IN THE DISTRICT COURT IN AND FOR LEFLORE COUNTY

STATE OF OKLAHOMA

PATSY FREDERICK, Individually
and as Next Friend of STEPHEN
J. SIMMONS, Deceased,
Plaintiff,
vs. Case No. CJ-2013-00259
DENNIS CARTER, D.O. and Judge Jonathan K. Sullivan
DANIEL HOLDMAN, M.D.,
Defendants.
_____/

The deposition of ANDREW STOLBACH, M.D., was held on Tuesday, February 17, 2015, commencing at 9:25 a.m., at the Offices of Gore Brothers Reporting & Videoconferencing, 20 South Charles Street, Suite 901, Baltimore, Maryland 21201, before Susan A. Kambouris, Notary Public.

REPORTED BY: Susan A. Kambouris

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APPEARANCES (Continued on the next page.)
APPEARANCES CONTINUED:

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PROCEEDINGS

Whereupon,
ANDREW STOLBACH, M.D.,
was called on for examination by counsel, and after being duly sworn according to law, was examined and testified as follows:

EXAMINATION BY MR. HURT:

Q Doctor Stolbach, I am Roger Hurt. I represent Doctor Holdman, the physician who took care of Mr. Simmons in the Emergency Room. I will be asking you a series of questions here today. First, I need to know, have you ever given sworn testimony in a medical malpractice case before?

A Yes.

Q How many times?

A Six or seven times.

Q Of those six or seven times, have any of those involved an aspirin overdose?

A No.

Q If we were to split those into cases for the Plaintiff and cases for the Defendant, how would

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you split those up?
A Two, I think, have been for the Plaintiff and the rest have been for the Defense.
Q Who is the last defense lawyer you worked with on a medical malpractice case?
A Erin Hess.
Q Could you spell Erin, please?
A E-r-i-n H-e-s-s. She is based in Cleveland, Ohio.
Q Who is the last Plaintiff's lawyer you have given testimony for?
A I would say a firm in Annapolis and I am having a blank.
Q Have you ever testified at trial in a medical malpractice case?
A Yes.
Q Can you tell me about the incidents or instances?
A The last time I testified in trial was in Cleveland. This was a case with Miss Hess, and the case was about a woman, an older woman with diabetes, and some other medical problems that went to an emergency department with an abscess in her lower back, and she had a CAT Scan performed with contrast to look at the extent of the abscess, and,

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unfortunately, her kidneys got worse and worse after that point, and she ended up needing dialysis, although she ended up getting a lot better. It was my opinion -- I testified that the CAT Scan and the contrast were clinically indicated, because of all her risk factors, they needed to exclude a significant abscess, make sure she didn't have anything really dangerous, life threatening going on. Before the CAT Scan, there was evidence of kidney problems already.
Q Do you know what the jury result was?
A I believe the jury found in favor of the defense. I left before that.
Q Is there any other trial you have testified in?
A Yes. I testified in a trial -- this was the one in Annapolis.
Q Okay.
A This time, I testified in support of the Plaintiff. So, there was a man who presented to an emergency department. He was a 50-some year-old man. He had a fever, and cough, and tachycardia, and he went to the Emergency Department. They gave him some IV fluids and they discharged him. They gave him some other medications, too. At the time

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of discharge, he was actually more tachycardic and hypotensive than when they first saw him, and, sadly, he died two or three days later of pneumonia related to influenza. I felt -- still feel that if they had kept him longer, observed him, gave him fluids, gave a chest x-ray, he would have lived.
Q Do you know what the result in that case was?
A That case was settled. I don't know the details of the settlement.
Q Did it settle during trial?
A There was something funny that happened that I don't understand, where we had with the trial, and, after the trial, the attorneys told me that they had actually settled beforehand, but I believe the man that died, his family felt strongly that they wanted to have a trial. That was the way it was explained to me.
MR. GRAVES: Maybe high low.
MR. CONNOR: Yes.
MR. HURT: I am not sure I understand it. I don't purport to understand Maryland Law.
Q So, in this case, do you know how Mr. Graves knew to contact you?
A No.

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Q Have you ever advertised your services as a broker to lawyers who work in malpractice?
A No.
Q Did you ever ask Mr. Graves how he contacted you, how he found out about you?
A Last night, I believe he asked me because I think one of -- somebody that you work with had contacted me, but I don't know how she found me.
Q Was it Rachel?
A Yes.
Q Okay. As you sit here today, Doctor Stolbach, are you ready to give your full and final opinions in this case?
A Yes.
Q Okay. Do you feel you have looked at everything you need to to render every opinion you will at trial?
A Yes.
Q You have brought with you two notebooks. Is this your entire file on the case?
A No. I have one notebook that has a number of depositions. One notebook has a summary of the case, and medical records, and some Poison Control. I also have looked at transcripts from the Poison Control Book, but I didn't bring that here because

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those are digital.
Q Okay.
A I have two more notebooks with depositions of Doctor Carter and Doctor Holdman that I didn't bring today because they were heavy and I was walking here.
Q So, if I wanted to get a laundry list of the depositions you have looked at, could you give me a list starting with the notebook, and, then, the additional ones you have looked at?
A Sure. Charles Bond, Randall Badillo, Darla Ford, Laurie Tankersley, Phillip Hebert, William Belk, Roger Blackwood, Patsy Frederick, Erica Vanhook, Mark Simmons, and Dennis Carter, and Daniel Holdman.
Q Okay. Have you looked at the deposition of Karen Singleton?
A I don't recall.
Q Do you recall who Karen Singleton was?
A No.
Q And, then, the medical records you have looked at involves a summary or a chronology prepared by Mr. Graves' office?
A Yes.
Q The records from Eastern Oklahoma Medical

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Center, in Poteau?
A Yes.
Q The EMS records of LeFlore County, which is Poteau?
A Yes.
Q And Mercy Hospital records in -- I think that's Fort Smith, is that correct, sir?
A Yes.
Q And, then, there is -- what is the last one?
A Poison Control.
Q The Poison Control Records showing at least what they entered into the record about various telephone calls?
A Yes.
Q Have you actually listened to the conversations on the Poison Control Records?
A No.
Q You have accepted what the transcripts say as true?
A Yes.
Q Okay. How big is Eastern Oklahoma Medical Center? How many beds?
A I remember the -- I believe I read the Emergency Department had about 10 beds, but I don't

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know how large the rest of the hospital is.
Q Have you ever worked at a hospital of that size?
A I have only worked at a hospital of that size when I was a medical student.
Q And which hospital was that?
A This is Dorchester General Medical Center, on the Eastern Shore of Maryland.
Q And how long did you work there as a medical student?
A About a month.
Q How many beds is the hospital you primarily work at, how many beds is it, both the ER and inpatients?
A I don't know. People ask me that a lot and I don't know, but it's a very big medical center, Johns Hopkins.
Q It is a teaching hospital?
A It is a teaching hospital, yes.
Q Under Maryland Law, to your understanding, are you immune from suit practicing at a teaching hospital?
A I don't know. I don't think so.
Q Okay. Have you ever been sued for malpractice yourself?

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A Yes.
Q How many times?
A Twice.
Q Do you know how often, on average, doctors who work in the Emergency Room get sued?
A No.
Q Did either of those cases have to do with an overdose?
A No.
Q Okay. Can you tell me what they were about?
A Sure. The first case -- both these cases were in between -- about 2002, when I was a fellow in New York. I am working at St. Luke's Regional Medical Center. The first case, there was a gentleman who was not my patient, but he had come to a number -- he had come to the hospital a number of times and complained of chest pain, and at the visit after -- I was working the second to last time that he came, and I believe the next time he came, he ended up, unfortunately, having a heart attack. Now, the time before, I was working that day, and there is one line in the chart where it said, "Doctor Stolbach notified that patient was hungry." My name was mentioned. So, unfortunately, because

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my name was mentioned, I was brought in, but, eventually, I was dropped. The second one was about the same time period, I was working in the Urgent Care Section of the Emergency Department, and a woman came in -- she had tripped and fallen, and hurt her ankle, and I had ordered an x-ray of her ankle and an x-ray of her foot. Both showed no fracture. We sent her home on crutches. I told her to see -- you know, we have her discharge instructions and said, "See an orthopedist." The next week, unfortunately, she did not see an orthopaedist in the next week, and she waited three weeks. When she saw the orthopedist three weeks later, there was a fracture the radiologist didn't see on the first x-ray, and I didn't see on the first x-ray. I actually don't think it was there on the first x-ray. I think it was not visible radiologically. That fracture required surgery. So, she saw the orthopaedist, and he did a surgery, and, unfortunately, the surgery didn't heal that well. She lost some range of motion. They named me and the orthopaedist. I gave a deposition two or three years ago. Every year, I have to check and see what is going on with it for my credentialing at Hopkins. Every year, the attorney says, "I think

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they are going to drop you. Nothing is really going on." As of two weeks ago, the case was -- I had to follow-up for my credentialing again. The case is still alive. The attorney thinks I am going to be dropped.

Q Still pending?

A Still pending.

Q In looking at the Emergency Room records when Doctor Holdman was treating Mr. Simmons, and the care Doctor Holdman rendered, can we agree that everything Doctor Holdman ordered was indicated?

A No, I don't agree with that.

Q What was not indicated?

A I can't give a comprehensive list, but the patient didn't necessarily need -- Mr. Simmons didn't need the Benzodiazepine, or the opioids, like, Morphine or Haloperidol.

Q That's on the floor. We will get to that. My question is, to kind of break it down a little bit. So, if you will follow along with that. While in the Emergency Room, not up on the ICU.

A Okay.

Q Is there anything Doctor Holdman ordered that was not indicated?

A If you want, we can look through each

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thing or you ask me specifically each thing he ordered. It might be easier for me. I can tell you.

Q Does anything jump out at you, anything he ordered that was contraindicated?

A In my view, his breach in the standard of care more had to do with the things that he didn't do and he didn't order.

Q Okay.

A So, I can't think of anything right now that he ordered that wasn't indicated, but I would have to really take it one item at a time.

Q Okay. Well, on the top of your head, you cannot give me anything you think was contraindicated that Doctor Holdman ordered, is that true?

MR. GRAVES: In the ER?

MR. HURT: In the ER.

A Not off the top of my head.

Q You do have criticism as to what was not ordered in the ER?

A Yes.

Q We will get to those. Did you do a calculation in this case in terms of milligrams per kilogram?

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A Yeah, I did a rough one. I think it was about 200, but it depends on -- I think the weight was an estimated weight, 200 pounds. The, and amount of pills was 50 to 60 an estimated amount of pills. Pill counts are never reliable. So, when I look at these estimates, I always think is it a lot or is it not a lot? Was it significant? This was a significant amount.

Q So, the number that you calculated, though, around 200 milligrams per kilogram is not considered a serious dose, isn't that true?

MR. GRAVES: Object to the form.

A Oh, no. I mean, as I said before, reported doses are often unreliable, but once I start hearing more than 150 milligrams per kilogram, I start thinking this could be a significant Salicylate.

Q But you just told me before the deposition sometime in your review of this case, you, in fact, did a calculation, rough calculation of the milligram per kilogram, did you not, sir?

A Yeah.

Q Why did you do that?

A Because it gives me an idea of whether it is a significant ingestion or insignificant

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ingestion. Sometimes, if it is an order of magnitude less working at the Poison Control Center, and they say a kid took three pills, and I do a weight calculation, and it comes out to 15 milligrams per kilogram, I can say, stay home, it is not a big deal, but if it is in the hundreds, then, I would say, I want to know more, does the patient look sick, are they tachycardic, do they have a high respiratory rate?

Q The calculated number you came up with of 200, is that considered a serious overdose?

MR. GRAVES: Object to form.

A It can be, yes.

Q You don't know, Doctor Holdman, I take it?

A No.

Q Or any of the healthcare providers in this lawsuit?

A No.

Q Can we agree that Doctor Holdman was working very hard to try to help this man both in the ER and on the floor?

MR. GRAVES: Object to form.

A I don't know how hard he was working.

Q Do you remember his testimony that he literally was drenched in sweat at the end of his

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shift?

A I do recall reading that, yes.

Q And that this was one of the top three exhausting shifts he has ever had?

A I don't remember that part, but I believe you.

Q How many times did Doctor Holdman go to the floor, the ICU Floor to try to help?

A I remember several times that he did, but I would have to go to the chart to get you an exact number.

Q Have you ever done that where you have had to be the only physician in charge of an ER, yet, perhaps, half a dozen times, go to the ICU, and try to help a combative patient?

A No.

Q Would you agree with me that all of the symptoms that Mr. Simmons had in the Emergency Room, all of the clinical symptoms pointed to a mild to moderate aspirin overdose?

A No.

Q Tell me what symptom in the Emergency Department did not point to a mild to moderate aspirin overdose?

A Sure. Physicians, when we talk about

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symptoms, we distinguish them from signs. Symptoms, we talk about things that people complain about and signs are things that we observe.

Q Okay.

A When you are asking about symptoms, do you mean it in that same --

Q I am going to re-ask the question to make sure we are on the same wavelength. What signs or symptoms did Mr. Simmons display that were not consistent with a mild to moderate aspirin overdose?

A Sure. He -- the signs that Mr. Simmons demonstrated were severe tachycardia, at times, up into the 140's, severe tachypnea for a long, sustained period of time, several hours. His respiratory rate was in the 40's.

Q In the Emergency Room?

A In -- throughout his time of care. So, I can consult my chronology here.

Q Absolutely.

A So, when he first presented, his heart rate -- I am looking at the summary here -- when he first presented, his heart rate was 127 and his respiratory rate was 28. So, that's what I would call a moderate to severe tachypnea and a moderate to severe tachycardia.

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The next vital signs that I see here -- so, at the time he -- right around the time he is going to the ICU, his pulse was 126 and his respiratory rate was 39. About 30 minutes prior, his heart rate was 141. So, both of these cases, his heart rate, it is 127 to 140-something, his respiratory rate is very fast, and that's a sustained period of time of several hours before he is going to the ICU. So, his vital signs are one set of signs that were significant. His behavior -- so, he showed signs and it's around the time of, you know, when he is going to the ICU that he begins to show signs of severe central nervous system toxicity from Salicylates. That's a sign of severe poisoning. And his Ph and his blood gases also is pretty concerning in that his --

Q My question is just directed to the Emergency Room right now.

A Okay.

Q Okay. Have you told me every sign and symptom that's concerning in the Emergency Room?

A Diaphoresis, and nausea, and I would put those as -- in the signs of moderate or significant Salicylate toxicity. He showed those in the Emergency Room, as well.

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Q The anxiety, do you recall the testimony about what provoked his anxiety?
A I don't recall what provoked it. I only recall reading testimony from his mother that he had been anxious or nervous about something at his home.
Q Do you remember seeing it charted in any record that his anxiety increased when the family was around?
A Yes.
Q That would be inconsistent with Salicylate toxicity, to have increased anxiety when the family is around, isn't that true?
A It's not inconsistent with Salicylate toxicity. It could be a separate issue. Somebody could be anxious and Salicylate poisoned at the same time.
Q Do you remember the testimony about any unusual tan lines Mr. Simmons had?
A I don't recall that testimony.
Q Do you remember Darla Ford talking about how he was resistent to taking his shirt off to do an EKG?
MR. GRAVES: Object to form.
A I don't recall that.
Q And do you recall that she saw and, then,

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reported to Doctor Holdman that she saw the outline as though he had been tanning while wearing a woman's brazier?
MR. GRAVES: Objection.
A I don't remember that.
Q Have you ever taken care of an Asperger's patient in the Emergency Room --
A Yes.
Q -- for an aspirin overdose?
A No, not for an aspirin overdose.
Q How many cases of an aspirin overdose have you treated?
A Probably about 20 to 30.
Q Did all of them survive?
A No.
Q How many died?
A Maybe two or three.
Q Did you see it documented anywhere that any family member told any healthcare provider that it was enteric-coated aspirin?
A In this case today, in the Mr. Simmons' case?
Q Yes.
A I don't recall. I remember in the depositions reading that it's an issue that goes

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back and forth.
Q Wouldn't you expect if a family member truly told the healthcare provider about that, whether it is a triage nurse, assigned nurse, doctors, somebody would have charted that?
A I don't know. I don't know what people would have charted. Often, the family member might see a pill and not think that the specific formulation is important. So, if they see a bottle of aspirin, they don't know if it's important or not it is enteric coated, so they will just say aspirin. Often, the person charting might not know if it's important or not. They might just hear enteric-coated aspirin and they might write aspirin.
Q So, you don't really know what happened about this enteric-coated business and whether an Asperger's patient somehow got his hands on enteric-coated aspirin?
MR. GRAVES: Object.
A I don't remember reading exactly what the family told EMS and what the family told the hospital.
Q Do you remember when the family found the bottle?
A No, but I remember at the time of triage,

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it was part of the triage notes that when he came to the hospital, I think from the very beginning, I think the story was he took on 50 to 60 aspirin. I believe they even had the size of the pill, 325 milligrams. From the time he walked in the door, they knew it was aspirin, and they were 50 to 60 pills, but I don't -- I remember reading about the controversy in the depositions, but I don't remember coming to a conclusion about it.
Q There are controversies in this case in terms of what the family says and what the healthcare providers charted at the time, correct?
A From reading the depositions, it seemed like there was a controversy about whether the family had said it was enteric coated and I don't remember having an opinion on what the family said.
Q Okay.
A I ultimately concluded that at the time the patient presented, it was clear that the family had said he had taken 50 to 60 aspirin, they were 325 milligrams. To me, that was enough information to take care of the patient.
Q Okay. But my question as to the enteric coated, you don't have an opinion as to whether that was told to the healthcare providers or not?

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A Not right now, no.
Q Okay. Are you critical of Doctor Holdman for admitting the patient?
A No.
Q Finding a doctor that would be the admitting doctor?
A No.
Q You read in this case and it's in the record Doctor Schumpert was a doctor who refused to take care of this patient?
A I read that, yes.
Q Are you critical of Doctor Schumpert in this case?
A I would have to know more about why he refused to admit the patient.
Q Let's say it is 10:00 o'clock at night and he just doesn't want to mess with it?
A I would be critical of a doctor whose only reason for not admitting a patient was it was 10:00 o'clock at night.
Q You are not critical of Doctor Carter for agreeing to being the admitting doctor, are you?
A No.
Q Did he have less anxiety when he went to the floor than what he had in the Emergency Room?

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A I don't know. I have never completely bought into the description of him being anxious; however, it seems that there is times when the symptoms that they are perceived that the treating physicians are perceiving anxiety seemed to wax and wane.
Q Okay. If this is a serious aspirin overdose, wouldn't you expect the anxiety to continually rise?
A Again, I don't know if anxiety is the right term. I think the tachycardia and the tachypnea, the diaphoresis, the sweating, they are perceiving as anxiety, and, then, the confusion, to me, those are all signs and symptoms of Salicylate poisoning. In general, those symptoms are steadily worsening throughout the Emergency Department, and, then, in the ICU. There is times when they do wax and wane. That's not surprising. At times, he gets some sedatives and things that would push some of those symptoms in the other direction, but, in general, his course is for the tachypnea, the tachycardia, and the confusion, all of that is getting worse from the time he comes in to the end.
Q If, in fact, it's true that his anxiety went up when the family was in with him, and that

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that was a repeatable pattern, you would not expect that to be due to Salicylate poisoning, would you, hypothetically?
MR. GRAVES: Object to the form.
A Again, someone can have anxiety and Salicylate poisoning at the same time. So, those things aren't mutually exclusive. Salicylate poisoning causes confusion. So, it can make you more anxious, and a lot of the symptoms -- the signs and symptoms of Salicylate poisoning are similar to signs and symptoms of anxiety, only more severe. So, if they are misperceiving the tachycardia, tachypnea, and diaphoresis as signs of anxiety and not Salicylate poisoning, I don't think that's correct. To be clear, I don't think it's correct to attribute severe tachycardia and severe tachypnea for this period of time to anxiety.
Q Okay. But that wasn't my question, sir. My question is: If, hypothetically, his anxiety goes up when the family goes and sees him and it goes down when they are not with him, that would not be related to Salicylate poisoning, wouldn't you agree, hypothetically, if that happened?
MR. GRAVES: Object to form.
A Hypothetically, a person can be Salicylate

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poisoned and their family can also make them nervous.
Q You would agree this was a multiple ingestion over several hours of Salicylates?
A I don't know.
Q Isn't that what Doctor Holdman charted?
A I don't remember exactly what he charted. I remember that he had taken -- the patient, it seems like, from the report of the family, that he had reported taking 50 to 60 pills several hours to presenting -- prior to presenting, and I don't recall over how many hours.
Q Did he not chart that there were several ingestions?
A If you can show me that or point me to that in the chart.
MR. GRAVES: I think it is 122 or 121. I object to the form. It mischaracterizes the document.
Q "Ingestion occurred over several hours." Do you see that?
A Okay, yes. Several hours.
Q Okay. So, this was not just one ingestion, correct?
MR. GRAVES: I object to the form of this question. It does not say, "Ingestion occurred

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over several hours." He just wrote in "several" and circled minutes and hours below. I disagree with that characterization.

MR. HURT: Okay. I am confident in the question. So, please answer it.

A Yeah, it says -- it looks like says, "Ingestion occurred," and if you are saying that word is --

Q Several?

A -- several, and, then, he circles, "hours," and, then, there is another circle which is over the words, "friends" and "minutes." I don't know if the friends -- it might be he is trying to refer to the mode of arrival with friends or it might be he is trying to say the ingestion was over minutes to hours.

Q Well, look below "several." He says, "Duration" -- he circled minutes and hours?

A I am not entirely clear what he is trying to say, but from a standpoint of managing the patient, those details shouldn't change the initial management of the patient. It shouldn't -- those details, whether he took them over minutes or a few hours, shouldn't change the initial or subsequent management of the Salicylate poisoning.

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Q Okay. So, do you think this was an acute ingestion?

A In Salicylate poisoning, the terms "acute" and "chronic" and "subacute ingestions" have specific meanings. An acute ingestion we define as an ingestion of Salicylates in somebody that doesn't previously have a body burden or isn't previously taking a lot of aspirin. So, those are usually either suicidal ingestions, or suicidal gestures, or ingestions due to anxiety, or unintentional ingestions in young people. A chronic ingestion is generally somebody that's taking Salicylate everyday, and they already have some body burden of Salicylate, and, then, at some point, they either just accumulate too much or they take a little bit too much more, and it just pushes them over the edge. I don't know if he was taking Salicylate everyday. So, this, to me, sounds like it was either an acute ingestion or a subacute ingestion.

Q Okay. That would be your opinion?

A That's my opinion.

Q Okay. What do you believe Doctor Holdman should have done that he did not do in the Emergency Room?

A To name a few things, I believe that

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the -- as soon as the patient walked in with a history of Salicylate poisoning, a history of significant Salicylate ingestion, and these vital signs, they should have recognized that this was a sick patient, and that he had clinical manifestations that were consistent with Salicylate poisoning, so he looked like he had Salicylate poisoning, and the history said that he had Salicylate poisoning. So, I think he should have just readily recognized that it was Salicylate poisoning. What they heard matched up with what they saw. I think he should have -- once he got the first level back, which confirmed the diagnosis that was already very strongly suggested in the history and physical exam. So, you have got that level in the low 50's. They should have started bicarbonate, they should have given activated charcoal, and they should have been sending in another level to start to see which direction the levels are going. Because if the level is continuing to go up -- bless you -- if the level is continuing to go up, that would be an indication that they need to think about hemodialysis. I think that if they had done that, and you would have gotten levels closer together, and you are giving the bicarb, either -- hopefully,

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the bicarb would have resolved the symptoms, and he would have just -- the patient would have progressively gotten better, or if you had been giving the bicarb and the bicarb wasn't quite enough to resolve the symptoms, I feel that Doctor Holdman should have seen the levels just creeping up, and he should have found a center that would perform hemodialysis, and transferred him to get hemodialysis.

Q Okay. Doctor Holdman did give activated charcoal, did he not?

A Yes.

Q Okay. So, I don't understand that criticism. You would concede he gave activated charcoal?

A Yes.

Q Okay. So, we can scratch that off the Criticism List, correct?

A He did give activated charcoal and I think that was correct.

Q So, in terms of -- in terms of something active in the Emergency Room, your criticism is, he did not give sodium bicarb in the Emergency Room?

A In the Emergency Department, I feel he should have given sodium bicarbonate very early in

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the course. He didn't do that.
Q And how early?
A As soon as the first level came back, he should have started sodium bicarb.
Q When Mr. Simmons was in the Emergency Department, he was compensating for acidosis with his tachypnea, correct?
A Well, the tachypnea was -- when somebody in Salicylate poisoning is tachypneic, there are two reasons that they are tachypneic. So, one reason is the direct poisoning of the respiratory center in your brain, so the Salicylate is tricking your brain to make you breathe too fast, and that's a respiratory alkalosis, and there is also what is called a compensatory respiratory alkalosis, when you are breathing fast, because you have an acidosis. And what I always teach our students and what I teach our residents is that when you see somebody with Salicylate poisoning, their Ph -- when the Ph is a little bit high, it's actually a good thing. It's better than the alternative of the Ph being a little bit low. I will explain, when you are first Salicylate poisoned, you have the respiratory alkalosis, and your Ph is 7.5 or so, which is higher than normal. Normal is 7.4. At a

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Ph of 7.5, because of the way Salicylate is, because it's a weak acid, at a Ph of 7.5, it's not able to get into your brain, it's not able to get into your tissues very well, but it can, and it can't poison you as well. The lower your Ph gets, the more the Salicylate is able to poison you. So, when you first see -- in early Salicylate poisoning, their Ph is 7.5. There is nothing wrong. In fact, we would indicate giving bicarb, which would raise your Ph a little bit, even further, but it would protect you from the Salicylate getting into your tissues and it would also eliminate the Salicylate faster. When your Salicylate -- when your Ph, I should say, starts dropping down to 7.4, now, that's as a result of the poisoning of Salicylate on your metabolism. So, when your metabolism is poisoned, you are not able to make energy as efficiently. You start getting acidosis from that. When you start getting that acidosis, your Ph drops. So if somebody is Salicylate poisoned, a person with Salicylate poisoning with a Ph of 7.4, even though that's a "normal Ph," that's a sicker patient than a Ph -- than a Salicylate-poisoned patient with a Ph of 7.5.
Q The arterial Ph will almost always be higher than the venous Ph, correct?

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A Yes.
Q Okay.
A But you can use the venous Ph to estimate the arterial Ph because it is often pretty close.
Q Okay. You believe at least in terms of your criticism in the Emergency Department, you believe Doctor Holdman should have started sodium bicarb at what rate?
A He should have -- we usually recommend giving it about at what we call twice maintenance. That's usually 200 cc's an hour.
Q How many amps?
A We would recommend putting 3 amps in a container about the size of a liter without any more sodium in it. So, that would be a D5W, not in the normal saline bag, but a D5W, and to give that at about 200 an hour, 100 to 200 an hour, depending on their size. I think for him it would be closer to 200.
Q 200 milliliters or cc's per hour?
A Yes.
Q Okay. Are there any other risks to giving sodium bicarbonate?
A There is risks to every therapy in medicine. In this case, the risks of sodium

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bicarbonate are pretty trivial compared to the risks of Salicylate poisoning.
Q Again, my question is simply: Are there risks to giving sodium bicarb?
A Yes.
Q What are those risks, sir?
A If you run the rate too fast, you can make somebody's sodium level too high, but that can be avoided by not running the rate too fast, and, also, by checking periodic sodiums whenever you check the Salicylate concentration. Another risk could be if you are not careful and you ran the rate too fast again, you can make the Ph actually go too high. But that risk can be avoided by checking of Ph every time, again, you are checking the Salicylate and the sodium level. My experience with treating Salicylate poisoning, we never have bad outcomes from the bicarbonate therapy. The bad outcomes have been from the Salicylate.
Q Let me ask you this: There was a textbook article excerpt -- textbook excerpt, I should say, that was faxed by Poison Control to the Emergency Department at Eastern Oklahoma Medical Center. Did you review that?
A I took a look at that, yes.

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Q Are you critical of anything in that textbook excerpt?

A No, for the most part, I thought everything in that excerpt seemed reasonable, but I would have to look at it point by point to see if there was anything I could nitpick on.

Q If that article said a significant or serious level was 90 in terms of serum Salicylate, would you disagree with that?

A I agree that 90 is a serious significant Salicylate level.

Q Do you think 50 is a serious Salicylate level?

A I think 50 could be a very serious level if the other signs and symptoms indicate significant Salicylate poisoning.

Q Do you think the clinical signs and symptoms take precedence over the Salicylate level?

A I think the clinician has to look at both of them together. In this case, a patient like Mr. Simmons, with a real significant Salicylate level, and coupled with signs of significant toxicity, so severe tachypnea and tachycardia, that, to me, paints a picture of somebody with significant Salicylate poisoning.

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Q Okay. My question to you, though, is: If you see a Salicylate level of 52, which I think is what the first one was in this case, sir, is that a serious level?

A If I get a consult of a Salicylate level of 52, I am going to have a series of questions. I am going to say, what's -- tell me what the respiratory rate is, tell me what the heart rate is, and tell me what the Ph is, and I am going to use all of that information. Tell me what the patient's mental status and behavior is like. I am going to use all of that information to decide how sick I think they are. But 50 -- it's always a level that I would recommend sodium bicarbonate.

Q What if it was 40, would you recommend sodium bicarb?

A So, now, we are getting to the point where people might -- I think different people might disagree, but if you told me about somebody with a level of 40, exactly 40, and they had no signs and symptoms of Salicylate poisoning, I might say, let's get another level in two hours, see what direction it is going. Let's also get a Ph. Let's give them charcoal. If the next level was 35, then, I would be totally happy with not giving bicarb. If the

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next level was 45 in my practice pattern, I would then start the bicarb. I know from this -- the handout that they got, they recommended bicarb at the equivalent, I believe, of 25, and that's without any other signs and symptoms, and I don't think that's unreasonable, but I might not do it exactly the same.

Q Actually, that document, that page that talks about 25 to 75, it did not come out and recommend that you give sodium bicarb at 25, did it?

A I thought it did. I can look at it.

Q Please do, if you could. I think you have it right there in your left hand. I think what you are looking at right now is the textbook excerpt. Could you tell us which page you are looking at right now?

A So, yeah, right now, I am looking at the textbook excerpt, which is SIM 000194.

Q And does that textbook excerpt say to give sodium bicarb at a level of 52?

A So, here is what I see: "Concentration greater than 250, but less than 750."

Q Doctor, I am going to cut you off because my question was on the textbook excerpt --

A Okay.

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Q -- which you have turned the page since I asked the question.

A Sure.

Q In the textbook excerpt, is there anything that says you give sodium bicarb at a level of 52?

A So, to be clear, the first thing I just said, so, I was then looking at SIM 000192 Management of Salicylate Poisoning. I saw that for a concentration greater than 250, but less than 750, which are the terms we are talking about before was greater than 25 or less than 75. Now, you are asking me about the textbook.

Q Yeah. I haven't asked about that other article yet, what was put together by Poison Control.

MR. GRAVES: Object to the form. I think that was part of the Poison Control Packet.

MR. HURT: But I believe the other part is what was prepared by Poison Control.

MR. GRAVES: I didn't understand that in the context of your first question.

A So, it says, "Treatment: Treat metabolic acidosis with intravenous sodium bicarbonate. Do not allow the Serum Ph to fall below 7.4." In this case, they are using the metabolic acidosis as the

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indication for bicarbonate, not -- they don't give a specific Salicylate concentration in this textbook.

Q And we can agree that the first venous blood gas had a 7.44. So, according to the article sent by the textbook -- excerpt, I should say, sent by Poison Control, the Ph is not at a level that he should give it, correct?

A That's not correct. You see, this is where people can get confused between acidosis and acidemia. To doctors, they mean two different things. And, so, an acidemia is very simply whether your Ph is below 7.4 or above 7.4. So, if your Ph is below 7.4, you have acidemia. If it is above 7.4, you have an alkalemia, and the osis, acidosis, and alkalosis are processes that change your Ph. So, in Salicylate poisoning, from the moment you take your Salicylate poisoning, the moment you take your big overdose of aspirin, and you are starting to absorb it, as I said before, in early Salicylate poisoning, your Ph may be 7.5 or 7.55. So, you have -- that's an alkalemia, because you Ph is above 7.5. At that time, you have a respiratory alkalosis because the Salicylate is poisoning your brain, and making you breathe too fast, and that's a respiratory alkalosis, that process is a respiratory

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alkalosis. You have a co-existent, like we said before, or a compensatory respiratory alkalosis because you are breathing fast, but you also have the metabolic acidosis. So, from the very beginning, you have the metabolic acidosis. You just don't have an acidemia yet, because your alkalosis is stronger than your acidosis. Because of that, that's keeping your Ph alkalemic.

MR. HURT: I am going to move to strike that as nonresponsive.

MR. GRAVES: It is precisely responsive.

MR. HURT: No.

Q My question is based on -- just make sure we are looking at SIM 00194. Okay?

A Yes.

Q Is there anything on that page which appears to be Page 332 and 333 of the textbook, anything there that says that there is a Salicylate level or a Ph level that Doctor Holdman should have ordered bicarb in the ER? Just looking at what was sent to him by Poison Control?

A So, this textbook that you are referring to says, "Treat metabolic acidosis with intravenous sodium bicarbonate." So, to take that very

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literally, they are saying to treat the process that's making your Ph start to drop, and if I look at the very first -- every Ph I see or every -- not every Ph, every blood gas I see, there is evidence of a metabolic acidosis, even though, for the most part, the Ph doesn't drop below 7.4. So, I see the metabolic acidosis, and I know it is there because when I see somebody that is breathing 20, or 30, 40 times a minute, and their Ph is above 7.4, or it's is close to 7.4 -- when you see somebody breathing that fast, and their Ph almost looks almost "normal," you know that there is a metabolic acidosis there, and especially when they say, "I took 50 to 60 aspirin."

Q So, in reading under Page 332 of Bates 194, where it says, "Treat metabolic acidosis with intravenous bicarbonate, do not allow the Serum Ph to fall below 7.4," applying that to the Ph we have, which was the venous Ph of 7.44, you would agree the arterial Ph was probably above 7.5 at that point in time, isn't that true?

MR. GRAVES: Object to form.

A No, I don't know that that's true. I believe the arterial Ph was, at least -- I agree the arterial Ph was probably about 7.44, maybe --

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Q Maybe higher?

A Maybe a little bit higher. It's impossible to say exactly what it was.

Q Okay. Incidentally, did you ever see Mr. Simmons described as lethargic in the Emergency Department?

A I don't remember that specific term.

Q We certainly know he was combative on the floor and had to be restrained?

A Yes.

Q Being combative and having to be restrained is not a lethargic patient, correct?

A It's -- I think of -- I don't think of lethargy and combativeness as being the same, but I see them both as being potentially a sign of being delirious and having --

Q But lethargy and combativeness -- and his combativeness was he struck a nurse. You know that?

A I read that, yes.

Q It took four or five people to get him down to restrain him with the leather restraints. Do you recall that?

A I remember it took a number of people to restrain him.

Q And I can tell you, at least, some of them

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I have met are pretty good-sized fellows. Have you ever done that? Have you ever had to be one of four or five people to restrain a patient?
A Yes.
Q Do you know what K2 is?
A Yes.
Q What is that?
A K2 is -- well, it's a mountain in the Himalayas, but it's a trade name that people have used to sell illegal synthetic cannabinoids. So, it's an illegal synthetic Marijuana-type drug. Some people have put a label of K2, giving it a brand name.
Q How many times was Doctor Holdman told by Poison Control they thought there was something else on board?
A I don't remember how many times.
Q At least twice?
MR. GRAVES: Object to the form.
A I remember, at least, once during the first phone call.
MR. GRAVES: I object to the form. Doctor Holdman was never told anything by Poison Control on the first phone call.
A Yeah, I want to correct my last statement.

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It wasn't Doctor Holdman that talked to the first --
Q It was Mr. Hebert, was it not?
A I don't remember exactly which person, but it was --
Q Okay.
A Was Mr. Hebert one of the nurses?
Q He was a nursing supervisor.
A Nursing supervisor. The person that spoke the first time to the first poison specialist, but, yeah, he was told at least once that they thought it was something.
Q Is that something you do when you get a history of an overdose, do you consider other medications on board?
A Yes.
Q And a tox screen, a urine tox screen only will screen out a few of the many things that can be on board, true, sir?
A Yeah. Urine tox screens aren't comprehensive.
Q Right. In fact, if the body has not metabolized some of those medications, it won't show up in the urine even though the drug has been ingested, isn't that true?
A There is drugs that people can take that won't show up on the urine tox screen.

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Q Right. Okay. You are not critical of Doctor Holdman going up to the floor a half dozen times to try to help?
A I am not critical of him going up to the floor and trying to help.
Q Okay. And, as he told us in the deposition, he was there as a strong pair of hands, do you recall that?
A I believe you if you say so. I don't remember reading that specifically.
Q The records have indicated that the nurses were supposed to call the periodic labs to Doctor Carter, do you recall that?
A I don't remember reading that specifically. I believe you.
Q Look at Page 10050. Do you see Doctor Holdman's note at 12:40 in the morning?
A Yes.
Q This is around the time the patient is admitted to the floor?
A Yes.
Q You understand that?
A Yes.
Q The patient repeatedly requested family stay out of the room as he gets more anxious in their presence. Do you see that?
A Yes.
Q Do you think that's just the Salicylate explaining that behavior and that desire?
MR. GRAVES: Object to form.
A As I have said, I think somebody can be both anxious and be Salicylate poisoned at the same time. I think Mr. Simmons had signs and symptoms of severe significant Salicylate poisoning throughout.
Q Doctor Carter agrees to admit to OBS and follow labs and levels in ICU. Do you see that?
A Yes.
Q Now, are you critical of any of the nurses for not calling Doctor Carter throughout the night?
A I don't want to comment too much on nursing standards of care. I am not a nurse. I know where I work, nurses will call me about abnormal vital signs and patients that look worse despite the fact that they are doing all the therapies that I have ordered. So, I would hope that if I have a patient I have ordered a bunch of therapies for and they are getting worse, nurses would be calling me, bugging me, asking me to come see the patient.

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Q The patient was not hyperthermic in the Emergency Department, was he?
A I think the first temperature of 104 was after he left the Emergency Room.
Q In fact, it was around 7:00 o'clock that that first hyperthermic temperature came back, isn't that true, sir?
A That sounds right.
Q Now, one of the things that can affect acid levels in the body is lactic acidosis, correct?
A That's correct.
Q If I am fighting two, three, four people for 45 minutes to get restrained, you would expect there to be some lactic acidosis just from that, correct?
A Often, yes, but these aren't mutually exclusive with Salicylate poisoning because Salicylate poisoning can make you more agitated and it can make you fight more. Salicylate poisoning also is poisoning the mitochondria in those muscles that are making you fight. So that when a normal person fighting a lot makes X amount of lactic acid, a Salicylate-poisoned patient fighting a lot make 2X amount of lactic acid.
Q The elevated CPK, you noted that, did you

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not?
A Yes.
Q That was due to his fighting restraints, correct?
A Yeah. In this case, the most likely cause of that was from his exertion.
Q Right. And to exert to elevate his CPK to a level of 664, that would not be a lethargic patient, would it?
A Well, lethargy and agitation, you can go back and forth between the two, and, in fact, definition of delirium, such as a delirium that could be caused by Salicylate poisoning, we call it a waxing and waning mental status. Just alternating between periods of having different levels of consciousness and alertness.
Q Well, he didn't wane until he got some medication, correct?
A I don't know if that's correct.
Q Can you show me in the record where he waned prior to getting some sedative medication in the ICU after he was restrained?
A Well, it's the spaces between the charting. So, if you see somebody gets really agitated, and it takes a lot of people to restrain

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them, and, two hours later, the same thing happens, presumably, there is some period in the middle where things seem to settle down for sometime.
Q Did you ever see where he settled down?
A I will refer to this summary. Off the top of my head, I can say for sure there was not a constant wrestling match from the time he was in the ICU until 7:00 in the morning. I know there were periods of lull.
Q One can have a lull and not be lethargic, true?
A I would define lethargy as somebody just being quiet and exhibiting a lack of energy. Somebody could not be fighting, but also not be lethargic at the same time. It says here, "2:17, beginning to become agitated," and at 1:46, "He is anxious, unable to stay in one position." Then, "Able to get patient up in bed, cleaned, and repositioned." So, he is kind of anxious and upset, but, then, he throws up, and, now, he is kind of calm, and they clean him up, and reposition him. Then, about 30, 40 minutes later, he is agitated again. Fifteen minutes later, he becomes combative and he is retrained.
Q According to the record, is it 45 minutes

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after he became combative before he is restrained?
A To be very precise, I see the word, "combative," here, at 2:30 and the soft leather restraints, I see around 3:00 o'clock.
Q Is it 3:00 or 3:15?
A The summary says 3:00. I could go back to the chart, but the charts agreed with the summary.
Q Okay. Well, it will speak for itself whether it is 30 or 45 minutes.
A This whole chart -- when I look at this in its entirety from the moment he comes in until 7:00 in the morning and beyond, I see a patient who is just slowly becoming more confused, and more agitated, and more delirious as times goes on, which is consistent with Salicylate poisoning.
Q His behavior in the ICU could be consistent with his autistic disease, true?
MR. GRAVES: Objection.
Q Isn't that true, sir?
A No, I don't think autism should cause somebody to have a fast heart rate, and a fast respiratory rate, and severe agitation for this period of time, especially when it's somebody who usually lives alone at home.
Q Okay. He lives --

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A He is semi-independent.
Q He lives underneath his father's apartment. So, he does live alone, but he is supervised heavily. You understand that?
MR. GRAVES: Object to form.
A Somebody that has a degree of independence, and this is completely out of character for him to be -- he doesn't go through life fighting and being needed to be restrained.
Q Okay. But, as far as we know, this is the first time he has ever been kept in a hospital overnight, isn't that true?
MR. GRAVES: Objection.
A I don't remember reading about prior hospital admissions.
Q Okay. You saw where they had to put an IV in his knee?
A I don't remember reading that, but I remember there was a time when they were having trouble getting access.
Q In fact, on the communication that Doctor Holdman has with the Poison Control, he tells us, "He has pulled out four or five of the IV's." Do you recall that?
A I remember he had pulled out a few IV's,

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yes.
Q Okay. And to put an IV in the knee is tenuous IV access, at best, correct?
A Yeah. Usually, that is not the first place you want to look for a vein.
Q Okay. And did you read any testimony about how he reacted to simply having the blood pressure cuff go on and squeeze his bicep?
A I don't remember specifically the blood pressure cuff, but I remember his periods of agitation.
Q Okay. Once he, Doctor Holdman comes to the floor, other than continuing to give sodium bicarb, is there any other criticism you have of Doctor Holdman?
A I feel that Doctor Holdman should have recognized that this was a significantly Salicylate-poisoned patient, and that the levels -- I believe, by this point, now, you have, at least, two levels. They are not going down, that they are heading in the wrong direction. I feel that Doctor Holdman should have recognized that this was somebody they should start thinking about being more aggressive and getting dialysis for.
Q Okay. Do you have any other criticism of

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Doctor Holdman on the floor?
A To be complete, how I would have managed the case if I were Doctor Holdman, if I walk in and see this patient with his respiratory alkalosis and his Ph starting to drop close to or below 7.4, and he is showing signs of Salicylate poisoning in the brain, he is getting more aggitated, and he is tachypneic and tachycardic, I would say, get me another Salicylate level right now, make sure that -- start the bicarb from the minute one that he sees him, and let's find a nephrologist somewhere that can get us some dialysis. So, that's how I would have managed it and how I think the standard of care for an emergency physician to manage it. So, everything he did that wasn't that, I disagree.
Q Okay. So, kind of distilling to the essence your criticism of Doctor Holdman in this case, you feel he should have started bicarb early?
A Yes.
Q And continued it?
A Yes.
Q And you assumed that the combativeness is a sign of the Salicylate poisoning deteriorating his mental function, correct?
A That's the way I think he needed to

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interpret it. In the context of having that high Salicylate level and the vital signs, yes.
Q Okay. Do you recall reading his own mother's testimony that she felt his behavior when he became combative was because he was aware from his environment and that that is what was casing it?
A I remember -- I don't remember that specifically, but I remember her talking about his behavior.
Q Would it be appropriate with autistic patient for a doctor to ask the opinions of the family, who know him better than the healthcare providers, what their thoughts are about his behavior?
A It is certainly appropriate for them to get input from the family.
Q Okay. You don't fault Doctor Holdman for doing that?
A I don't fault him for getting input from the family, no.
Q You have no reason to think Doctor Holdman did not want a good reaction -- a good result, I should say, for this patient?
A I don't have any reason to think that he didn't want the patient to do well.

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Q And just the fact that he went up to the floor, went to the floor six times, I believe it is charted in this case, just to try to help?

MR. GRAVES: Object to form.

Q That shows, at least, as far as you are concerned, his heart is in the right place?

MR. GRAVES: Object to the form.

A I wouldn't talk -- I wouldn't be able to speak in those kind of sentimental terms, but it's evidence -- that's doing his job. If a nurse calls you to the floor and asks for help, that's something that you are supposed to do.

Q Well, working in the ER and having patients there, Doctor Holdman would be perfectly within his right to say, hey, call Doctor Carter, I am treating patients in the ER?

MR. GRAVES: Object to form.

Q He could have done that, couldn't he?

A I don't know what the specific rules were at that hospital.

Q Typically, ER doctors are not encouraged to go up to the floor unless it is some sort of Code Purple or emergency like that, isn't that true?

A Different hospitals are different from each other. For example, I know that there are

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hospitals where ER doctors are expected to do the codes up on the floor overnight. They are expected to intubate patients overnight. I just don't know exactly what his assigned duties were for the ICU.

Q Where is Poteau?

A In Oklahoma.

Q Where?

A I don't know.

Q North, south, east, or west?

A I imagine it is east because it said Eastern Oklahoma Medical Center.

Q Well, that's a good deduction. If I asked you this, I apologize. Did he report tenderness to anybody?

A I don't remember reading a report of tenderness, no.

Q What is the ER staffing ratio at Johns Hopkins in terms of physician/nurse?

A I don't know specifically.

Q Okay.

A It's different at different times of day for the number of physicians and nurses and doctors.

Q Do you work in an ER other than at Johns Hopkins?

A I have always -- I have credentialed work

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at Howard County General. I haven't worked there in more than a year. In the last year, I have only worked at Johns Hopkins.

Q Why have you not worked at Howard County General?

A Because I prefer not to. It is further from my house. So, I like to have all of my shifts scheduled at Johns Hopkins?

Q Is it a smaller hospital?

A It's smaller, yes.

Q When you work a shift in the emergency department, do you always have residents with you?

A At Johns Hopkins, I usually have residents with me, but we don't always have residents.

MR. HURT: We have been going for awhile. Do you mind, sir, if we take a short break?

THE WITNESS: No.

MR. HURT: Okay. I think I need a break.

(Recess taken -- 10:46 a.m.)

(After recess -- 10:55 a.m.)

MR. HURT: Back on the record after a break.

Q Are you ready to proceed, sir?

A Yes.

Q The Ph from 3:34 in the morning until 7:30

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in the morning only dropped from 7.39 to 7.38, the PC02 went up, and the base excess went down. What do you attribute that to?

A So, I attribute that to continued tachypnea on the part of Mr. Simmons. So, he is still breathing really, really fast from the Salicylate poisoning, and, so, he is able to kind of keep his Ph around 7.4, although as I stated before, that is actually a sign that he is -- of significant poisoning when your Ph is near 7.4. You want it to be higher, but I attribute that to a sign of him just having continued sustained tachypnea, just breathing fast.

Q I mean, does it not show that he was able to compensate for the acidosis from 3:34 in the morning until 7:30 in the morning, sir?

A You can only do that for so long. So, you can only breathe hours and hours, and I look at his vital signs, he is breathing -- I look at 1:20 and he is breathing at 39. At 2:15, he is breathing at 45. At 3:28, he is breathing at 48. At 3:30, he is breathing at 49. So, you can only do that for so long. At 3:45, he is breathing at 45. So, he is able to -- for a certain amount of time, he is able to keep his respiratory rate at a point that is

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staving off the acidemia, because once that Ph starts to drop, the effect compounds because as the Ph drops down, more Salicylate is able to be absorbed into your tissues, and you are more poisoned, and, then, your Ph drops more, and, then, more gets absorbed, so once the ball starts rolling, things -- people usually fall apart pretty quickly. But for this period of time, he is able to -- with his respiratory rate, he is staving that off.

Q Yes. And that's the question I wanted you to acknowledge, that the Ph drop of only 1 from 7.39 at 3:34 to 7.38 at 7:30 reflects an ability to compensate, at least during those times, by the rapid respiration, correct?

A When you look at the patient in his entirety, you realize that this is somebody who is really sick, and that this can't go on forever, and that you are going to need to do something to get rid of that Salicylate while you have this brief window of opportunity that he is able to breathe fast enough to keep himself in the game, so-to-speak.

Q Well, that's the point. By 7:30 in the morning, he is still in the game. He is still salvageable, correct?

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A I don't know the exact point at which he becomes not salvageable or not savable. Certainly, when he came into the hospital, he could have been saved. His life could have been saved. The picture that I see when he first walked in, I see Salicylate-poisoned patients like that that survive. You know, by the time he gets intubated, he is very ill. So, somewhere around 6:00, 7:00, 8:00, 9:00 in the morning, unfortunately, I think he turns a corner where he passes a point of no return. I don't know exactly when the time is.

Q Well, let me just ask you then: Are you critical of any of the care he received in the ambulance being transported to Mercy Fort Smith?

A No. Again, I don't like to get in too much into the details of emergency medical services, so, EMS, ambulance standard of care, because they have their protocols and different levels of training that I am not always familiar with. So, as a doctor, I would do things differently, but they are not doctors. So, the short answer is I can't criticize their management.

Q You would not have intubated him at a level of 12 rate in the ambulance, would you?

A As a doctor, if I was intubating somebody

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that was Salicylate poisoned, if I felt like I had to do it as a last resort, I would do it in a certain way where I intubated you and gave you bicarbonate at the same time, and, then, tried to ventilate you very quickly, but they are not doctors. So, I can't hold them to that standard. I don't know what their protocol says.

Q Well, what would you have set the ventilation rate at on the ambulance on the way to Mercy Fort Smith?

A Something fast that I thought the patient could tolerate.

Q 30, 40?

A The 20's. I don't know specifically.

Q You would not set it at 12, would you?

A As a doctor, I wouldn't set the respiratory rate of a Salicylate-poisoned patient at 12.

Q Okay. And that's really why he died, isn't it, because they set it at 12?

MR. GRAVES: Object to form.

A I disagree. I think all of the events from him taking the aspirin to all of the treatment that he got while he was in the hospital contributed to his death. Specifically, not getting the bicarb,

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to not being dialyzed properly. At some point, he had, you know, he passed the point of no return.

Q Well, you know, Doctor Clark was a doctor who refused to see the patient in the ambulance, I think, or emergency department when there were heart rhythm changes. Are you critical of him?

A Without knowing what his -- all of his reasons, I don't want to be critical of him. That being said, if I am at a hospital, and somebody says to me in the ambulance bay, I have an EKG I want to show you, I am worried about it, I would personally go look at it even if it wasn't my patient.

Q Okay. Do you recall what the Salicylate level was at Mercy Fort Smith?

A I don't recall. I know that towards the end, the level was in the 70's. I don't remember what it was at Mercy Fort Smith.

Q Do you recall it being 46?

A I don't remember seeing that.

Q Would you expect the level to be higher than it was at EOMC if it truly was a Salicylate death?

A You would -- I would expect it to usually be, but a level of 46 would not be inconsistent with what I have seen before.

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Q Why would you usually expect it to be higher than what it was at EOMC?
A I would expect it to be higher, a little bit higher, a little bit lower, about the same.
Q Okay.
A 46 is a little bit lower than I would expect, but it is still consistent with Salicylate poisoning.
Q But it surprises you, does it not, sir, it's only 46 at Mercy Fort Smith?
A It is less than I would expect, but there are explanations for it. If you are so sick that you are not profusing your gut anymore, your level might be lower. If their lab is calibrated differently or incorrectly, the level might be a little bit out of range.
Q Okay.
A But when I look at all of the levels before, you know, 50-something, 50-something, 60-something, 70-something, coupled with his Ph, and his physical examination, it all paints a picture of somebody with just worsening Salicylate poisoning. So, clearly, if the level at the last place comes back at 40-something, I don't look at that level and say, oh, he is better, you know. I still --

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Q An otherwise strong, healthy young person can, however, compensate for days with a Salicylate poisoning, can they not?
A No, I disagree that somebody can't breathe between 40 and 50 breathes a minute for -- like this, with this degree of Salicylate poisoning. So, not with this degree of Salicylate poisoning, no.
Q But his breathing at 40, 50, 30, whatever it was, it didn't go down because he couldn't breathe, it went down because he is put on a ventilator with a setting of 12, correct?
A A couple of things are happening over this period of time and it's -- I can't uncouple them all. They are all related. So, one, he is getting sedatives and respiratory depressants that slow your respiration. He is getting Benzodiazepines and morphine for -- because of what they are interpreting as agitation that they are trying to treat. So, that is going to slow your respiratory rate. Another thing that is happening, he has to be getting tired. You are breathing that fast. You can't do it forever. If you ever run a marathon or do sprints, you can't do that for hours and hours. He is getting tired. Then, at some point, they give him Diprivan or Propofol in order to intubate him,

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and that is going to slow your respiratory rate, but the reason that they are doing that is because they are looking at him, and he looks so bad from all of the breathing that he is doing.
Q Okay. But back to my question. Even with medications, his breathing didn't go down, and I know you are telling me, at some point, it would, but it really didn't go down until he got intubated, isn't that true, sir?
A The intubation was about the period of time that he is decompensating and falling apart, and I don't -- I can't figure out from reading the chart exactly what triggered their mind, we want to intubate him now, but I imagine it's because he just looks so bad. He is breathing so fast, he is confused, he is altered, and they say, wow, this guy looks so bad from his Salicylate poisoning that he looks like somebody we need to intubate.
Q Okay. Do you think it is possible that he would have lived if they had not intubated him?
A I think it's more likely than not at that point, he would have died no matter what.
Q But it's possible he would have lived had he not been intubated at that level of 12?
MR. GRAVES: Object to form.

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A A lot of things are possible, but I feel that that's unlikely and I think it's more likely than not he would have died at that point, regardless.
Q Can I --
A Sure.
Q I will tell you what, have I now heard, really, all of your criticisms of Doctor Holdman?
A All that I can think of. As I said, there is -- I described before a certain way that I think this should have been managed, and, you know, to stay with the emergency medicine standard of care, and to the extent he didn't do those things, I felt like he deviated.
Q Well, that's my whole point. Have you told me, at this point, everything you felt Doctor Holdman didn't do that was a departure from the standard of care?
A I think -- as I said before, the extent that he didn't recognize the significance of the Salicylate toxicity earlier, that he didn't promptly administer sodium bicarbonate, that he didn't recognize the Salicylate level that wasn't declining, and he didn't recognize the bad blood gas as a sign of significant poisoning, and he didn't

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recognize all of that as a sign that he needed to pursue dialysis, I think was -- I disagree with that management.

Q Okay. So, at this point, I have heard all of your criticisms of Doctor Holdman?

A Those are all of the ones that I can think of right now, yes.

Q And you have prepared for your deposition knowing that I would be here and lawyers would be here asking you questions, correct?

A Yes.

Q Okay. And in terms of your preparation and having had time to think during the deposition, is there any other criticism of Doctor Holdman that you intend to offer at the time of trial you have not told me about already?

A Nothing that I can think of right now.

MR. HURT: Okay. I will pass the witness.

EXAMINATION BY MR. CONNOR:

Q Doctor, we have met before the deposition started. I am Jim Connor. I represent Doctor Carter. In listening to you here this morning and some of the things that you have said, it seems to me important to you that you stay within your area or areas of expertise, is that a true statement?

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A Yes.

Q For example, you testified earlier that when asked about the nurses that you said, I am not a nurse, so I want to stay away from testimony regarding nursing standard of care, correct?

A Yes.

Q You were also asked about some opinions regarding the EMT's, and you said that is not what I do, either, and I want to stay away from that, correct?

A Yes.

Q You also made the statement that you wanted to stay with emergency medicine standard of care, do you recall that?

A Yes. I feel an emergency physician should be judged according to emergency medicine standard of care, and that there is a certain standard when you treat a poison patient -- there is a standard of care for treating a Salicylate-poisoned patient that a physician should stay with.

Q Do you know that there is an expert -- do you know Doctor Gerard?

A No.

Q Do you know who he is?

A I don't believe I have met him.

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Q Do you know that he has been listed to offer standard-of-care opinions regarding the care of Doctor Carter in this case?

A No.

Q Do you know what kind of doctor, what specialty Doctor Carter is?

A Doctor Carter, I forget exactly what he -- he practiced as an internal medicine doctor.

Q Okay. Would it refresh your memory if I told you that he was a family practice doctor?

A Yeah.

Q Okay. And you are not a family practice doctor?

A No.

Q You are fellowship trained as a specialist in emergency medicine, correct?

A That's correct.

Q And you are additionally fellowship trained in the subspecialty of toxicology in your field, correct?

A Yes.

Q Is it true that you do not intend to offer family practice standard-of-care opinions or criticisms regarding Doctor Carter in this case?

A I would only offer criticisms about the

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standard of care for treating Salicylate poisoning.

Q Okay. Doctor Carter is a family practice physician, correct? We just --

A Yes.

Q All right. And, so, any criticisms that you would offer against him would be criticisms of a family practice physician, correct?

A There is a certain standard that a physician who is treating a patient with Salicylate poisoning needs to stay with. Whether you are internal medicine, or family medicine, or ICU, or emergency medicine. So, I would have criticisms of him for not staying with that standard.

Q Are you trained in family practice?

A No.

Q Okay. You didn't do a residency in that. You have never practiced as a family practitioner, have you?

A No.

Q Okay. So, are you telling the ladies and gentlemen of the jury, Doctor Stolbach, that you intend to offer, as an emergency physician with a subspecialty in toxicology, that if allowed to do so by the judge, you intend to offer standard-of-care criticisms of Doctor Carter?

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A As an expert in toxicology, who provides consultation, as does family doctors, internal medicine doctors, and ICU doctors, and emergency medicine doctors who take care of poisoned patients, I feel that I could offer a valid opinion on whether or not he met the standard of care for treating a poisoned patient.

Q Who are you boarded by?

A The American Board of Emergency Medicine sponsors the Emergency Medicine Board and the Toxicology Sub-board and that is co-sponsored with the -- the Toxicology Sub-board is co-sponsored with the -- I think it is the American Board of Occupational Medicine.

Q Okay. And are you a member of -- is it the American College of Emergency Physicians?

A Yes.

Q Okay. And are you a member of that?

A Yes, I am.

Q And are you a fellow of that?

A Yes.

Q All right. And does the American College of Emergency Physicians have any ethical rules or guidelines regarding your participation in medical malpractice cases as an expert witness?

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A I know that they do. I don't know them off the top of my head.

Q Do you think if they do that there are any that would have any application to the case that we are here on today?

A I don't know.

Q Do you think that confining your expert opinions to your area of specialty would be one of those?

A As I said before, I am confining my opinions to my areas of expertise, which are emergency medicine and medical toxicology.

Q Okay. Well, you said that earlier you weren't comfortable in offering opinions regarding the EMT care because you are not an EMT. Did the EMS or EMT service have a medical director?

A I presume they did.

Q Okay. You don't remember that?

A I don't remember -- I don't remember that.

Q Do you know whether that medical director who -- you would presume that person would be a doctor?

A Usually, yes.

Q Okay. Do you know whether they consulted with a doctor on the decision to intubate the patient?

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A I don't remember that.

Q Would you have told them to intubate the patient when they did? I mean not intubate. Excuse me. I misspoke. The decision to ventilate, to put the patient on the ventilator?

A If they had asked me how to ventilate the patient, I would have told them to try to ventilate the patient quickly, set the ventilator at a high rate.

Q What if they had asked you, Doctor, should we just prophylactically put this person on the ventilator for transport to Fort Smith, what would you have said?

A You know, again, I am not a medical director for EMS and I don't know -- I didn't train them. I don't know what they are comfortable doing. I don't want to ask them to do something that I think that -- to use lay terms -- I think they are going to mess up. So, I just would have to know more about their training and I think the medical director would be in a position to know specifically what they can do.

Q Was the patient put on a ventilator because he needed it at that point in time or essentially prophylactically for the transport?

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A I don't remember what their thought process was.

Q Does that matter in this case, in your mind?

A Ultimately, it's important that you -- ultimately, it's important that you do the right thing, but I don't know -- I would be curious to know why they did what they did.

Q If the medical director for the EMT's advised them to prophylactically put this patient on the ventilator for transport and set the ventilator at 12 reps per minute, would you be critical of that?

A If I am working in an emergency department, if I am working in an ICU, I would be critical of that decision. I don't know if there is something that specifically has to do with the transport or something that has to do with the capabilities of those medics that the medical director thinks that that's the best way to do it. Again, in the hospital setting, I would be critical of that rate. I don't know why the medical director chose that rate for transport.

Q Well, you think that that ventilator

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setting was contraindicated in this case?
A I think that if that was in the hospital or an ICU, that that rate would be too slow.
Q Okay. And you know that Doctor Carter was not called about that by anyone, right?
A I believe you if you say that.
Q Okay. And you know that Doctor Carter ordered that the patient be intubated as opposed to ventilated for the transport, correct?
A Again, I don't remember that parsing, but I believe you.
Q Well, I mean, that's a significant difference. I am not just parsing words. Is it not?
A Well, only that whenever we intubate people, we almost always mechanically ventilate them. So, when I say to my residents, we need to intubate this guy, they automatically call for the ventilator. Those two things go together.
Q But you don't know how it is in Poteau at the Eastern Oklahoma Medical Center, correct?
A Well, patients in Poteau, without being glib, they need to breathe, also. So, you give -- I imagine a doctor, when they say intubate, they mean intubate and ventilate, because you can't just

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intubate them and not let them breathe.
Q You imagine that? I mean, are you telling the ladies and gentlemen of the jury that in Poteau, with this EMS that you say you are not qualified to offer any opinions about, that when Doctor Carter tells -- gives an order to intubate the patient, that he is telling them to mechanically ventilate the patient, to put them on the ventilator, is that what you are saying?
A I want to be clear. In any qualified doctor, whether they are in Poteau, or Baltimore, or anywhere, when they say, I want to intubate a patient, and they are giving them a sedative in order to accomplish that intubation, they are almost always implying -- essentially always implying that I also need to mechanically ventilate this patient.
Q Okay. How often -- how often, since you said they are always implying that, tell me how often patients that are prophylactically intubated, but not put on a ventilator for transport from Poteau to Fort Smith, how often does that happen? I take it you would think it virtually never happens based on your testimony, right?
A I don't know.
Q Well, would you be surprised if that

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happens regularly?
A If you are going to intubate somebody and not mechanically ventilate them, then, you need somebody to be bagging.
Q I am talking about putting them on a ventilator with a preset respiration rate.
A I don't know how often they choose a preset respirator rate to mechanically ventilate somebody with a transport.
Q Tell us if you intend to offer standard-of-care criticisms of Doctor Carter at trial, what those are?
A So, I -- again, I feel that when Doctor Carter assumed care of the patient, he should have recognized the abnormal vital signs, he should have recognized that the labs were signs of significant Salicylate poisoning, coupled with the vital signs, he should have recognized that the patient wasn't getting better, and was, in fact, getting worse, and that the continued respiratory rate, and the change in mental status and respiration were all signs of that, and he should have had the patient on bicarb from the first minute, and he should have pursued dialysis, transferring him to a place where the patient could get dialysis.

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Q But he did that, right?
A And I feel that -- much more promptly.
Q Well, from the time he saw the patient until the time he started trying to transfer the patient, how long was that?
A The time he assumed care of the patient in the middle of the night, after midnight. I don't know when he first saw the patient. I think it was later in the morning, around 6:00 or 7:00, and the patient was transferred within several hours from that.
Q Well, can you be any more specific in response to my question? Do you remember what my question was?
A Can you repeat your question?
Q Yes. My question was: How much time elapsed from the time he saw the patient until he started putting a transfer into motion?
A I would have to look at the chart to get the exact number. So, he assumes care, you know, around 1:00 or 1:15 in the morning, when the patient goes to the ICU, and he -- his H&P is written at 7:09 and it has an exam. So, I imagine sometime an hour, half hour before that, he performs the exam at 6:30. Although at 9:10, it says, "Doctor Carter

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stated he was still in the hospital at Mountain Gateway." I am not clear whether he had left and come back or whether he just hadn't gotten there yet. But, at 9:48, the case manager has called regarding orders from Doctor Carter for the patient to be transferred.

Q What was Doctor Carter told when he was called about this patient the first time?

A I don't know the details of the conversation between Doctors Holdman and Carter.

Q Did those details matter to your opinion?

A It matters for both of them. It's the responsibility of both of them to have a good conversation where all of the relevant information about the patient is conveyed.

Q Okay. Is there any aspect of this family practitioner's care that you don't intend to criticize in this case as an emergency physician?

A Well --

Q Is there any part of his care as a family practitioner that you are uncomfortable criticizing as an emergency room doctor?

MR. GRAVES: Object to the form.

A I am -- to the extent that his care deviated from the correct way, the standard of care

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for treating Salicylate poisoning, I disagree with it.

Q Okay. Well, you keep saying that. The only standard of care, at least -- I don't know how it is in Maryland, but, in Oklahoma, it is what a similarly-trained physician would do in the same or similar circumstances. So, his standard of care is that of a family practitioner. All right? Just assume that hypothetically for me. And not what you think the standard of care is for treating Salicylate poisoning. If that's true, are you still comfortable offering standard-of-care criticisms of him?

MR. GRAVES: Object to form.

A I don't entirely agree with your statement. I feel that internal medicine and family practice doctors, intensive care doctors, and emergency medicine doctors all can take care of Salicylate-poisoned patients, but if a doctor hears about a Salicylate-poisoned patient, and that doctor says, I don't know anything about this, this isn't part of my practice, then, they shouldn't accept the admission. They shouldn't take over care of that patient.

Q I don't know what you are telling me

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there. Are you now telling me that you have an opinion he should have declined to take this patient?

A My opinion is that it's within the standard of practice of a family doctor, an intensive care doctor, an emergency medicine doctor to take care of a Salicylate-poisoned patient, but if a patient -- if a doctor of any type is assuming care of a patient for a disease that he doesn't think he is qualified to take care of, that should come out right at that moment if the doctor thinks he or she is not qualified to take care of a certain kind of presentation or if he thinks it is not within his practice to take care of that, that should come out right at that moment.

Q I don't know why you are telling me that. Are you -- do you believe that Doctor Carter made some comment that he wasn't qualified to take care of the patient?

A I don't recall reading anything like that.

Q Are you critical of Doctor Carter's education, training, or experience as a family practice doctor?

A I am not critical of Doctor Carter's education.

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Q Okay. Well -- and you wouldn't even be in a position to really evaluate that, would you, since you are not a family practice physician?

A I am not a family practice physician, but I feel there is a standard of care for treating Salicylate-poisoned patients that physicians need to stay with.

Q What was the mechanism of his death?

A So, he died from Salicylate poisoning. Mr. Simmons died from Salicylate poisoning. The mechanism of dying of Salicylate poisoning is that Salicylate is a metabolic poison. So, it is poisoning your mitochondria, poisoning your ability to use energy, you are not able to get ATP out of your energy, out of metabolisms. It is like having your foot on the gas pedal while the car is in neutral. You just end up generating a lot of heat without generating a lot of energy. In neurons, so, nerve cells, they become poisoned, and neurons and nerve cells are unable to do what they are supposed to do. So, patients become delirious, and agitated, and confused, patients get progressively worsening acidosis, as the Ph drops, cells are unable to carry on normal functions, and metabolism is further compromised.

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And, in his case, at a certain point, he is unable to maintain compensation by breathing fast enough. He tires out. The Salicylate more and more converts to a form that's taken up by cells, and nerve cells, and you have more cells dying, and being poisoned, and more metabolic derangement. Finally, he is unable to -- the cells don't have enough energy, and you see him with -- unfortunately, he has cardiovascular collapse and death.

Q Did I hear you testify earlier that you felt that his life was not salvageable by 6:00, 7:00, 8:00, or 9:00 o'clock in the morning?

A I said that, yes.

Q And that's the best you can do?

A Unfortunately, I can't be -- there is no precise point where I can look and say, this is the point where he would have lived or died. Sometimes patients surprise you, and they look really sick, and they do better than you expect. Sometimes patients that you think are going to do fine fall apart, but from my experience in treating a lot of Salicylate-poisoned patients, you know, when I take the presentation from when they first come in, everybody I have seen like that lives. And when I

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look at the presentation of when he -- right about the time that he was intubated, everyone I see like that dies. I think there was one patient that experienced a brain death, but had a horrible outcome. So -- but I don't know exactly where that point passes where he would have lived. I don't think it is knowable.

Q You agree that the nurses throughout the night never once called Doctor Carter with any report or any lab results on the patient, correct?

A I don't remember reading any of that.

Q You haven't seen any evidence that they ever called him?

A I don't see evidence of that.

Q Yet, you have said that there were concerning lab values during that time period. You testified to that earlier?

A Yes.

Q Yet, you refused to be critical of the nurses because you are not a nurse, correct? Isn't that what you said?

A I refuse -- I don't like to use the term, "refuse." I don't want to critique everything they do about whether or not they met the nursing standard of care.

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Q Do you intend -- again, if allowed -- and I will preface all of these questions about your opinions about a different standard of care than your own with this statement that, if allowed by the court to do so -- but do you intend to offer an opinion that Doctor Carter should have come into the hospital when he was first called?

A It's my opinion that if he had had -- if the conversation between Doctors Holdman and Carter had been -- had conveyed all of the necessary information, then, Doctor Carter probably -- I would expect him to be more involved.

Q Let me go back to my question. I will try to ask a better question of you, more precise. Based upon the knowledge that you have as you sit here today, do you have an opinion as to whether or not Doctor Carter should have come in when first called?

A It's my opinion that from when he assumed care of the patient, he should have been more involved in the care, and I don't necessarily think that he, from the first moment needed to be done, he needed to come in necessarily, but if he is going to assume care of the patient, he should know the, you know, relevant details, and he should be abreast of

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these lab values, and I would, to the extent that that communication doesn't occur, I blame the two doctors that are supposed to be having that conversation.

Q Well, I mean, I was trying to you give you lots of chance here, but I was trying to give you a chance with that question to tell me what you knew and didn't know, but let me try again. Are you telling me that you have an opinion as to whether or not Doctor Carter should have come in when you don't have any idea what the discussion was between Doctor Holdman and Doctor Carter?

MR. GRAVES: Object to the form.

A It's my opinion that if their discussion had had the relevant details about the patient, about Mr. Simmons, that their discussion had had those relevant details, that Doctor Carter would have been more involved. That involvement could have been from calling in more frequently to find out about the labs, it could have been him coming in to see the patient.

Q So, just to be clear, you don't know what occurred in that discussion, correct?

A I don't know exactly what was said during that discussion.

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Q Do you know anything that was discussed in that discussion?
A I know that they talked about Mr. Simmons, and they talked about admitting him for Salicylate poisoning, but I don't know the details.
Q And you wouldn't tell this jury that a physician has to come in in the middle of the night for every single person that takes too many aspirin, would you?
A I wouldn't tell the jury that a physician has to come in in the middle of the night for every single patient, but I would say before a jury that if a patient is assuming care of a sick patient, he needs to be involved in the care.
Q Okay. Well, assuming care of a sick patient. Let's go back to my question. Do you remember what that was?
A Can you ask it again, please?
Q My question was: Are you telling the ladies and gentlemen of the jury that a physician has to come in in the middle of the night for every patient that ingests too much aspirin?
A If a physician has a sick patient, for whatever the reason, and he is assuming care, he is the doctor of record, his name is on the chart, he

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or she should be involved in the care. Now, if that patient is sick from taking too much aspirin, then, he should be involved in the care. There are times when he can do that from home.
Q Do you -- are you involved in a lot of care from home as an emergency physician?
A As a toxicologist, yes, but not as an emergency physician, no.
Q Do you have -- do you see patients in the office?
A I don't have an office practice, no.
Q If allowed to do so, any other criticisms that you have of my family practice client, Doctor Carter?
A Just from what I remember, just what I have talked about.
Q Any other specialties of physicians besides ER doctors, and, now, family practice doctors that you have criticized their standard of care under oath before today?
A No. I feel qualified to give an opinion for emergency medicine and for standard of care for doctors taking care of poisoned patients.
Q Back to my question: You have offered standard-of-care opinions about emergency room

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physicians before, correct?
A Yes.
Q And you have done that today, correct, with Doctor Holdman?
A Yes.
Q Right. You have also today offered standard-of-care criticisms regarding a family practice doctor, correct?
A Regarding the care of a family practice doctor for a Salicylate-poisoned patient, yes.
Q Which is, in fact, the care of a family practice doctor, correct?
A Yes.
Q All right. Other than those two specialties, what other specialties of physician have you made standard-of-care criticisms of under oath before today?
A Sure. I have given opinions under oath about emergency physicians, and I gave an opinion under oath about a prescription from a primary-care physician that one side believed that the prescription poisoned him, and I disagreed the prescription poisoned him. So, again, it was an opinion on a toxicology case.
Q Right. That's a causation opinion on

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toxicology, correct?
MR. GRAVES: Object to form.
A It's sound like a legal term, but, yeah, they were asking me whether I thought that this drug had caused the patient's death. It was well within my expertise as a toxicologist to give an opinion.
Q Were you asked in that case and did you offer an opinion whether that primary-care physician departed from the standard of care in prescribing that drug?
A No.
Q Okay. Would you have offered that opinion if asked?
A In that case, I wouldn't have offered an opinion on whether he was within -- whether he should have prescribed the drug.
Q Do you not see the distinction that I am making here between offering standard-of-care opinions regarding emergency room physicians, offering causation opinions about the toxicological effects of anything that's within your expertise, and, then, taking the next step of offering standard-of-care opinions about a specialty other than your own? You don't see that at all?
A In this case, I feel very qualified to

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offer a standard-of-care opinion because, as a toxicologist, I take call at the Poison Center, and I will get calls from family doctors, and internal medicine doctors, and ICU doctors taking care of poisoned patients, and, so, I know what they are supposed to do. I know what the standard of care is, how they are supposed to take care of these patients, and I know you what they are supposed to know about poisoning, and I know the things I am supposed to be able to help.

Q Okay. And, so, you learned that from taking Poison Control calls?

A Yeah. It is part of my toxicology training, we take call for the Poison Center, and we would do bedside consults. So, a doctor would ask us to come to the bedside, and help them, and we would do that. I currently take call from the Maryland Poison Center and I also informally do consults at Hopkins.

Q Okay. So, I just want to get a listing of the reasons why you would tell this judge that you are an expert in the standard of care of a family practice doctor in this case and one is, you take Poison Control Center calls and have in the past, right?

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A Yes.

Q No. 2 would be what?

A So, the reasons why I am an expert to talk about the standard of care for, in this case, a family medicine doctor taking care of an aspirin or a Salicylate-poisoned patient are because I take call for the Poison Center, and we are routinely giving advice to family doctors, and other doctors about how to care for a poisoned patient.

Q So, you learn about their knowledge, and their practice, and their standard of care by giving them advice, right? You talk to them?

A I listen to them, I talk to them, and I know what they are supposed to be doing, and I try to help them do their job.

Q What is No. 2 on the list?

A So, I have experience doing bedside consults, as well, in toxicology.

Q What does that mean?

A It means when you go see a patient at the bedside, a poisoned patient, a toxicology patient.

Q Okay. But you, as a toxicologist -- are you a toxicologist?

A Yes.

Q Okay. You, as a toxicologist going to the

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bedside to see a patient for a toxicology consult, how does that better educate you on what the standard of care is for a family practice doctor?

A Because I know how they should be managing this case of Salicylate poisoning.

Q Okay. Is there a No. 3 as far as your reasons why you would tell the judge in this case that he or she should allow you to offer standard-of-care opinions regarding a family practice doctor?

MR. GRAVES: I am going to object to the form. Jim, at this point, we are really --

MR. CONNOR: Just object to the form, Dan.

MR. GRAVES: It is argumentative. It goes on and on.

MR. CONNOR: Well, it's --

MR. GRAVES: The case law that you are -- you cited a law, Jim.

MR. CONNOR: Object -- Dan, Dan, Dan, Dan.

MR. GRAVES: It doesn't have to be the same discipline. You know the law. You are just arguing with the guy.

MR. CONNOR: Well, I am irritated. Okay?

MR. GRAVES: Well, good. Me, too. I am.

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sitting here listening to it. I am irritated.

MR. CONNOR: It's irritating and I didn't expect it from this doctor, but it is what it is. Go ahead. I don't mean to cut you off, because you know I respect you, but --

MR. GRAVES: I respect you, too. You go right ahead.

MR. CONNOR: Object to form and we will move on.

MR. GRAVES: All right.

Q Is there a No. 3 on the list of reasons you would tell our judge as to why you should be allowed to offer standard-of-care criticisms of my family practice doctor in this case?

MR. GRAVES: Object to the form.

A I feel that there is a standard of card for taking care of aspirin-poisoned patients and that --

Q I am sorry.

A -- that doctor needs to meet that standard of care.

Q Okay. Maybe I wasn't clear on the question and the list that we were making. You have told me that several times about why you feel that you can. My question is: What specific education,

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training, or experience have you had that makes you familiar enough with the standard of care for a family practice doctor to offer standard-of-care criticisms? No. 1 on that, you said taking Poison Center calls and talking to primary-care physicians as a part of that. No. 2, you said bedside consults on toxicology issues with patients. Is there a No. 3 as far as your education, training, or experience that gives you expertise in the family practice standard of care?

MR. GRAVES: Object to form. Asked and answered.

A You know, my education and training in toxicology has given me the experience to be familiar with taking care of poisoned patients and knowing what the standard of care is for taking care of poisoned patients.

Q Is Doctor Carter a toxicologist?

A No.

Q Is he an emergency room doctor?

A No.

Q And just to close this down, is there a No. 3 or have you told me all of the foundation for your expertise in family practice that you would intend to tell me?

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MR. GRAVES: Object to the form.

A I have given you -- to use a legal term -- my foundation for expertise on poisoned patients.

Q You have told me all of the opinions, if allowed to do so, you would anticipate offering regarding Doctor Carter?

A Yes.

Q I would like you to list out for me -- and feel free to combine them if it is easier or individualize them if you want -- I would like you to list out for me the good care provided by Doctor Holdman and/or Doctor Carter in this case?

MR. GRAVES: Object to the form.

A That's challenging for me because there is -- as I mentioned before, there are a lot of deficiencies in their care where I feel like they didn't meet the standard of care, but, eventually, bicarbonate was started. I thought it was too late. I thought it was bad it was started too late, but starting it was better than nothing. Charcoal was given. Eventually, plans were made to transfer the patient to dialysis. I think it was done way too late. I think that was, at least, a sign that they had recognized, at some point, that it was a really sick patient. I recognized that especially Doctor

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Holdman seemed to be very much involved in the care. He went to the room on a number of occasions. It seemed to be when nurses were asking for help, he would try to give help, even though his energies could have been directed to doing other things for the patient. It was a positive thing that he remained involved in the case.

Q Anything else?

A That's all that comes me right now.

Q When you testified earlier when Mr. Hurt was asking questions, I think when you review the transcript, you will find this to be an exact quote. When you said that you wanted to stay with the emergency medicine standard of care, what did you mean by that?

A I would have to look at the specific context of when I said that. Maybe we were just talking about -- I don't know. I would have to look again at what the context was and how the question was asked.

Q Would the emergency medicine standard of care be applicable to Doctor Carter, in your opinion?

A No.

Q Would the tox -- would the standard of

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care of a toxicologist, like yourself, be applicable to Doctor Carter?

A I don't expect him to know as much as a toxicologist would know. He should meet the standard of care for treating a poisoned patient.

Q Would you be held to a higher standard than Doctor Carter in treating a poisoned patient? Should you be?

A I should be held to the standard of a toxicologist when treating a patient.

Q Which is a higher standard of care than that of a family practice doctor in this context?

MR. GRAVES: Object to form.

A I should be expected to know more things, be able to do more without asking for help for a poisoned patient.

MR. CONNOR: I have no further questions.

MR. HURT: I have a few follow-up.

EXAMINATION BY MR. HURT:

Q What kind of doctor is Doctor Holdman?

A He works in an emergency department. I don't remember his specific residency and board certification in his deposition.

Q He is not residency trained in emergency medicine, is he?

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A I don't remember from his deposition what his training is, but if you are telling me that, I agree with you.

Q So, all of the questions about -- let's assume he is a family practitioner, like Doctor Carter is, if I ask you all of the questions about Doctor Holdman, your answers would be the same about Doctor Carter, wouldn't you?

A If you are working in an emergency department, you should be able to meet the standard of care for an emergency physician.

Q Even if you are not residency trained, in your view?

A You should -- you shouldn't accept the position if you feel like you are going to be performing duties that are outside of your training.

Q Do you know how many small rural hospitals in Oklahoma that do not have or cannot get a physician to work in their emergency department?

A No.

Q If I were to tell you it's prevalent in smaller counties with tort claims hospitals, public trust hospitals, would you have any reason to disagree with me?

MR. GRAVES: Object to form.

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A I would believe you if you told me.

Q Okay. And, at least in terms of Doctor Holdman's training as a family practice physician, you would agree with me he did the best he could do with his training, correct?

MR. GRAVES: Object to form.

A I don't know -- I can't comment whether he did his best. He seemed to be very involved in the care.

Q And he certainly did what he thought was best, we can agree with that, can we not?

MR. GRAVES: Object to the form.

A I don't have any reason to think that he didn't do what he thought was best.

Q Okay. Now, we know that Doctor Holdman tried to get Doctor Schumpert to come in and Doctor Schumpert wouldn't come in for whatever reason. I asked you earlier about criticisms of Doctor Holdman and you did not mention anything about the conversation with Doctor Carter, correct, when I asked you about the criticisms?

A I believe you are right. I believe I didn't mention that criticism.

Q Okay. Having had difficulty to find a doctor, having found a doctor who was willing to come in, like, Doctor Carter was willing to assume care, I should say, do you have any reason Doctor Holdman wouldn't tell him about the vitals, and lab tests, and things like that?

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A I don't know what the contents of that conversation were. I always tell my residents, you know, communication, it's a two-way street. Both of them are responsible for getting that key information across. So, I don't know what the information -- I don't know what information was conveyed in that conversation, but if all of the information that was important didn't go from Doctor Simmons to -- not Doctor Simmons. I am sorry -- it didn't go to Doctor Carter, then, about Mr. Simmons, from Doctor Holdman, then, it's on both of them.

Q Okay. So, basically, from 1:00 o'clock on, you put everything that happens downstream on both of these doc's?

A I feel that from the moment that Doctor Carter assumes care of the patient, he has some responsibility. Because Doctor Holdman is the doctor that's there, he is the boots on the ground, he is also responsible for the patient, as well.

Q How high do you think the Salicylate level went in Mr. Simmons?

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MR. GRAVES: Object to form.

A I don't know. There was a level in the low 70's, 75. So, mid 70's.

Q Okay. Then, there is a level of 46 a few hours later, in Mercy. Do you have an opinion how high it went?

A I don't have an opinion about how high.

Q Okay. Have I heard every criticism you of Doctor Holdman, and, I guess, Doctor Carter, too, have we reached that point, so that the attorneys for Doctor Holdman and Doctor Carter are not surprised at anything you say at trial?

A Everything I can think of right now.

MR. HURT: Okay.

MR. GRAVES: I just have a couple of questions.

EXAMINATION BY MR. GRAVES:

Q Doctor, would you expect a Doctor transferring a patient with Salicylate poisoning to -- if there is going to be any chance of mechanical ventilation, to convey the proper settings for the transport ventilator to the EMT's?

MR. CONNOR: Object to the form.

A I would hope so. Yeah, that would be an expectation.

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Q It would be below the standard of care if there needed to be a special ventilator setting to not convey that to the EMT's before they transport after you have ordered intubation?

MR. CONNOR: Object to form.

A There is -- if it is important to ventilate the patient at a certain rate, then, you should order that.

Q To a reasonable degree of medical certainty, would Stephen Simmons have survived if his care had been managed properly, as you have testified today?

MR. CONNOR: Object to the form.

MR. HURT: Object to the form.

A Yes.

EXAMINATION BY MR. CONNOR:

Q Doctor, any reason to think that Doctor Carter was not trying to do his best to help this patient?

A I don't have any reason to believe that.

MR. CONNOR: I have nothing further.

MR. HURT: What I would like to do, Dan, is I would like to mark this, here, and his chronology, and get it in color, because he has yellow highlighting, and I would also like to mark as

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--why don't I just start marking.

(Stolbach Exhibits 1 through 3 marked for purposes of identification.)

EXAMINATION BY MR. HURT:

Q Doctor Stolbach, what is marked as two pages for Exhibit 1, can you tell us what that is?

A Yes, that's a deposition outline. It's titled, "Deposition Outline Carter, M.D." and it's a Summary of Lab Values for Mr. Simmons.

Q And, Exhibit 2, what is that?

A Exhibit 2 --

Q It is a multi-page document.

A Exhibit 2 is a multi-paged document that summarizes the medical care that Mr. Simmons received at Eastern Oklahoma Medical Center and at Mercy Hospital.

Q And that was prepared by Mr. Simmons' attorneys, who sent it to you?

A Yes, and I also read the record, and I didn't see any discrepancies.

Q Thank you. And, Exhibit 3 is the Audio Transcription of the Poison Control Center call speaking with Doctor Holdman, again, arranged to be transcribed, and sent to you by Miss Simmons -- Mr. Simmons' attorneys, correct?

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A Yeah. I believe I saw the transcript already.

MR. HURT: Okay. That's all I have.

MR. GRAVES: Are you going to get those copied?

MR. HURT: He can get these back, but I would like to mark these so they are attached to the deposition.

MR. GRAVES: Sure. He will read and sign.

(Deposition concluded at 12:02 p.m.)

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CERTIFICATE OF DEPONENT

I hereby certify that I have read and examined the foregoing transcript, and the same is a true and accurate record of the testimony given by me.

Any additions or corrections that I feel are necessary will be made on the Errata Sheet.

_____

Andrew Stolbach, M.D.

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State of Maryland:
County of Baltimore, to wit:

I, Susan Kambouris, a Notary Public of the State of Maryland, County of Baltimore, do hereby certify that the within-named witness personally appeared before me at the time and place herein set out, and was examined by counsel.

I further certify that the examination was recorded stenographically by me and this transcript is a true record of the proceedings.

I further certify that I am not of counsel to any of the parties, nor in any way interested in the outcome of this action.

As witness my hand this 24th of February, 2015.

_____

SUSAN A. KAMBOURIS
Notary Public

My Commission Expires:
May 17, 2017

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ERRATA SHEET
JOB FILE NO. 98716

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