IN THE CIRCUIT COURT

THIRD JUDICIAL CIRCUIT

MADISON COUNTY, ILLINOIS

ARTRISCHIA KINGERY, Individually

and as Administrator of the Estate of

JOHN J. KINGERY, Deceased,

Plaintiff,

vs. No. 09-L-216

ST. ANTHONY'S HEALTH CENTER,

Defendant.

_____/

DEPOSITION OF KENNETH C. FISCHER, M.D.

Monday, April 22, 2013

1:10 p.m. - 2:21 p.m.

1190 NW 95th Street, Suite 402

Miami, FL 33150

Stenographically Reported By:

JANINE P. CARROLL, FPR

Florida Professional Reporter

APPEARANCES:

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(Via telephone)

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I N D E X

Deposition of KENNETH C. FISHER, M.D.

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Deposition taken before Janine P. Carroll, Florida Professional Reporter and Notary Public in and for the State of Florida at Large in the above cause.

THE COURT REPORTER: Swear or affirm that the testimony you're about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: Yes, I do.

(Documents marked Defendant's Exhibits A and B for identification.)

THEREUPON,

KENNETH C. FISCHER, M.D.

having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. KAMYKOWSKI:

Q. Will you please state your name, for the record?

A. It's Dr. Kenneth C. Fischer.

Q. Dr. Fisher, I'm Mandy Kamykowski. I'm here to take your discovery deposition in the case Artrischia Kingery has brought against my client, St. Anthony's Health Center.

It's my understanding that you have been retained by Ms. Kingery's attorney to offer expert opinions in

this case. Is that your understanding of your involvement?

A. Yes, ma'am, it is.

Q. And can you tell me, do you remember when you were first contacted by Mr. Bartholomew?

A. I would estimate it to be a few weeks prior to my receipt of a submission from Mr. Bartholomew dated 7/16/08 -- I'm sorry, 5/15/08, which is the medical records that he had at that time on Mr. Kingery. So I think our discussion may have taken place in late April or early May of 2008.

Q. Okay. And we're here today at your office at North Shore -- North Shore Medical Center, is that what it's called?

A. Yes, ma'am, it is.

Q. In Miami.

Have you ever met Mr. Bartholomew in person?

A. No.

Q. Just spoken to him on the phone?

A. That is correct.

Q. All right. And I understand, I know I have not taken your deposition before, but I think my partner, Ed Bott, has deposed you once or twice before, so I know you have given depositions in the past. Correct?

A. I have.

Q. On average now as an expert witness, how many depositions are you giving in a year?
A. I'd estimate 30.
Q. And can you break those down into how many you -- in medical malpractice cases?
A. No.
Q. Okay. What other types of cases do you offer opinions in?
A. Premise liability cases, motor vehicle accidents, workers' compensation matters, maritime cases.
Q. And you're a neurologist, correct?
A. Yes.
Q. So the cases that aren't medical negligence cases you're offering causation and damages testimony; is that correct?
A. Yes, ma'am, that's correct.
Q. And in all the 30 cases that you give depositions per year, how many are for the plaintiff and how many for the defendant?
A. Okay. It's a strange breakdown. For medical negligence cases it's primarily for the plaintiff. In other non-medical negligence cases, other than the treating physician, it's primarily for the defense.
Q. Okay. Can you give me just a little bit of background? I've marked an updated copy of your CV,

which has a date, it looks like it was dated January of this year, 2013, and it's been marked as Defendant's Exhibit B. Can you just give me a quick background on your medical training and your employment history until today?
A. Sure. I received my MD degree from Duke University School of Medicine in North Carolina in 1971. I did a year of internal medicine training at the University of Miami, completing that in '72. I did my residency in neurology at the University of Miami, completed that in '75.
In July, '75 I was on the full-time faculty as Assistant Professor of Neurology at the University of Miami. I had that position for one year and went into private practice in the northern part of Dade County from '76 through '93 in a group. It was called different things, as people came and went, but basically it was a multi-physician single specialty group in neurology.
However, in 1993 I went to solo practice at this location, and I've been here the last 20-plus years.
I retained a teaching position as a voluntary Associate Professor at the University of Miami. I've been teaching consistently since '75, on a voluntary basis since '76.
Q. And when you say teaching, did you actually do

didactic teaching or are you doing -- teaching in the classroom or teaching when you do clinic here, or at the hospital?
A. I teach at the University of Miami School of Medicine in Jackson Memorial Hospital, which is a teaching hospital, and I teach the residents and students in neurology. It's basically hands-on clinical work.
Q. Are you Board Certified in neurology?
A. I am.
Q. And when did you obtain your Board certification?
A. April, 1978.
Q. And have you had to re-sit for the Board exam or have you been grandfathered in?
A. You're correct. I'm sorry to interrupt you.
Q. That's okay.
A. Up until 1992 or '3 there was no reassessment process, and those people who had been Board Certified before then were, so-called, grandfathered in.
Q. Explain to me what it means when you testify you're voluntary faculty for University of Miami.
A. I don't get paid.
Q. Are there other -- so prior to that, prior to when you became voluntary faculty, were you actually getting paid as a faculty member there?

A. Yes.
Q. And you have admitting privileges at what hospitals currently?
A. North Shore Medical Center and what's called University of Miami Hospital, used to be called Cedars. You'll see in old CVs it says Cedars. It didn't lose the name, it just changed its name in late 2007, became University of Miami Hospital. Also at St. Catherine's Rehabilitation Hospital, and also Jackson Memorial Hospital. That's a teaching hospital. I have privileges there, but I don't typically have patients there other than my teaching responsibilities.
Q. Okay. And as far as your practice here, are you the only neurologist in your practice right now?
A. Yes.
Q. And give me a typical week. How many patients do you see and what kinds of conditions do you treat?
A. Sure. I see, in the office, approximately 20 patients a day, so it's about a hundred a week. In the hospital, typically five to eight per day, so in a given week that's 35 to 50. And in a hospital half the patients are stroke patients. The last five years I've been director of the stroke center where -- a joint commission certified primary stroke center. I'm in charge of that since October of 2008.

And I review every stroke patient, but I see a large number of the stroke patients personally in the hospital on an acute basis.

Q. I'm sorry to interrupt. Are you talking about here at North Shore?

A. That's correct. I'm sorry. That's what I meant.

Q. And, continue. I'm sorry, I didn't mean to interrupt you.

A. So I see, as I say, about 50 patients in the hospital per week, half of whom are stroke patients. I see about a hundred patients per week in the office, about 25 percent of whom are stroke patients, and the other whole gamut of neurological adult disorders, seizures, migraine, neck pain, back pain, dementia, Parkinson's Disease, multiple sclerosis, and the like.

Q. Okay. And you are here today to offer opinions with respect to the care and treatment that Mr. Kingery, who is now deceased, received back in 2007 at St. Anthony's health center; is that correct?

A. Yes, ma'am.

Q. Can you tell me what you reviewed to prepare for your deposition?

A. Sections of the hospitalization of St. Anthony's which began on April 3rd, 2007. Antecedent outpatient records from Mr. Kingery from Dr. Patel, and a deposition

given by Dr. Carlos Yu, Y-U, in October, 2011.

Q. The cardiologist who implanted the pacemaker in this case, Dr. Lutan, has also been deposed. You haven't reviewed his deposition?

A. No, ma'am, I have not.

Q. Do you think there's any need for to you review that before you can offer final opinions in this case?

A. Not particularly because I'm looking at the neurological aspect. I mean, I wouldn't object to reading it, but I doubt it would change my opinions.

Q. Okay. And the select hospital records that you have, are they all from the April 3rd admission to St. Anthony's in 2007?

A. Yes, ma'am, they are.

Q. And it doesn't look to me like it's the entire hospitalization so I may at some point --

Joe, if we could maybe have the doctor make a copy of what you sent him?

Just so when I get back to my office I have every page that you reviewed.

A. Sure. I can give it to Madam Court Reporter before we leave.

Q. That's fine with me. Whatever you guys want to do.

And what you have in front of you here today, and

what you just described on the record, that's the sum total of what you have reviewed to prepare for your deposition today, correct?

A. Yes, ma'am.

Q. Okay. And I have been provided by Mr. Bartholomew, the Plaintiff's, and it's the amended designation of expert witnesses -- or witness -- witnesses that was filed in this case in -- last August, of 2012. And in there it offers, apparently what appear to be the opinions that you are prepared to give in this case.

I'm going to hand you that exhibit, ask you to just look it over quickly.

You don't need to read it out loud, but look it over quickly and I'll ask you questions.

A. I'll do that.

Q. Thank you.

A. Yes, ma'am. Thank you.

Q. And you can keep that in front of you. I have a copy myself in case -- and feel free to look at the -- or any of the records at any time I ask you questions, if you need to.

A. Thank you, ma'am.

Q. And take your time.

The purpose here today is for me to discover all

the opinions that you have that relate to the, either the violation of the standard of care, causation, or damages that you might have and will be prepared to offer if you were asked to come and testify at trial. Okay?

So after looking at Exhibit A, which is Plaintiffs' Amended Designation Of Expert Witnesses, there are two paragraphs there that have been provided to me as far as the opinions that you are prepared to offer in this case.

After having an opportunity to look at those two paragraphs, is there anything else outside of those two paragraphs, and we'll go through them in great detail, that you believe you would want to add to this disclosure as far as your opinions in this case?

A. No, I think this sums up my opinions appropriately and accurately.

Q. Okay. Let's start first, then -- well, and the opinions that you are prepared to offer in this case, or the way I understand it, and I'm just going to paraphrase, is that the stroke that Mr. Kingery had on the 6th of April, 2007 was either caused, or contributed to be caused by an infection that resulted from the hematoma he developed in his pacemaker site after his pacemaker insertion on the 4th of April. Is that correct?

A. That is correct.
Q. Let's start first and talk about standard of care, which it looks like, you know, one of the statements that is in this disclosure is, that it's obviously below the standard of care to have left a sponge in a surgical procedure that was not intended.
So is it fair to say that your opinion is that the hospital staff, in allowing a sponge to be retained in the pacer site, breached a standard of care?
A. Yes, it is, madam.
Q. And is it it your opinion that any time a sponge is left in a patient's body after a surgery, that the standard of care is breached by someone?
A. Yes.
Q. There's no circumstances that a sponge could be retained and the standard of care not be breached?
A. To my knowledge, that is correct.
Q. Okay. What experience do you have, if any, in the performance of, or treatment of patients that have just undergone pacemaker insertion?
A. Well, people who have undergone pacemaker insertion have cardiac disease, and concomitantly, many of them have neurologic disease, particularly stroke. And it's not uncommon for pacemaker patients to have abnormal heart rhythm, which would cause a higher

incidence of cardioembolic disease, that is to say emboli stemming from the heart, going into the brain, causing stroke.
So it's not uncommon for me to see a patient who recently had pacemaker insertion who's having stroke symptoms, either TIA or full-blown stroke, to evaluate them and determine the cause of their stroke in relationship to their underlaying cardiac disease, if any.
Q. And can you just tell me, then, in your words what you believe the mechanism of the causal link between the retained sponge and Mr. Kingery's pacemaker site and his stroke that occurred two days after the pacemaker was inserted?
A. Sure. Mr. Kingery was not a well man. He had significant cardiac disease, and when he entered the hospital on April 3rd he was having symptoms of left cerebral TIA. He had had episodes of loss of vision, blurred vision in his left eye for up to ten minutes, followed by restoration of vision. He also had difficulty -- he'd lost consciousness and he had difficulty with his speech after these episodes.
He was having documented pauses, indicating that he was having significant bradyarrhythmia, low heart rate, and what was happening was the low heart rate was

causing reduced cerebral circulation, and he had an impairment of circulation which can be due to his left hemisphere, particularly to the left carotid artery, which is the main artery, subserving the left side of his brain, which would control the vision in the left eye, and also would control his speech mechanism.
So what he was having, as the doctors correctly suspected, he was having these bradyarrhythmias being symptomatic, and the result of that, they appropriately decided to install a pacemaker.
Now, Mr. Kingery eventually was found, not before the pacemaker insertion, but after the stroke, to have a total occlusion of the left internal carotid artery. This was documented on a CTA, that's a computerized tomogram of the arteries, on April 10th. This occlusion likely, within reasonable medical probability, was acute. Acute because there was no previous problems of this nature. It was totally -- you wouldn't be walking around with a total occlusion like this in the vast majority of patients, and it became occluded during his hospitalization.
In other words, it was probably significantly stenotic and that stenosis caused him, when his blood cir- -- his blood flow was diminished by the pauses and the reduced cardiac output, the reduced flow through the

-- particularly through the left internal carotid circulation to have the amaurosis fugax, that's A-M-A-U-R-O-S-I-S, F-U-G-A-X, and the transit aphasia, and then what's happening is he would -- the highgrade stenosis he was having with reduced flow would have small emboli stemming from the carotid artery, going to the left middle cerebral artery circulation causing the aphasia, and going to the left ophthalmic artery causing the visual change.
Q. Can you tell me the timing of when those changes were occurring?
A. When he came to the hospital April 3rd he was documented to have episodes -- several episodes like that.
Okay. So they put the pacemaker in. Unfortunately, the sponge was left in, the hematoma and an infection developed. And he was sick. Over the next two days, between the 4th and the 6th, he had pain, he had fever, he had infection, active infection. This caused them, eventually, to remove the pacemaker. They found the hematoma, and later on -- and they also found the retained sponge. The retained sponge, more likely than not, was the cause of this infection and hematoma.
But when a person has a significant stenotic lesion, and is subjected to an acute infection, which he

was, and also to substantial fluctuation of his blood pressure, which he was, that would cause total occlusion of that highgrade stenosis. And that total occlusion was a direct cause of the major stroke Mr. Kingery sustained the evening hours of 4/6/2007. He was suddenly found to be fully unresponsive, unable to speak, and had a total right-sided weakness. He had a total left cerebral syndrome. And he was found to have, basically a left middle artery -- left middle cerebral artery stroke.

The mechanism of that stroke was, as the carotid artery closed up, either one of two things happened; either there was no circulation through the carotid artery causing a stroke, or more likely, another large embolism fled the highly stenotic and now occluded left carotid artery, traveled upstream, and created a large occlusion of the left middle cerebral artery causing the stroke that he sustained on April the 6th, 2007.

So that's basically a synopsis of it. The acute illness stemming from the hematoma and infection caused an occlusion of a highly stenotic artery which Mr. Kingery had antecedent to his admission.

Q. And is it your opinion that the occlusion from the infection from the hematoma, the occlusion was caused from inflammation, or what's the mechanism of the --

A. I'm sorry, say that again.

Q. The occlusion of the carotid artery that you talked about that caused the stroke, is it your opinion that the infection caused inflammation that caused the occlusion, or what's the mechanism of the occlusion that you're opining about?

A. Abrupt changes in the -- people with infection have a higher incidence of stroke, it's been well demonstrated, plus the abrupt changes in his blood pressure up and down, probably the most likely direct cause of the occlusion.

Q. And he had a history of coronary artery disease; is that correct?

A. He did.

Q. And he had poorly treated hypertension; correct?

That's a bad one. Not poorly treated. He had poorly controlled blood pressure; is that correct?

A. Well, I was looking at his blood pressures from Dr. Patel. He had one episode which was very high, and then he had actually better control. It wasn't great control, but it was not -- he seemed to be complying and Dr. Patel was monitoring him pretty carefully and he -- actually, the latter part of the records I have from Patel, he was doing better. His blood pressure wasn't a hundred percent controlled, but it was reasonably

controlled, and he was coming in on a fairly regular basis and probably taking his medication.

So up until the hospitalization -- when he came to this hospitalization, though, it got way out of control, and it was right after the pacemaker had been inserted.

Q. And you talked about infection at the pacemaker site. Can you show me, or point to me in the records what the basis of your opinion that he developed an infection at his pacemaker site is?

And the reason I ask is, when I look at the laboratory results in this case, they did multiple cultures of his blood from the hematoma site, and from his pacer site, and maybe you can direct me to a page that I haven't been able to see, but I haven't seen anything that shows he actually has -- objective evidence that he developed an infection at that site.

A. Well, it was described as being weeping, which would be suggestive of an infection.

Okay. Looking at the note from Dr. -- and this is a tough name for me, Sivaswami, S-I-V-A-S-W-A-M-I, this is on 4/7/07, he describes the patient has a large lump on his left upper chest that is his pacemaker that is somewhat discolored and appears to have hematoma. There is an incision and it seems to be healing and is

slightly tender.

So right there, that's some suggestion of some infection when you have tenderness.

Q. And do you know what the date of that examination was?

A. Yes, 4/7.

Q. So the pacemaker was inserted on 4/4, correct?

A. Correct.

Q. And on 4/7 he's got tenderness. Is tenderness something that you would expect a patient to have at a pacemaker insertion site less than, you know, three days after it was implanted?

A. Maybe, maybe not, but it was there. Again, tenderness is a sign of infection.

Q. And the stroke that you're opining about today happened on the 6th, correct?

A. That is correct, ma'am.

Now, okay, here's an operation from a James A. K-L-I-E-F-O-T-H. This is on 4/7/07. This is pre-operative diagnosis; hematoma of the pacemaker pocket. Post-operative diagnosis; hematoma of the pacemaker pocket, and he evacuated the pacemaker.

And he notes a 76-year-old man who had a pacemaker placed and the pocket has been expanding and he spiked a fever.

Now, a hematoma by itself without infection would not likely cause a fever, and the man did have a fever. So this Dr. Kliefoth is suggesting. And he also notes in his description, there were bubbles that came from the pocket and the old blood was brownish in color.

So the presence of bubbles, again, that's something that's commonly seen with infection, and it's more than one would see with just a plain hematoma. So he's not using the word infection, but we have a fever and bubbles, and expanding lesion. That suggests an infectious process.

Q. Did you see anywhere in the records where the signs and symptoms that you're talking about here, the fever, the bubbles, and I think you talked about the tenderness of the site, actually bore out to show any objective evidence of an infection by way of laboratory tests, or anything like that?

A. Okay. Well, if you look at the pattern, when he came in Mr. Kingery had a normal white count and had a normal differential. That was on the 3rd. By the 5th, his white count was slightly up, but not enormously up, but his differential changed and he had more than 70 percent neutrophils, which is a shift to the left, and a shift to the left is often a sign of an infection.

Q. And when you're talking about infection, Doctor,

just so that the record is clear, are you talking about a bacterial process that causes an infection?

A. Yes, ma'am.

Q. And can a left shift also happen if there's a viral process going on?

A. No. That's a good question. And as a matter of fact, a viral process causes a lymphocytosis, the opposite. So the fact that Kingery developed a left shift would be suggestive of a bacterial as opposed to a viral infection.

Q. Now, Doctor, wouldn't you also, I mean, and please correct me if I'm wrong, wouldn't you also -- although he had some of these laboratory values and the other signs, subjective signs that you talked about, blood cultures were done from the hematoma evacuation, and I don't know if you saw the results of those, but maybe we can find them and you can look --

A. Yeah, I have them.

Q. Okay.

A. They were negative, but blood cultures aren't a hundred percent. And also, he was on antibiotics, which would suppress -- in other words, they put him on antibiotics empirically, and that would suppress the development of any positive cultures. It was appropriate. You want to get the patient treated, so I

wouldn't argue with the antibiotics, but that would suppress any blood cultures.

So the blood cultures were done -- the results were the 11th, the 13th, and so forth, and he was already on antibiotics by that time.

Q. As far as your testimony that the blood cultures would suppress --

A. No, antibiotics would suppress --

Q. Yeah, I'm sorry. Antibiotics would suppress the evidence of growth of bacteria in the blood cultures. Would you also expect, though, that the antibiotics would then also suppress his other signs and symptoms that you're talking about today, the bubbles, the tenderness around the site, the --

A. Yes, it would. It probably was less marked than it would have been. In other words, he had -- he would have been much worse had they not given antibiotics, and he would probably have had a higher white count than just a shift to the left, but that was partially suppressed by the provision of antibiotics.

Q. And, Doctor, do you know what date the records show that the hematoma first developed?

A. Let's see here. It was removed on the 7th. Let me look at the notes.

I know it was there on the 7th. It wasn't there

on the 4th. I don't have -- I don't know, I don't have good documentation of the status on the 5th and 6th. I know he had the stroke on the 6th. They removed it -- I gave you the date of the removal.

Q. Do the records you have from the hospital include the nurses notes or is it --

A. No.

Q. So consult notes and radiology, and labs is that what you have, pretty much?

A. And some In Progress notes too.

Q. And In Progress notes.

Well, Doctor, let me -- I went through the records, and I'll make representation as to what I found.

I did have the opportunity to look at the nurses notes, and you're correct on the timeline, that he had -- the pacemaker was inserted on April 4th, correct?

A. Yes, ma'am.

Q. And he developed the signs and symptoms of the stroke on April 6th, and I have the time of that about 17:00, so 5:00 p.m. Does that sound correct to you?

A. That's consistent with my understanding, yes, ma'am.

Q. And that Dr. Kliefoth evacuated the hematoma on the 7th.

A. Yes.

Q. Which we already talked about.
In that interim time, from my review of the records, I show that on April 5th at midnight the nurses are documenting -- they're looking at his surgical wound, and that's what nurses are supposed to do when they're monitoring a patient post-operatively. Then at midnight his dressings were dry and intact. This is on April 5th. At 4:20 a.m. his dressing was dry and intact; at 7:40 a.m. his dressing was dry and intact and he was in no distress.
At noon on the 5th, both Dr. Gondi, who was a cardiologist, as well as a representative from the pacemaker company, examined him and found his dressings to be dry and intact. And that on the 6th of April, the date that he had his stroke, the dressings -- or his wound was not noted to have any oozing, and he continued to stay on the antibiotics for -- IV antibiotics post-operatively, and he was also taking aspirin, a daily dose of aspirin.
Was that information that you knew before that?
A. Well, it wouldn't change my thinking because the kind of infection he had would not be reflected on the external dressings. He had a retained sponge which was causing the infection. That would be something inside. You wouldn't see that. The nurses would not see that,

even with a careful evaluation of his wound site.
Q. Okay. Well, maybe I'm misunderstanding part of your opinion. Is your opinion that the development of the hematoma was a direct cause of the retained sponge?
A. I'm not sure about that. I mean, but the retained sponge was causing the infection.
Q. Okay.
A. The infection was what I'm saying is the proximate cause of the stroke.
Q. So your testimony today is that the outward signs, what his dressings looked like when they were changing his dressings on his pacer site -- and my understanding is the pacer is actually just a subcutaneous pocket that's placed in the patient's body and then there are leads that go from that into his heart. Correct?
A. Yes.
Q. Okay. So the site of the infection, are you opining that it's not just in that pocket or was --
A. Well, let's see. The description -- let's go back to this, where the gentleman describes it here. Let me find that for you. One second.
And this is a report of Dr. Lutan who actually put the pacemaker in and then replaced it subsequently.
Q. And what date is that report?

A. This is on 4/16/07.
Q. Okay.
A. On the second page of his report, this is the procedure to remove the current system, replace it with a new system.
He says the left side was then exposed. One percent Xylocaine was infiltrated to create an area of local anesthesia along the original incision line superior to the implanted pacemaker. An incision was made along the original incision line. Old suture material and scar tissue encountered while dissecting to the pacemaker and suture sleeves of the leads was excised. The old myotonic Cylosdr-T, that's C-Y-L-O-S-D-R, hyphen T, serial number 76044928, was explanted from the pocket. After the pacemaker was explanted, so it's below the pacemaker, a Raytec, R-A-Y-T-E-C, sponge was discovered and removed.
So this is something that was below the pacemaker. There's no way the nurses, even with a careful inspection of his surgical site, and his wounds could be clean as gold, and they would not have seen that. It was below the pacemaker. So that's why it was not visualized during that period of time you specified.
Q. So essentially what you're testifying is, that where the sponge was located underneath the pacemaker,

which is the metal -- actual medical device that was put into the patient's subcutaneous pocket --
A. That's what Dr. Lutan is describing, yes, ma'am.
Q. And your testimony is that it is in that area that this infection occurred, not more superficially where the nurses who were changing his dressings and documenting what the exterior of his skin looked like would be able to see?
A. That's correct.
Q. Okay. If I told you that Dr. Lutan has testified during his deposition that during this procedure where he discovered the retained sponge he saw no signs or symptoms of infection, would that change your opinion?
A. No. I mean, you can't visualize -- you would have to -- well, first of all, he's seeing scar tissue, but you can't -- he's not doing a biopsy, he's just taking the thing out. So the answer is, that shouldn't be in there, and a retained sponge where it was would cause inflammation and infection. There's no way it could not do that.
Q. Okay. And that's the opinion that you're offering here today, is that the sponge itself caused an infection and you believe that based on the fact that the patient had tenderness, that there was bubbles upon

evacuation of the hematoma, and that he was on antibiotics, and he had a fever, that he had an infection?

A. Plus, as you mentioned, he had developed a change in his white blood count pattern with a shift to the left, which is indicative of bacterial infection.

Q. And, again, you believe that even though no bacteria grew on any of the cultures that were done on Mr. Kingery, that was just a function of the antibiotics doing what they were supposed to do?

A. Yes. In other words, the cultures were drawn after the antibiotics were started, so that would suppress any blood culture growth.

Q. Okay. Doctor, do you know, based on your education, training, or experience, what the incidence of hematoma development after a pacemaker insertion is?

A. No.

Q. You don't know that?

A. I don't know that.

Q. Do you know what the incidence of infection at the pacemaker insertion site is without a retained sponge?

A. I do not know that.

Q. And you briefly touched on the -- I don't know if it's a phenomenon or a condition, and I'm going to

pronounce it incorrectly, I guarantee it, but amaurosis fugax?

A. Fugax.

Q. Oh. So you pronounce -- not French, it's --

A. It's Greek, actually.

Q. Okay. So amaurosis fugax, can you describe that to me a little bit more in detail, please?

A. Sure. The carotid artery is the main artery of the interior circulation. For example, if I take the left carotid artery, which is most important in right-handed people, it subserves 80 percent of the left side of the brain. And the first artery -- it's a bounding artery right in here if you put your hand on your neck (indicating). The very first artery off that is the ophthalmic artery.

Now, if one has a significant stenosis of the internal carotid artery measuring greater than 70 percent, one can have little clots of blood -- see the reason why it's important, 70 percent, if you have 70 percent stenosis, that causes a 50 percent reduction of the circulation.

Q. 50 or 15?

A. Five-oh.

Q. Okay. Thank you.

A. When you get that reduction you start having a

sludging of the blood and clots form. Now, if the clots form, the first artery which it can go is the ophthalmic artery. Okay? So a small clot will come from the stenotic carotid artery, circulate through going to your ophthalmic artery. The ophthalmic artery controls the ability to see. So the person will have a little clot going to the ophthalmic artery, and for a period of typically between two and 15 minutes, it could be 30 seconds, but usually it's something around two minutes up to 15 minutes, the patient will have isolateral, same side, loss of vision just in the eye on the same side of the stenosis. That's called -- that's what's called -- it's a fleeting loss of vision, and in Greek that's amaurosis fugax.

Q. And this patient, Mr. Kingery, was documented as having that condition when he had his TIA on the 3rd, correct?

A. Yes, ma'am.

Q. And are you aware of any literature that indicates that when you have amaurosis fugax that an impending stroke is more likely going to happen?

A. Oh, there's ample literature on that. If you look at any standard textbook of neurology, look at the -- any book, talking about TIA, if you look at the American Stroke Guidelines, they talk about amaurosis --

it's a classic thing you tell, you know, a third year medical student taking neurology, I lecture to the students, or the residents about, you see TIA, you look immediately for chronic stenosis. That's well known.

Q. And they did that in this case, correct?

A. Yes.

Q. And they found it?

A. Yeah, but unfortunately they found it late. In other words, what happened, and this was a little complicated. Mr. Kingery had cancer of the larynx and he had scarring on his neck. So they did on -- when he came in they were concerned about that symptom, and appropriately they did a carotid ultrasound. The carotid ultrasound showed some disease on the right, but they couldn't visualize the flow on the left because of the scarring from the previous laryngeal surgery, so they couldn't evaluate on the ultrasound the carotid artery, its patency. Likely, it was stenotic, but not occluded at that time. You don't have a pre-stroke study to verify that.

Q. But would you know that he was at least throwing small enough clots that were causing him to have this amaurosis fugax in his eye?

A. Correct.

Q. Okay. Is that evidence that he did have some,

like you said, some stenosis --
A. Oh, absolutely.
Q. -- but the level of occlusion we don't know?
A. Well, I wouldn't use the word occlusion. Level of stenosis.
Q. Okay.
A. He had no -- I don't think he had any occlusion, to see if you're occluding prior to stroke. He likely had highgrade stenosis, probably -- definitely greater than 70 percent, but less than a hundred.
Q. And did you have an opportunity to look at both -- there were multiple cardiology consults on the patient before he had the pacemaker. I think Dr. Lutan's partner actually consulted with him on the 4th, or the 3rd.
A. What was his name?
Q. His name is Dr. Gondi.
A. I have seen notes of Dr. Gondi. I'm not sure I saw his consultation. I did see notes from him.
Q. Well, then I guess I can probably just make this an easy -- a short answer to my question, but with respect to the pre-stroke workup that Mr. Kingery got at St. Anthony's by the various consults who saw him, he saw critical care specialists, he saw cardiologists, and then after if his stroke he saw Dr. Yu. Is that the way you

understand it?
A. That's exactly right.
Q. You don't have any opinions that any of the treatment they provided were any sort of cause, or contributing cause to his ultimate stroke on the 6th; do you?
A. No, I have no opinions in that regard.
Q. And you're not critical of any of the care and treatment he received leading up to his stroke other than the retained sponge; correct?
A. That's correct, ma'am.
Q. Okay. That makes it easier.
A. Okay.
Q. And on the 4th of April, before the pacemaker was inserted, when Dr. Gondi -- I'm just finding it in my notes -- when Dr. Gondi did examine the patient and he made the determination that a pacemaker would likely help Mr. Kingery with respect to the -- I think he had a four second pause in his heart that happened on the evening before. Do you remember seeing that?
A. Yes, I do.
Q. I think Dr. Gondi basically said he thought that the patient was having two different and separate problems, one was a bradycardia from a cardiac standpoint, and then he was also having a cerebral

vascular problem.
Is it your opinion that those are two intertwined and related here?
A. Yes.
Q. You don't believe there's any chance that he was having two separate and distinct problems that are not causally related to each other?
A. I would disagree with that opinion, because I think that the bradycardia was invoking these TIAs.
In other words, when you have a pre-existing stenosis and you have significant runs for bradycardia that would reduce cerebral blood flow, if you're already compromised in one artery, that's going to potentiate TIAs. So I think those -- in fact, he was having concomitantly the loss of consciousness and the focal neurological deficits, they were coming at the same time, so I think they were related.
Q. And those two things could have occurred -- or were occurring absent the infection that you believe he developed after the pacemaker?
A. That's right.
Q. Okay. Do you perform, or interpret transesophageal echos?
A. No, I don't do that.
Q. Cardiologists do that?

A. That's correct.
Q. And do you perform, or interpret echocardiograms with the bubble studies?
A. No, I do not do that.
Q. Do you know the purpose of the bubble studies?
A. Sure.
Q. Can you describe it for me?
A. If you have a right to left shift of the heart, in other words, if you have a so-called PFO, patent foramen ovale, that could be seen, you do a study and you put the air in and it shouldn't go to the right heart, to the left. If it does, that suggests there's a hole that's causing the paradoxical embolization.
Q. Okay. I just want to make sure that I -- I'm going to try to see if I understand your causation opinion in this case, and if I don't get it right, please let me know because I want to leave here making sure that we understand each other. Okay?
A. That's fine.
Q. What you've told me today, and I think I understand it, is that the patient came in with a significant history of cardiovascular problems, correct?
A. He did.
Q. Okay. And because of that -- and he also had his

history of laryngeal cancer for which he was treated with radiation that likely caused him some stenosis of his carotid arteries?

A. Well, I don't know about that, but it caused his neck to be fibrotic. There might have -- now, that's a good question. Was his antecedent stenosis strictly arteriosclerotic, or was it also exacerbated by the radiation? The answer is, I don't know the answer to that question because we don't have a studies before the original cancer was treated.

In any event, he did have, in my mind, significant highgrade stenosis of the left internal carotid artery and fibrosis in his left neck from the previous radiation and the original treatment.

Q. And when you say significant, we already talked about, we don't know the exact percentage of the stenosis, or the grade of his stenosis because they were unable to view his carotid artery on that doppler study, correct?

A. Yes. I would think it would be at least greater than 70 percent, and likely more.

Q. And so because of that pre-existing condition, is it your opinion then that when the sponge was retained in his pacemaker site that caused him to have -- and I'm making sure I understand this, you're not saying that the

infection itself, you're saying the infection caused him to have increased blood pressure, which either then made that carotid artery become fully occluded, or caused him to throw a clot that caused him to have the stroke on April 6th?

A. Well, it did become fully occluded, yes, and that total occlusion caused clotting -- the initial clot to develop stemming from the occluded left internal carotid artery flowing to the left middle cerebral artery and caused the stroke of April the 6th.

Q. Okay. I think I understand you.

A. Good.

Q. I just wanted to make sure that was it. The mechanism of the infection relating to the inclusion is the increase in the blood pressure. Is that what you're saying?

A. Well, infection itself, infection itself, can take a person who has a, how should I put it, predisposition to stroke, and certainly Mr. Kingery did, and make it -- a person who's hanging by a thread into having a stroke. That's one mechanism, infection, or the vast fluctuations in the blood pressure he was sustaining. Either of those two, or the combination of those two was causative of the stroke he had on the 6th.

Q. Okay. Now, from what I can tell from Exhibit A,

the one paragraph of the opinions that you were offered to discuss here today, or that you were prepared to opine today, it sounds like we have talked about what you believe the relationship between the retained sponge and his April 6th stroke are. Is that correct?

A. Yes, ma'am.

Q. Are there any other medical opinions that you have that we haven't discussed on that fact?

A. No.

Q. Okay. Now, I don't know if you know this, but Mr. Kingery passed away about 14 months after he had his stroke.

A. I didn't know that, but I'm not surprised.

Q. Okay. Are you here today to offer any opinions that the stroke that you believe was caused by the infection in his pacemaker site caused or contributed to cause of his death?

A. I couldn't do that right now, madam, because I don't know the details of his expiration. But it could be if Mr. Bartholomew wants to utilize me in that regard he'd have to send me some records from this point in time from April of 2007 till he died in late 2008. If he were to do that, I'll ask him to notify you so you can inquire of me, but at this point in time I have not been asked to discuss that.

MS. KAMYKOWSKI: Joe, do you plan on having him tie in the death or -- you know, I know we've kind of talked about this before, but I wasn't exactly sure where we were going with respect to that ultimate causation question.

MR. BARTHOLOMEW: I don't know if we need it or not. I don't think it's even going to be an issue. I mean, this is a man that went to a nursing home with absolutely no function whatsoever as a result of the stroke. To suggest that the stroke didn't cause the contributing cause of death, I think would be pretty remote. So I may have him look at the records or I may just have -- not. I didn't even realize that was an issue we have. I can't imagine that you guys are taking the position that the stroke wasn't causally related to his death. I mean, he was, you know, basically institutionalized in a rehab facility from the time of his stroke until his death, as you know.

MS. KAMYKOWSKI: Well, I do know that, but, Joe, you might -- I mean, you know, you and I can talk about that and argue it later, but I mean, I think obviously, if you were going to -- if we took this case to trial and you were going to submit it as a wrongful death case, you have to have somebody who

ties the death in, not just you saying that the records, you know, show that he was institutionalized and died there.

So, I guess in my mind you still have to have somebody that can say it, and whether you will find a treater -- I don't know. If Dr. Fischer's going to do it, you know, I kind of wish we would have had him look at that stuff before I came down here for the second time, but I guess, you know, we can talk about that later.

You and I will a difference in opinion as to what those elder care records show his condition was after he left, but -- and ultimately what he died of, I guess.

MR. BARTHOLOMEW: Well, what is your understanding as to what he died of?

MS. KAMYKOWSKI: Well, I don't know if you saw -- the death certificate showed that he had -- it was from coronary artery disease with extensive arthrosclerosis. It doesn't talk anything about any sort of an impaired neurological function, or anything that I think would necessarily be related to the retained sponge, but that -- you know, obviously that's just me, you know, and I have experts who will support that position.

MR. BARTHOLOMEW: Well, you know, I guess we can talk about it later. I guess if it's going to be an issue that someone's going to try to take the position that this man didn't die from, you know, all -- that the severe stroke didn't contribute to his death, I mean, you've got a man who was completely bedridden for -- you know, from the time this happened until his death, but whether the ultimate precipitating cause was the fact that he may have -- I don't know, I mean, the autopsy -- I don't know there'd be an autopsy, but why don't we just agree to disagree. I mean, that may be more of an issue that relates to what we're going to do in terms of resolving it.

MS. KAMYKOWSKI: True. No, true. I was just making sure -- I wanted to know if Dr. Fischer had any opinions as to whether or not -- and it sounds like he potentially --

MR. BARTHOLOMEW: I thought it was in your best interest to try to prove that the death was causally related since we're trying to -- I thought we were trying to resolve it in that way. If you want to take the opposite position and be responsible for the year and a half of rehabilitation, or whatever it was, then that's fine. We'll fight about

that at a later date.

If I need Dr. Fischer to say that the death was causally related to the stroke, and then that's his opinion after looking at the records, I'll let you know.

MS. KAMYKOWSKI: Okay. And, Joe, you know, when I get back to St. Louis I'll give you a call and we can talk about it because I know -- you know, we've talked about this before about a resolution of this case, so I think we can probably -- hopefully, you and I can come to some sort of agreement on it.

MR. BARTHOLOMEW: Okay.

BY MS. KAMYKOWSKI:

Q. But as far as today's deposition is concerned, Dr. Fischer, we've talked about the fact that your opinion is that the sponge caused an infection, and that infection, in one way or another, caused the development of the full occlusion of his left carotid artery that then developed into the middle cerebral artery infarct, or stroke on the 6th, correct?

A. You understood me perfectly, yeah, ma'am.

Q. Okay. I just wanted to make sure we got that right.

And as far as the evidence that you base the opinion that you have that he developed an infection,

we've talked about the fact that there was documentation that he had tenderness at his pacemaker insertion site, and you believe that's a sign, or a symptom of infection. Correct?

A. Yes.

Q. And the fact that he had a left shift that was shown on laboratory values. I don't know that we established what date that left shift appeared.

A. I'll find it here.

Q. I may have, and I apologize.

A. I didn't say the dates. I can tell you on the 3rd his initial CBC was normal with -- his white count was normal and he had no left shift. I believe on the 5th is when it -- okay. I'm looking at a page here -- I'll show you what I'm looking at.

Q. Let me see what date that is.

4/3, 4/6, 4/7. Okay.

A. Baseline one, this -- on the 3rd was antecedent to the provision of the pacemaker. He had a white count of 6.6, which is normal. And he had a differential of 50.6 neutrophils. That's normal. No left shift. Okay? On the 6th and the 7th he has additional white counts. It's up to 8.8 and 10.3, and that's still not elevated. However, if you look down, the neutrophil count, which should be below 65 percent, was 71.9 and 71.1 percent on

those two determinations, so -- and the commensurate drop of lymphocyte count. So here we developed, between his baseline and the provision of the pacemaker, a left shift, which is indicative of bacterial infection.

Q. Okay. So we talked about the left shift that we just discussed, and we also talked about the tenderness at the pacemaker insertion site, and you also cited to the hematoma, the bubbles that were seen when the hematoma was evacuated.

A. Yes.

Q. Were there any other signs or symptoms that you relied on in coming to the opinion that he did have a bacterial infection at his pacemaker site prior to his stroke?

A. He had temperature of 101.8, I believe.

Q. Do you remember when that was recorded?

A. I'm sorry, I'll look -- I've seen it in the notes.

No, it's a note here on 4/7 from Dr. Kliefoth that he had spiked a fever. He didn't specify the temperature. That's prior to the removal of the pacemaker on the 7th.

Q. And not actually the removal, that was prior to the hematoma evacuation, correct?

A. Yes. I'm sorry.

Q. I think the pacemaker ultimately wasn't removed until about a week later.

A. The 16th. You're correct, madam. It's removal of the hematoma, per se.

Q. Okay. Are there any other facts from the records that you are relying on in support of your position that he had a bacterial infection from the retained sponge at the time that his stroke occurred on the 6th, other than what we've already talked about?

A. No, ma'am.

Q. And as you sit here today, do you know what his deficits were when he was discharged from the hospital following his stroke to the long term care facility that he went to?

A. His discharge summary states his neurological status remained unchanged, and therefore -- this is written on May 1st. That's the day of his discharge. Unchanged would be, I guess consistent with Dr. Yu's consultation on April 7th, which was he was aphasic with a dense right hemiplegia. So that would be his status on discharge.

Q. And other than what's in the discharge summary, you don't have any other records that would allow you to opine as to the subsequent care and treatment, or damages that he sustained as a result of the stroke, correct?

A. You're correct. I have no information after May 1st, 2007.

Q. Are you aware, Doctor, of statistics that a patient with a prior TIA has a 16-fold increase in the risk of stroke in the next several days after the initial TIA?

A. That's absolutely true.

Q. And that can happen without any other factors, just a simple fact that they had certain, either cardiovascular or another neurological issues that developed into a TIA and that just the sheer incident of that on its own can cause a 16-fold increase in the risk of stroke, correct?

A. Yes, that's true.

Q. Did you review any literature or do any research to help you offer the opinions that you have given today in this case?

A. No, ma'am, I did not.

Q. It's all based on your training, experience, and education as a neurologist?

A. Yes, it is.

Q. Do you know what you have been charging Mr. Bartholomew to review this case for him?

A. Sure. I charge -- well, actually, this goes back to 2008 so my charge was slightly lower perhaps, but

maybe the first submission was that, but since then it's $500 per hour for reviewing records, $800 per hour for conferences, $800 per hour for depositions.

Q. And do you know how many hours you have into this case so far?

A. I don't know exactly. I can tell you. I can find out for you momentarily. You want me to do it now or at the end? I can find out immediately for you.

Q. You don't have an estimate as you sit here?

A. Well, an estimate, let's see.

I estimate the records would be about $1,200; conferences, $400; deposition today was -- asked for three hours, so it's $2,400. So 24 -- about $4,000.

Q. And if you are asked to come to trial in Madison County in Illinois, would you travel there to testify on behalf of the Plaintiff in the case?

A. Sure. Be glad to.

Q. And do you have a different, either a door to door or a per day fee?

A. No. Blanket charge, $5,000 for the trip, plus, you know, airfare and lodging, whatever.

Q. I didn't see on your CV any articles or other publications that you've written with respect specifically to infection and stroke. You haven't written on that topic, have you?

A. No, ma'am, I have not.
Q. Okay. Do you have any sort of research interests or specialty that you write on, or are studying at this point in time?
A. I'm involved in some current stroke research. One is a study on anti-platelet drugs in TIA. In other words, to see whether a combination of -- it's a national study sponsored by the University of Michigan and NIH in which we're studying whether aspirin and Plavix together is superior to aspirin or Plavix alone for acute TIA.
And also, I'm involved in a project sponsored by the University of Miami and some local stroke centers, including ours, where we do -- we're going to inject stem cells in patients with acute stroke to see if there's any improvement in their outcome.
Q. And are both of those ongoing studies right now?
A. That's correct.
Q. When are there anticipated completion dates, do you have any?
A. They're relatively early in their program.
Q. And they're multi-year test periods?
A. Yes.
Q. Okay. How long have you been offering opinions as an expert in medical malpractice cases?

A. The first time was in the latter part of 1976.
Q. And if you can give me an estimate, how many depositions have you given in medical malpractice cases since then?
A. I've given about 700 depositions. I'd say probably 300 medical practice cases.
Q. And, again, the majority of those for plaintiffs in malpractice cases?
A. Yes.
Q. Is that greater than 90 percent for plaintiffs?
A. No. Things have evolved. In other words, when I first was retained as an expert I had more defense cases than plaintiff. It equalized probably in the early nineties, or mid-nineties, and then it became more and more for the plaintiff. And now I'd say about 90 percent of the patients -- of the medical negligence matters I gets are on behalf of the plaintiff as opposed to defense.
Q. And just going from those numbers you just gave me, approximately 300 expert depositions you've given in medical malpractice cases, after those depositions, how many of those have you gone on to testify at trial?
A. I'd estimate I had 40 or 50 appearances at trial in medical negligence cases.
Q. Have you testified in the State of Illinois

before?
A. Yes.
Q. How many times?
A. I testified in Chicago back in 1989. It was a defense case actually, Glassman versus some hospital in Chicago. And I testified in Chicago, I guess about five years ago in a stroke case for a plaintiff. And I also testified in the St. Louis area for a Mr. Hopkins in a case about three or four years ago. It was a stroke case also, I think, but I don't remember the name of the case.
Q. That was in Missouri state court?
A. No, it was in Illinois.
Q. But in the St. Louis metropolitan area?
A. Yes. I know I flew into St. Louis and they drove me to someplace in Illinois.
Q. Have you worked with Mr. Bartholomew before this case?
A. I have.
Q. Do you know how many times?
A. I'd estimate five or six cases I've reviewed for Mr. Bartholomew.
Q. Have you given depositions in all of those cases?
A. Just about.

Q. Have you testified at trial on behalf of Mr. Bartholomew or anybody in his office?
A. No, I have not.
Q. Okay. Are there any other opinions that you would offer in this case if you came to testify at trial other than what we've already talked about today?
A. Potentially about the effects of this stroke on the demise of Mr. Kingery.
Q. But to offer those opinion would be only if you were to able to review additional records?
A. Yes. At this point I'm not prepared to talk about that.
Q. And if you happen to -- I mean, obviously Mr. Bartholomew would let me know if you review any additional records and they change your opinions, or if you need to add additional opinions.
A. Sure. That's fair.
Q. Hopefully I will know that before you do.
A. Probably will.
Q. And just to make sure that the record is clear, other than the simple fact that a sponge was retained in Mr. Kingery's pacemaker pocket from that insertion procedure on April 4th, you have no criticisms of the care and treatment that he received at St. Anthony's, whether by the nursing staff post-operatively, or by any

of the physicians that saw him; is that correct?
A. You're correct.
MS. KAMYKOWSKI: Okay. Joe, I think that's all I have.
Do you have anything?
MR. BARTHOLOMEW: Yes. A couple things.
Mandy, just so we're clear about it, I mean, his opinion about the sponge, I mean, he's certainly -- if there's no further miscount or whatever that would be, I assume you're assuming that's part and parcel of his opinion?
MS. KAMYKOWSKI: As far as the standard of care and liability?
MR. BARTHOLOMEW: Yes.
MS. KAMYKOWSKI: Yes.

CROSS EXAMINATION

BY MR. BARTHOLOMEW:
Q. Doctor, let's talk just briefly in general about Mr. Kingery when he left the hospital in terms of his neurological function.
What was the status of that, as you understand it from the records?
A. Okay, sir.
Mr. Kingery was, on May 1st, 2007 Mr. Kingery was very impaired neurologically. He was described by Dr. Yu

on his visits I have for several days, and also upon discharge by the attending physician, that he was unchanged from Dr. Yu's evaluations. And I say he was, Mr. Kingery was, globally aphasic and right hemiplegic, which means he could not speak and he could not use, at all, his right side.
To go into more specifics, let's look at Dr. Yu's consultation report on April 7th where he describes in more detail his status. Dr. Yu notes he was awake, able to follow commands, has no intelligible speech. He had diminished response to visual threat on the right half of the visual field. In other words, he couldn't see to the right.
He had reduced sensation of the right side of his face in all three divisions, and he had a right central facial neuropathy, which means he had a facial droop. He appeared to have no trouble handling his salivary secretions. He had a flaccid, which means he was like floppy, right hemiparesis. He had hypoactive muscle reflexes, and this is -- this may be a typo -- with a left extensor plantar response. I would expect a right, but he wrote left. I'm not sure why he would have left because he had no right cerebral problem.
And basically he said, this is a patient with a left middle cerebral artery territory infarct with a

nonfluent aphasia and flaccid right hemiplegia.
So then we have the records saying that he had no change in his status from that time until his discharge.
So we have a good idea that he was lying there, unable to speak, total right-sided weakness, and -- which he was very -- and floppy tone. He was very, very impaired.
Q. In general, does a patient like that, who, and if we assume he essentially remained like that until his death, would a patient like that pose a difficulty for a physician in treating cardiovascular disease?
A. Yes. For several reasons. Number one, this patient is subject to having multiple complications from this impaired status. The incidence of deep vein thrombosis, pulmonary embolization, aspiration pneumonia, urinary tract infection and urosepsis, decubitus formation and sepsis is enormous.
Secondly, because he had a documented major left cerebral infarction, the use of anti-coagulation is difficult because you can induce a hemorraghic transformation to a large ischemic stroke.
So, for several reasons, Mr. Kingery would present a major challenge for further care by a cardiologist or many other physicians.
MR. BARTHOLOMEW: Okay. Thank you, Doctor.

THE WITNESS: You're very welcome.

REDIRECT EXAMINATION

BY MS. KAMYKOWSKI:
Q. Doctor, just a couple of follow-ups. I just want to make sure that I'm clear on this.
The fact that Mr. Kingery came to the emergency room on April 3rd and was diagnosed with a TIA, that simple fact alone predisposed him to an increased chance of having a stroke regardless of any cardiac workup that he had at the hospital. Correct?
A. That is true.
Q. And he could have had this exact same stroke on April 6th, even if he hadn't had a retained sponge in his pocket. Correct?
A. Sure.
MS. KAMYKOWSKI: Okay. That's all I have, Joe.
MR. BARTHOLOMEW: Okay. Thank you. Great. Thank you, Doctor.
THE WITNESS: Thank you, Mr. Bartholomew.
MS. KAMYKOWSKI: Thanks, Joe.
THE WITNESS: Mr. Bartholomew, would you like me to read or waive on this?
MR. BARTHOLOMEW: Oh, I think you can waive.
THE WITNESS: Okay. That's great. Thank you, sir.

(Copy of Dr. Fisher's file marked as Defendant's Exhibit C for identification.)

(Deposition concluded at 2:21 p.m., reading and signing having been waived.)

CERTIFICATE OF OATH

STATE OF FLORIDA
COUNTY OF MIAMI-DADE

I, JANINE P. CARROLL, Notary Public, State of Florida, certify that KENNETH C. FISCHER, M.D. personally appeared before me on April 22, 2013 and was duly sworn.

Signed this 3rd day of May, 2013.

JANINE P. CARROLL
Notary Public-State of Florida
Commission No.: EE 070619
Expires: March 28, 2015

CERTIFICATE OF REPORTER

STATE OF FLORIDA
COUNTY OF MIAMI-DADE

I, JANINE P. CARROLL, do hereby certify that I was authorized to and did stenographically report the deposition of KENNETH C. FISCHER, M.D.; that a review of the transcript was not requested; and that the foregoing transcript 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, 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 3rd day of May, 2013 at Miami, Miami-Dade County, Florida.

JANINE P. CARROLL