yes.

Q. Anytime there's a sign or symptom that could be consistent with an acute stroke, EMS should take that patient to the emergency room?

MR. WHITMAN: Object to the form.

THE WITNESS: That's correct.

BY MR. SAALFIELD:

Q. If the rescue were telling this patient what you recall, that would be inappropriate. That's consistent with practicing medicine, isn't it?

A. It's inappropriate, I agree with you, sir.

Q. So you would agree with me that rescue should have taken this patient to the emergency room?

A. Yes, sir.

Q. And their failure to do so was negligence?

A. In my opinion it was.

Q. If they had taken her to the emergency room, do you have an opinion whether her ultimate outcome would have differed from what you understand it to be?

A. Here I'd be speculating. I mean, obviously, it's better to go sooner than later; in other words, the period of time of her appearance would have been earlier. In other words, eventually she came in 1:00 o'clock in the morning on the 17th. She could have come 5:00 o'clock in the afternoon on the 16th. And she had less burden of disease on the 16th than she had on the 17th. She had more fixed deficit on the 17th.

So potentially treatment could have been rendered her. But, again, I don't know exactly what the imaging would have been. We know she had -- I'm finishing up. We know on the 17th she has a significant dissection, which had propagated, as you correctly described, from the right vertebral artery through the basilar artery involving multiple tributaries in the basilar artery.

I don't know how much less anatomic disease she had on the 16th as opposed to the 17th. It would not have been more. So it would have been better to come. I don't know whether she could have been -- had a better outcome or not.

Q. What would have been treatment, assuming she did go and MRI confirmed the stroke in

the pontine as well as cerebellum?

A. Again, she might have -- let me look at this. She might have been able to get TPA for the initial stroke on the 16th. Let's assume for a second they brought her there at 5:00 o'clock in the afternoon on the 16th. Her symptoms were fresh, so she might have been a candidate for TPA.

Q. What's the window of time for TPA or what was it in April of '08?

A. Three hours.

Q. Three hours?

A. Yes, sir.

Q. It's greater now?

A. It's four and a half for intravenous TPA.

Q. Okay. Is that what you're talking about, intravenous?

A. Yes, sir. It's longer for intra-arterial.

Q. So, if intravenous or IV TPA -- well, the window begins from when for IV TPA?

A. The time of the onset of symptoms.

Q. And you're assuming that the onset was at or about 5:00 p.m.?

MR. WHITMAN: Object to the form.

THE WITNESS: 4:45 is when the first indication that Ms. White indicates that she was apprized of Ms. Luke having symptomatology.

BY MR. SAALFIELD:

Q. So you're saying you have no opinion, within reasonable medical probability, what effect IV TPA would have had if it was administered within the window of time?

A. Well, you see, no, I'm not saying that. Let me amplify so there's no confusion. It seems that she got better. Now, again, there's no medical documentation by any physician.

She, in her deposition and that of Tom Luke, her ex-husband, suggested that she improved and she may not have been a candidate for IV TPA or intravenous TPA the evening of the 16th.

She would have been a candidate for initiation of anticoagulation with IV heparin because, more likely than not, they would have discovered on the 16th the dissection had transpired that caused her symptomatology on the 7th, the 16th, and the further symptomatology the morning she woke up on the morning of the 17th.

So I don't know -- see, whether she

gets TPA or not depends on several things. Number one --

Q. IV TPA?

A. Yes. -- if she resolved or not. In other words, if she resolved, no treated TIA. So she would not have been treated with TPA on the 16th. Likely she would have received IV heparin on the 16th. Whether that heparin would have had better effect on the 16th than it did on the 17th, it's difficult to say because she already had a very large infarct -- or not infarct. She had a very large propagating thrombus in the vertebral/basilar distribution which was there on the 17th and likely was there probably to a similar extent on the 16th. Maybe slightly less, but certainly substantial based on the radiographs we have on the 17th.

So the question is, would earlier institution of the heparin have made a difference in her outcome? The answer is I don't know that. It may have. I don't know that for sure.

Q. You don't know one way or the other?

A. That's correct.

Q. Within reasonable medical probability?

A. The sooner the better. I can tell you

that if it had been instituted on the 7th when she probably had a much less burden of disease, she would have had a very good outcome.

On the 16th, it certainly wouldn't have hurt if it would have been started. I don't know how much benefit she would have sustained from that.

Q. If -- were there any other indications for treatment, assuming a diagnosis of stroke was entertained earlier on the 16th and 17th than possibly IV TPA or anticoagulation of heparin?

A. Yes.

Q. What else?

A. They might have tried some endovascular procedure.

Q. All right.

A. That might have included one of several things. They might have tried intra-arterial TPA and perhaps combined with merci, M-E-R-C-I, clot retraction.

Q. What discipline physician typically performs endovascular procedures?

A. A neurointerventionalist. It's a radiologist with special qualifications. There are some neurosurgeons that do it also, but most common

practitioner is a neurointerventionalist.

Q. Have you an opinion whether endovascular procedure, assuming it was indicated for intra-arterial TPA, would have made any substantial difference?

A. I don't know that. It might have. I would have considered it. But, respectfully, I don't know exactly what her radiographs would have shown on the 16th vis-a-vis the 17th.

Q. And whether they'd be any different on the 16th afternoon late versus the 17th you don't know?

A. I don't know that.

Q. You understood she got better after she was taken home from the office before awakening after midnight, early morning the 17th?

A. Well, she was better, but then she got worse in the late hours of the 16th about 10:00 o'clock she was not quite right. Her husband was checking her every hour. Her then husband was checking her every hour. She still was not right.

Q. Can you be more specific about how she was not right?

A. She was clumsy and nauseous, as I recall in his deposition.

Q. And then you understood she went to bed?

A. Yes.

Q. Awoke?

A. Correct.

Q. And what was her symptom complex upon awakening?

A. She couldn't express herself. Her speech was garbled.

Q. Some dysphasia?

A. It was probably dysarthria, severe dysarthria.

Q. She also had hemiparesis on the one side?

A. The right side, yes, sir.

Q. With respect to Dr. Portalatin, was he aware that she had any ambulation difficulties as you recall?

A. I don't see that either expressed in his note nor in his deposition.

Q. So you don't know one way or the other?

A. I don't know that.

Q. Do you fault him in any way if he did not know?

A. Yes. He should have inquired of the

patient, and he should have had the patient ambulate and check tandem gait and things of that sort, which might have told him about her capacity.

Q. And are you saying he didn't check her hands.

A. No. Tandem gait.

Q. Oh, tandem.

A. T-A-N-D-E-M.

Q. And how is that conducted?

A. The patient walks one foot in front of the other like a drunk driver test.

Q. Vertigo is not an uncommon symptom patients present to primary care physicians for?

A. It is not.

Q. Vertigo may cause a patient to feel as if they're drunk?

A. It does.

Q. And patients who have vertigo also may have some difficulty walking?

A. Yes, sir.

Q. Why is that?

A. Because they feel -- when they walk, they feel more dizzy and they feel like they can't control their balance. It's not uncommon.

Q. How long may that last?

A. It can occur for several days.

Q. Is meclizine commonly prescribed, as you recognize, for vertigo?

A. Yes, it is.

Q. Do you know how much -- how long she took -- how long she took meclizine after seeing Dr. Portalatin?

A. I don't know that.

Q. Your opinions critical of Dr. Portalatin, as I understand it for reasons you expressed, are (a) not sending her to the emergency room or arranging for a neurological consult that day or the next day?

A. Yes, sir. That's correct, sir.

Q. Any other criticisms than what we've discussed?

A. No.

Q. Does labyrinthitis cause vertigo?

A. Yes.

Q. Was meclizine effective in reducing her vertigo symptoms?

A. Well, she got better. I don't attribute that to the meclizine, rather the clearing of the embolus that she sustained on the 7th.

Q. So on the 7th, she didn't experience a TIA, but she had a stroke?

A. Well, that's a very good question, because clinically it was a TIA. Radiographically it was a stroke. It's been recognized recently in the literature that many TIAs, as many as half of them, are accompanied by radiographic findings of stroke, so the delineation has become blurred in that people who get recovered -- recover.

The old definition of TIA is the person has a total recovery from the neurological symptoms and findings within 24 hours. That being said, such a patient, in a substantial percentage of the time, half of which these people have radiographic findings of stroke. So much of what you call in the processing of redefining what we consider TIA as opposed to the old definition.

Q. You would agree with me that is a rare occurrence that a 32-year-old would experience a vertebral artery dissection and pontine and cerebellar strokes?

A. Rare, but not unheard of at all.

Q. Have you had a patient who has?

A. Yes.

Q. Not many?

A. Oh, actually, again, I see a lot of stroke patients. I see probably about 400 stroke patients a year. So I'll see many 32-year-olds with stroke. Not many, not a hundred. I may see maybe 10 or 15 patients a year of that age group with stroke.

Q. And typically are they hemorrhagic or ischemic or thrombotic?

A. Well, ischemic -- actually the delineations you've drawn are not quite exact. I'd say about a third of them are hemorrhagic in that age group from aneurysms. Of the ischemic ones, they could be either thrombotic or embolic. Both thrombotic and embolic are ischemic.

Q. But in ischemia, as I understand, is a lack of profusion that will lead to compromise of oxygenation of brain cells?

A. Correct.

Q. And that can lead to infarction of an area in the brain?

A. Yes, sir.

Q. That differs from thrombotic or embolic etiology of stroke, does it not?

A. No. You may have a thrombosis which means in situ in the artery. There's a blockage of

that artery. No further profusion is derived, and a certain area of the brain is starved.

The other way that can happen is, instead of being in the artery itself, it comes from another artery, either from the heart or the great vessels in the neck, and blocks an artery and distributes a profusion and causes ischemia.

Q. My understanding in this case, however, rather than low profusion, it's a thrombus or embolus that is causing her strokes?

A. Yes, sir. That's correct.

Q. Did the dissection cause complete occlusion of the right vertebral artery -- or left vertebral artery?

A. No. It was the right.

Q. Right vertebral, okay.

A. The answer is I think, yes, it did. It caused a substantial occlusion of that artery.

Q. My question, complete?

A. My recollection of the films was it did.

Q. When was that complete occlusion accomplished?

A. We don't know that, because some time before that scan was conducted, it likely was not

until the morning of the 17th, but I can't say with certainty. 17th of April 2008.

Q. I understand. Prior to which, however, there was infarction from emboli?

A. Yes, sir.

Q. So is there any cause and effect between the occlusion in the right vertebral artery or the extent of occlusion and embolization?

A. When you have a very large occlusion like that, even more embolization will occur in a large thrombosis in the artery.

Q. If a patient such as she, Mrs. Luke, was seen on or about April 7 and imaging demonstrated the possibility of a cerebellar stroke, what would be treatment of choice?

A. Okay. The progression would have been on the 7th is she would have gotten either initially a CT or preferentially an MRI. I can't say exact would have been done in the emergency room.

If you went to a neurologist's office, almost certainly an MRI would have been done first. If she went to the emergency room, probably a CT would have been first. That would not have been revealing for the reasons I discussed earlier.

She would have had an MRI, which would have demonstrated the cerebellar infarct. That, in turn, would be followed by a CTA or MRA, which would have demonstrated the dissection.

At that juncture, likely dissection would have been much lower gravity than that which was demonstrated on the 17th. It would have been treated successfully with intravenous heparinization, which would have stopped additional emboli from forming.

Q. And what is the likelihood statistically intravenous heparinization would have obviated any adverse sequelae from a stroke from a physical standpoint?

A. Substantially. I can't give you a definite number. More likely than not, the provision of IV heparin on or about April 7, 2008, would have avoided Ms. Luke having the strokes that she sustained on the 17th.

Q. Can you say any more than more likely than not? In other words, can you be more specific from a statistical likelihood, 70, 80, 90 percent?

MR. WHITMAN: Object to the form.

THE WITNESS: No, I have not seen any literature that gives that kind of numbers.

MR. WHITMAN: Object to the form.

BY MR. SAALFIELD:

Q. So 51 percent chance or more?

MR. WHITMAN: Object to the form.

THE WITNESS: Well, it could have been more than that, but at least that.

BY MR. SAALFIELD:

Q. Okay.

A. I'm just not ready. There's no controlled studies I can point to in saying 80 percent or 76 percent better.

Q. Any treatment recognized other than intravenous heparin?

A. Yes. There's some suggestion that one gets benefit using antiplatelet drugs: Aspirin, Aggrenox or Plavix.

Q. Between the two is one recognized and recommended more than the other; i.e., heparin versus antiplatelet drugs?

A. Well, there's no head-to-head study. However, most neurologists would utilize heparin in those circumstances, at least initially. And, in fact, they use Coumadin after the heparin for a period of three to six months. And based on the outcome of subsequent imaging, eventually the

patients are switched to aspirin or Plavix.

Q. How long would the IV heparin be administered?

A. Usually for a week.

Q. Hospitalization then would be for about a week?

A. Yes.

Q. Would you agree that vertebral artery occlusions with isolated cerebellar ischemia or brainstem ischemia is rare in a 32-year-old?

A. Yes.

Q. This patient didn't have a headache when presenting April 7, did she?

A. She did not.

Q. And wouldn't you expect, in most patients having a cerebral -- I'm sorry -- a vertebral dissection to experience a headache?

A. Many do, but many don't. In other words, the answer is probably the majority do, but you can't exclude a dissection by the lack of headache.

Q. And on April 7, from which you can determine, there was no clear-cut focal neurological deficits?

A. The only thing deficit, at least in the

records of Dr. Portalatin, no. The only focality I can find in any of the submissions to me is the fact that the patient and her father indicate she was leaning to the right. That's the only focality at all.

Q. And that could be caused from vertigo?

MR. WHITMAN: Object to the form.

THE WITNESS: Well, it suggests -- yes. The answer is yes. You can't distinguish just from that symptom whether it's a peripheral lesion of the right ear or right brainstem process causing that leaning.

BY MR. SAALFIELD:

Q. Would you expect a cranial nerve examination to be positive in some respect, assuming that the leaning to the right was consistent with a central condition?

A. You may or may not. You might have some nystagmus, not necessarily. You might have some facial asymmetry or facial sensory loss, but not necessarily.

Q. But more likely than not, you would expect some cranial nerve dysfunction?

MR. WHITMAN: Object to the form.

THE WITNESS: I can't say that. You

may not.

BY MR. SAALFIELD:

Q. You don't know. You may or may not?

A. That's right, sir.

Q. You can't say any more --

A. No, sir.

Q. -- definitively than that?

A. Correct.

Q. You said you were provided the stroke alert protocol guidelines?

A. From the Jacksonville EMS.

Q. And what did those guidelines -- stroke protocols indicate as far as when a patient such as she should be taken to the hospital?

A. A patient like this should be taken to the hospital.

Q. That was in the stroke protocol?

A. Yes.

Q. Are those similar to the ones you're familiar with down here?

A. Yes, sir, it is.

Q. You conduct Romberg --

A. Yes, sir.

Q. -- testing?

A. I do.

Q. Under what circumstances?

A. Looking for central versus peripheral lesions, also looking for patients with peripheral neuropathy. It's helpful in that regard.

Q. What symptoms would a patient manifest for you to institute Romberg testing?

A. Loss of balance primarily.

Q. And what would a patient complain to you about that would cause you to do Romberg testing?

A. Dizziness and falling. Actually, any new patient comes in my office, I do that as part of my routine examination, even if they have nothing whatever to do -- symptoms to do with it. It's a baseline neurological test we do on any new patients.

Q. Is there anything about the April 7 visit to Dr. Portalatin of any significance, including history, examination, findings and his treatment that is of any significance that we haven't discussed?

A. No. I think we've discussed it pretty thoroughly, sir.

Q. You have provided testimony as a forensic witness. By that I mean someone that's

retained by an attorney to give opinions --

A. Yes, sir.

Q. -- in cases? For how long now?

A. Since late '76.

Q. And have you authored any peer-review articles on signs and symptoms of strokes?

A. No.

Q. Have you testified at trials which involve issues with respect to diagnosis and treatment of stroke?

A. Yes, sir.

Q. Of the trials you appear in as a forensic witness retained by an attorney, what percentage may involve that subject matter? The majority or not?

A. At least half the trials I've been involved in in the last, at least, ten years have been in stroke cases.

Q. Do you hold yourself out as a pain management physician in any capacity?

A. I do.

Q. And what percentage of your practice is pain management?

A. Two to 3 percent.

Q. What kind of patients do you provide

pain management for on a continual basis?

A. Complex regional pain disorder patients. Chronic, unrelieved lumbar like the people who have failed back syndrome, failed neck syndrome, chronic peripheral neuropathy. Those are the main issues.

Q. Have you ever advertised your services as a forensic witness in any publications?

A. Yes. In 1993.

Q. What did you advertise in?

A. For a four-month period in Trial and Florida Bar News.

Q. Four months you say?

A. Four months.

Q. Why did you discontinue?

A. Because I keep a proportion of what I'm doing in terms of clinical practice versus nonclinical practice. I don't want to spend more time than I'm spending in medical/legal matters.

Q. I don't appreciate why you stopped?

A. I got deluged with responses, and I didn't want to spend more time than I'm spending then or now in medical/legal matters.

Q. From a time standpoint, what would you estimate your breakdown is as far as practicing

actively as a neurologist by contrast to doing forensic work?

A. 80 percent practicing as a neurologist, 20 percent other issues.

Q. With respect to income percentage, what would you estimate?

A. The same.

Q. Between the two?

A. It's 80 percent practicing neurologist; 20 percent other things.

Q. Is that a ballpark estimate or have you actually statistically analyzed it and come up with those numbers?

A. Both.

Q. What?

A. Both.

Q. When did you last analyze it?

A. I guess last year.

Q. How did you do so?

A. Just looking at my receipts.

Q. Tax returns?

A. Yes.

Q. Have you ever been disqualified or not permitted to give opinion testimony in a court of law?

A. One occasion, nothing to do with me, though. I'll describe to you. 1998, I was testifying in Houston, Harris County, Texas, and it was a malpractice case against a doctor and the resident staff.

In my deposition, I had been asked about the doctor and resident staff. I was not asked about the nurses. In Texas there's some sort of a letter that was required to be published and still is, I'm not sure the number of it, giving the witness's opinions. And the plaintiff attorney put forth the opinions against the doctor and the resident staff. He did not mention anything about the nurses.

To everybody's surprise in trial, he asked the question about the nurses. The defense attorney objected on the grounds that it was not discussed either in deposition or in the letter that was published, and the judge agreed. It was not my doing. It was rather I was not offered for that. That's the one time that it's happened.

Q. Are you scheduled to appear in any trials in the near future that you can think of?

A. Yes.

Q. Where?

A. One in Jacksonville, Florida, the second week in January. It's Torres versus some --

Q. That's settled.

A. What?

Q. It's settled.

A. Oh, really, I didn't know that. Thank you.

Q. You should have been notified, whoever retained you.

Any other?

A. Yes. It's in Panama City, I'm not sure of the county. It's a case of Donald Landry versus a doctor. I can't remember his name right now. It's an Arabic name. It's sometime in January as well.

Those are the only -- oh, there's a case in Cincinnati, Ohio. I'm supposed to testify in February. I'm scheduled.

Q. On behalf of counsel representing the patient or the provider?

A. The patient.

Q. And most of the medical negligence cases you're involved in is at the request of counsel representing the patient?

A. That's correct, sir.

Q. As far as the prior visits to Baptist Primary Care, any particular significance to any of the entries therein as it relates to any opinions you may have regarding Dr. Portalatin's care?

A. No. I mean, I find no significance of those entries into Dr. Portalatin's care.

Q. You saw where the patient had been diagnosed with sinobronchitis the visit before, which was March 28, 2008?

A. I did see that.

Q. And, in particular, that visit, anything about finding symptom complex or the like that to you impacted at all with regard to the April 7 visit?

A. The only thing remotely connected is that the patient had been prescribed Phenergan, which is an antihistamine not dissimilar to meclizine and was taking that at the time of her visit on April 7th without benefit in terms of her dizziness. But other than that, no.

Q. What -- I don't know if I appreciate it. So prescribed Phenergan March 28, how does that impact in any way with regard to what Dr. Portalatin should or should not have done?

A. Well, she was already on an

antihistamine unsuccessfully for the symptoms that she was describing to him on the 7th.

Q. And which symptoms in particular?

A. Dizziness and nausea.

Q. Any other?

A. Nausea.

Q. Is Phenergan routinely prescribed for dizziness?

A. Yes.

Q. By you?

A. I use it less often than others. It's very fleet producing. But the answer is it's -- I do prescribe it occasionally, not often.

Q. Have we discussed your causation opinions?

A. I believe so. Yes, sir.

Q. If not, and you have anything to add than what you told me, now's the time.

A. Okay. Just to make sure it's clear to you. Had Ms. Luke been remanded to a neurologist or an emergency room on or about April 7, 2008, she would have had eventually a detailed neurological examination. She would have had imaging, maybe a CT first, certainly an MRI thereafter, and either MRA or CTA thereafter.

These tests would have demonstrated ischemic disease of the cerebellum and would have demonstrated the vertebral artery dissection, but in a much lesser degree of severity than was eventually demonstrated on April 17th.

That demonstration would have caused the provision of treatments with IV heparin, which more likely than not would have prevented expression of more clots, prevented the subsequent strokes Ms. Luke sustained and resulted in a much better and likely normal neurological outcome for Ms. Luke. That's my causation opinion.

Q. Do you testify routinely with respect to disciplines outside yours?

A. Only if the providers are involved in neurological issues. For example, if a ER physician is presented with a clear-cut neurologic issue and fails to obtain a neurological consult, I would testify against that provider.

I also testify against -- I do causation opinions and damage opinions. In other words, a person comes into emergency room, is misdiagnosed by another discipline, I'm asked to say that had the diagnosis been made, the outcome would have been better.

Also what the ultimate -- I'm also asked to examine people and see what the neurological deficits are. So I would give testimony in that regard.

Q. In the presence of infarction to the right cerebellum, what cranial nerves might be affected?

A. It could be none. It could be the cerebellum is not far from getting brainstem involvement. If you had brainstem and pontine involvement simultaneously with the cerebellum involvement, you might have 5, which is the facial sensory; 7, which is facial strength; 8, which is audition, hearing. Those are the ones you might get.

Q. Did -- was there any hearing loss on April 7 that you're aware?

A. No, sir.

MR. SAALFIELD: All right. I think that concludes it, since I've got to get on an airplane and get back.

CROSS-EXAMINATION

BY MR. WHITMAN:

Q. Dr. Fischer, just for clarification that you, in addition to the materials listed on

Exhibit 2 to your deposition and that you were asked about, that on November 7, 2012, you were also provided with a copy of Paula's life care plan, correct?

A. I think I mentioned that.

MR. SAALFIELD: He did.

BY MR. WHITMAN:

Q. And also the correspondence includes a transmittal of and portion of Dr. Portalatin's June 2011 videotaped deposition?

A. Right.

Q. I just wanted to clarify that.

MR. WHITMAN: Okay. Nothing else.

REDIRECT EXAMINATION

BY MR. SAALFIELD:

Q. What significance -- did you look at the videotaped deposition?

A. Yes.

Q. What does that add to any of your formulated opinions?

A. No, sir. They do not.

Q. Nothing?

A. It didn't.

MR. SAALFIELD: Okay. Thank you.

MR. WHITMAN: I'd like the doctor to

read.

MR. SAALFIELD: I'll order etran and a regular.

MR. WHITMAN: Same thing.

(Whereupon, the deposition was concluded at 4:10 p.m.)

EXCEPT FOR ANY CORRECTIONS MADE ON THE ERRATA SHEET BY ME, I CERTIFY THIS IS A TRUE AND ACCURATE TRANSCRIPT, FURTHER DEPONENT SAYETH NOT.

CERTIFICATE OF OATH

STATE OF FLORIDA)

SS:

COUNTY OF BROWARD)

I, DEBRA PETRACCA, Shorthand Reporter, Notary Public, State of Florida, certify that Kenneth C. Fischer, M.D.r personally appeared before me on December 3, 2012 and was duly sworn.

Signed this 10th day of November, 2012.

DEBRA PETRACCA, Shorthand Reporter
Notary Public, State of Florida
My Commission: EE 132681
Expires: 09/22/2015

ERRATA SHEET

RE : Luke v. Portalatin M.D.
DEPO OF : Kenneth C. Fischer, M.D.
TAKEN : December 3, 2012

DO NOT WRITE ON TRANSCRIPT. ENTER ANY CHANGES HERE.

PAGE NO.	LINE NO.	CHANGE	REASON

State of Florida)

County of Broward)

Under penalties of perjury, I declare that I have read my deposition transcript, and it is true and correct subject to any changes in form or substance entered here.

_____ _____

Date Signature

CERTIFICATE OF REPORTER

STATE OF FLORIDA)

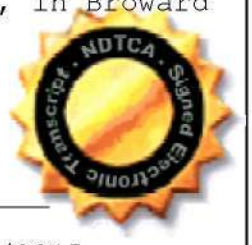
SS:

COUNTY OF BROWARD)

I, DEBRA L. PETRACCA, Shorthand Reporter, do hereby certify that I was authorized to and did stenographically report the foregoing proceedings pages 1 through 94, is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, or attorney, or counsel of any of the parties' attorneys 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 10th day of December, 2012, in Broward County, Florida



Debra L. Petracca
My commission expires 09/22/2015
Commission # EE 132681

U.S. LEGAL SUPPORT
One Southeast Third Avenue
Suite 1250,
Miami, Florida

December 10, 2012

Saalfield, Shad, Stokes, Inclan,
Stoudemire & Stone, P.A.,
Attn: John B. Saalfield, Esquire,
245 Riverside Avenue, Suite 400,
Jacksonville, Florida 32202

IN RE: Luke v. Portalatin, M.D.

Deposition of Kenneth C. Fischer, M.D.

Dear Mr. Saalfield,

The original deposition of Kenneth Fischer, M.D. taken in the above-styled cause on November 15, 2012 is being forwarded to you. Please allow 30 days from the date of transcription to file this with the court in order to allow proper time for the witness to read and sign it. The completed errata sheet will be sent to you when it has been completed.

Debra Petracca

In reference to the above-styled deposition, the following has occurred:

( ) The witness has not chosen to read and/or sign the deposition.
( ) The witness has read same and there are no corrections, additions or changes.
( ) The witness has read same and the corrections, additions or changes are attached.

If you have any questions, please do not hesitate to contact this office.

_____

Debra L. Petracca

WITNESS NOTIFICATION LETTER

December 10, 2012

Kenneth C. Fischer, M.D.

c/o
Milton, Leach, Whitman, D'Andrea & Eslinger, P.A.,
Attn: Joshua A. Whitman, Esquire,
815 South Main Street, Suite 200,
Jacksonville Florida 32207

In Re: Luke v. Portalatin, M.D.
Deposition of Kenneth C. Fischer, M.D.
U.S. Legal Support Job No: 968214

The transcript of the above proceeding is now available for your review.

Please call to schedule an appointment between the hours of 9:00a.m. and 4:00 p.m., Monday through Friday, at a U.S. Legal Support office located nearest you.

Please complete your review within 30 days.

Sincerely,

Debra Petracca

U.S. Legal Support
One Southeast Third Avenue
Suite 1250
Miami, Florida 33130
(305) 373-8404

cc: John B. Saalfield, Esquire