

IN THE COURT OF APPEALS OF THE STATE OF NEVADA

ANGELA DeCHAMBEAU, and)
JEAN-PAUL DeCHAMBEAU)
BOTH INDIVIDUALLY AND AS)
SPECIAL ADMINISTRATORS)
OF THE ESTATE OF NEIL)
DeCHAMBEAU)

Case No. 72879

Appellant,)

vs.)

STEPHEN C. BALKENBUSH, ESQ.,)
AND THORNDAL, ARMSTRONG,)
DELK, BALKENBUSH and)
EISINGER, A NEVADA)
PROFESSIONAL CORPORATION,)

Respondent.)

FILED

OCT 09 2018

ELIZABETH A. BROWN
CLERK OF SUPREME COURT
BY *E. Richards*
DEPUTY CLERK

DeCHAMBEAU NRAP RULE 40(c)
PETITION FOR REHEARING WITHIN APPELLATE COURT

A. FACTUAL AND PROCEDURAL SUMMARY

This case stems from a legal malpractice case filed by Petitioners on March 12, 2012. Respondents answered on March 28, 2012. The parties filed a joint case conference report and agreed the final date for expert disclosures would be June 17, 2013. The District Court issued a Pretrial Order on April 30, 2012. Regarding discovery, the Order stated, "continuance of trial does not extend the deadline for

completing discovery."
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Thereafter, the District Court granted Respondents' motion for summary judgment. Petitioners appealed. The Supreme Court reversed and remanded. The case returned to District Court for trial, and discovery remained closed. As the District Court's April 30, 2012 Pretrial Order stated, "continuance of a trial does not extend the deadline for completing discovery." Nonetheless, *sua sponte*, the District Court entered a Scheduling Order extending the deadline for initial expert disclosures to September 3, 2016. Dissenting, Judge Silver described this *sua sponte* order as "inexplicable." *DeChambeau*, 134 Nev. Adv. Op. at *12-13 (C.J. Silver, dissenting).

The unrequested 39-month extension of the stipulated deadline for expert disclosures was a windfall for Respondents. Respondents used this opportunity to disclose a new expert. Petitioners objected with a motion to strike the disclosure and a motion in limine to exclude the expert's testimony. The District Court denied both motions.

B. This Court Overlooked or Misapprehended a Material Fact in the Record

1. Petitioners Properly Objected to Respondent's New Expert

The opening paragraph of this Court's opinion states that neither party objected to the District Court's *sua sponte* scheduling order. Judge Silver, dissenting, also writes that Petitioners acquiesced to the District Court's 2016 scheduling order without objection. In fact, Petitioners twice objected to the newly

named expert. Petitioners moved to strike the new expert and filed a Motion in Limine to exclude his testimony from trial.

Similarly, the majority and dissent each take issue with Petitioners' perceived failure to object to the new scheduling order or preserve the issue. The district court's *sua sponte* order, unto itself, present an objectionable issue to Petitioners. There is no procedural avenue available to Petitioners to object to the unauthorized order simply for the sake of it. Instead, the new order must first present some deleterious effect before Petitioners had grounds for objection. Such an issue manifested when Respondents used their unrequested, thirty-nine (39) month discovery extension to announce a new expert. After this late disclosure, Petitioners twice moved to preclude the new expert. With their Motions to Strike and in Limine, Petitioners used an appropriate procedural avenue to voice their objection to the new expert afforded by the new scheduling order.

Thus, the Petitioners properly voiced their objection and discontentment regarding the new order and new expert.

2. Missing Transcript Exhibited Hereto

Upon appeal, this Court considered whether NRCP 16.1 required the parties to exchange expert reports. The opinion held that the reports were waived by stipulation, and the stipulation endured the District Court's 2016 scheduling order. The opinion focused extensively on the report requirement but did not address the

key issue, whether the District Court's unprompted, *sua sponte*, thirty-nine (39) month extension to notice experts was an abuse of discretion. Regarding this key issue, the Appellate Court noted within footnote 2 that a necessary transcript was omitted from the record, that transcript is attached hereto as Exhibits 1 through 5).

D. This Court Overlooked, Misapplied or Failed to Consider a Procedural Rule Directly Controlling a Dispositive Issue in the Case

1. This Court did Not Address NRCPC 16.1(e)

This Court's opinion largely omits any discussion of the key issue within this appeal, whether the district court's *sua sponte*, 39-month discovery extension constitutes abuse of discretion. The legal authority for a pretrial scheduling order is found within the black letter of Rule of Civil Procedure 16.1(e). The Rule states, "(e) Pretrial Orders. After any conference held pursuant to this rule, an order shall be entered reciting any action taken. This order shall control the subsequent course of the action unless modified by a subsequent order. The order following a final pretrial conference shall be modified only to prevent manifest injustice."

This Court's opinion makes no mention of Rule 16.1(e). This Court overlooked the Rule or failed to consider whether it permits a second scheduling order after remand.

2. *This Court did Not Consider the Abuse of Discretion Standard*

This Court did not consider whether Rule 16.1(e) permits the second scheduling order. Relatedly, this Court did not consider whether the *sua sponte* 39-month discovery extension constitutes an abuse of discretion.

An abuse of discretion can occur when the district court disregards controlling law. MB Am., Inc. v. Alaska Pac. Leasing, 132 Nev. Adv. Op. 8, 367 P.3d 1286, 1292 (2016), Shores v. Glob. Experience Specialists, Inc., 134 Nev. Adv. Op. 61, 422 P.3d 1238 (2018) (same), *also see* Bergmann v. Boyce, 109 Nev. 670, 674, 856 P.2d 560, 563 (1993) (holding that a decision made “in clear disregard of the guiding legal principles [can be] an abuse of discretion”).

In this case, NRCP 16.1 is controlling law. Pursuant to the Rule, the parties held an early case conference (NRCP 16.1(b)(1)) and discussed the “the form and substance of the pretrial order” (NRCP 16.1(c)(9)). The parties submitted a joint case conference report. NRCP 16.1(b)(1). The District Court entered a pretrial order appropriately adopting the parties’ stipulated deadline. NRCP 16.1(e). The process is controlled neatly by black letter within NRCP 16.1

Sua sponte, the Court veered from this codified, controlling NRCP 16.1 process. Judge Silver, dissenting, describes this erratic procedure. “The district court granted summary judgment after discovery had closed, and upon remand from the Supreme Court, the district court inexplicably, *sua sponte*, entered a new

scheduling order extending the time for expert disclosures.” *DeChambeau*, 134 Nev. Adv. Op. at *12-13 (C.J. Silver, dissenting).

The district court’s inexplicable, *sua sponte* order disregards controlling law within NRCP 16.1(e). Also, problematically, the inexplicable order does not reference or expressly overrule the original, 2012 pretrial order. The District Court’s erratic, unauthorized order constitutes abuse of discretion because it constitutes an utter disregard for NRCP 16.1.

This Court omitted any consideration of the abuse of discretion standard. Accordingly, rehearing is warranted.

E. Conclusion

In summary, both misapprehended facts and overlooked, controlling law warrant rehearing. Petitioners properly objected to the new scheduling order as soon as a prejudicial issue, the new expert disclosure, developed. Likewise, this Court must consider whether NRCP 16.1(e) permits a second scheduling order after remand, and, if so, whether the District Court abused its discretion by allowing an unrequested, *sua sponte*, 39-month discovery extension.

This Court should adopt the rationale set forth by Judge Silver and the Mississippi Supreme Court and issue an opinion providing such guidance. This Court should further enter an order striking the district court’s 2016 scheduling order, reversing the its denial of Petitioner’s Motion to Strike, and remanding for

new trial. The unrequested, *sua sponte* 39-month extension of discovery deadlines cannot stand.

Affirmation: The undersigned hereby affirms, pursuant to NRS 239B.030, that this document does not contain the social security number of any person.

Dated this 9th day of October 2018.

Respectfully submitted,



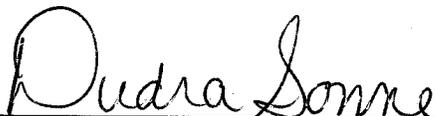
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 9th day of October 2018, I placed a true and correct copy of the foregoing **DeCHAMBEAU NRAP RULE 40(c) PETITION FOR REHEARING WITHIN APPELLATE COURT** in the United States Mail at Reno, Nevada, with first-class postage prepaid, addressed to the following:

Dominique Pollara, Esq.
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Reno, Nevada 89501



Employee of Kozak & Associates, LLC.
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EXHIBIT LIST

Exhibit No.	Document	No. Pages
1	Pretrial Conference Transcript	35
2	Trial Transcript- Day 1	46
3	Trial Transcript- Day 2	150
4	Trial Transcript- Day 3	82
5	Trial Transcript- Day 4	128

EXHIBIT 1

EXHIBIT 1

1 4185
2 STEPHANIE KOETTING
3 CCR #207
4 75 COURT STREET
5 RENO, NEVADA
6

7 IN THE SECOND JUDICIAL DISTRICT COURT
8 IN AND FOR THE COUNTY OF WASHOE
9 THE HONORABLE PATRICK FLANAGAN, DISTRICT JUDGE

10 --oOo--

11 ANGELA DECHAMBEAU, et)
12 al.,)
13 Plaintiffs,)
14 vs.)
15 STEPHEN C. BALKENBUSH, et)
16 al.,)
17 Defendants.)

Case No. CV12-00571

Department 7

18 TRANSCRIPT OF PROCEEDINGS

19 PRETRIAL CONFERENCE

20 January 10, 2017

21 2:00 p.m.

22 Reno, Nevada

23
24 Reported by: STEPHANIE KOETTING, CCR #207, RPR
Computer-Aided Transcription

1 APPEARANCES:

2 For the Plaintiff:

3 KOZAK LUSIANI LAW
4 By: CHARLES KOZAK, ESQ.
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6 Reno, Nevada

7 For the Defendant:

8 POLLARA LAW GROUP
9 By: DOMINIQUE POLLARA, ESQ.
3600 American River Dr.
10 Sacramento, California

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1 RENO, NEVADA, January 10, 2017, 2:00 p.m.

2
3 --oOo--

4 THE CLERK: Case number CV12-00571, Angela
5 Dechambeau versus Stephen C. Balkenbush, et al.. Matter set
6 for pretrial conference. Your Honor, we have Charles Kozak
7 and Craig Lusiani present in person and Dominique Pollara
8 present on the phone.

9 THE COURT: Ms. Pollara, can you hear us?

10 MS. POLLARA: I can hear you, your Honor. Good
11 afternoon and thank you for accommodating me in this
12 circumstance.

13 THE COURT: That's quite all right. We're all at
14 the vagaries of Mother Nature. We have a number of motions
15 in limine and I want to revisit this issue of the motion to
16 strike Dr. Calkins. I understand there's a request to have
17 one of the witnesses testify by videotape -- excuse me -- by
18 video conferencing. So, Mr. Kozak, I'll start with
19 plaintiff's counsel.

20 MR. KOZAK: Do you wish us to stand up?

21 THE COURT: Go ahead.

22 MR. KOZAK: This is a very key witness in this
23 case and we feel that it's critical that he be present to
24 testify. It doesn't seem to us that the reason that he gives

1 is substantial enough to avoid having him come out here and
2 be on that witness stand. He's not only going to be
3 testifying as to the medical issues, but also as to the legal
4 malpractice issues. So he's in both cases, so to speak. I
5 don't know how we're going to handle if this is supposed to
6 be a bifurcated trial.

7 In any event, there's lot of medical records to go
8 over with him. It would be a real imposition on us to have
9 to do this by videotape. So we're opposed to that.

10 THE COURT: Ms. Pollara, let me hear from you.

11 MS. POLLARA: Your Honor, obviously, these things
12 do happen sometime. When I was informed about this yesterday
13 morning from Dr. Morady, he told me that his wife had been
14 ill and that the surgery had been scheduled that morning, so
15 yesterday morning.

16 I had previously made arrangements for him to
17 testify on the dates, for him to testify back in September,
18 so this was obviously not something that I was happy to hear
19 about. But illness in a family member is something that
20 can't be avoided sometimes. And, unfortunately, he is
21 out-of-state and I don't have the ability to compel him to
22 appear.

23 In this situation, I do not want to lose the trial
24 date. I've spoken to Mr. Balkenbush at length about this and

1 we have been waiting quite sometime for it. We do have his
2 deposition testimony that Mr. Kozak took by written
3 questions. And so at this point, given the situation, what I
4 would do would be to proceed forward with the case. And
5 after giving it a lot of consideration, I think the best
6 thing to do is for us to go forward.

7 I have Dr. Smith scheduled to testify on Thursday
8 morning. Dr. Calkins is flying in from out of the country,
9 actually, to testify Friday morning. I was going to
10 originally put both him and Dr. Morady on that morning. But
11 at this point, I think I don't have an option except to
12 proceed with Dr. Smith and Dr. Calkins.

13 THE COURT: When would you expect Dr. Morady to
14 testify in your case, or is it Mr. Kozak's witness?

15 MR. KOZAK: No, your Honor. He's the defense
16 witness.

17 THE COURT: Ms. Pollara.

18 MS. POLLARA: Given what Dr. Morady has now told
19 me, at this point after considering the entire situation
20 further, and notwithstanding my letter, at this point, what I
21 would plan to do would be to read his deposition testimony,
22 because he's otherwise unavailable, and so I can do that at
23 any point.

24 The issues with regard to his testimony have more

1 to do, in my opinion, with the legal malpractice case. And
2 so I would have his testimony during the second phase of the
3 trial if we got that far.

4 THE COURT: Mr. Kozak, what about making
5 arrangements for a video conference in your case in chief?

6 MR. KOZAK: I don't think we really need Dr.
7 Morady in our case in chief.

8 THE COURT: All right.

9 MR. KOZAK: We have our own expert. We have Dr.
10 Morady's affidavit, also, that he filed with the original
11 complaint that Mr. Balkenbush filed. And, of course, we do
12 have his deposition on written questions. So I don't think
13 we really need him in our case in chief since we have both of
14 those.

15 THE COURT: All right. Well, I'll find good cause
16 to excuse Dr. Morady and allow the defense to use his
17 deposition and affidavit in their case, as well as the
18 plaintiffs.

19 Before I get down to the motions, are there any
20 other logistical problems we need to address? Do you have
21 any witnesses that needs special accommodations, either of
22 you? Just let me know. Mr. Kozak.

23 MR. KOZAK: I don't believe we have any witnesses
24 that need special accommodations. We do request that Dr.

1 Seifert be allowed to draw a diagram on the board indicating
2 how this catheter ablation procedure is done. And we do
3 intend to use high tech in the courtroom to show the
4 documents and so forth on the screen, which we will arrange,
5 of course, with our technical people. Other than that, I
6 don't think there's anything unusual.

7 THE COURT: Ms. Pollara.

8 MS. POLLARA: Your Honor, I know that we have
9 discussed demonstrative exhibits and I think that's part of
10 the discourse in the motions in limine. So I think drawing
11 things and so forth is typically something that occurs.

12 Given the schedule, Mr. Kozak and I have
13 communicated somewhat on that. I have Dr. Smith who is
14 coming in on Thursday morning. I don't anticipate having any
15 other witnesses on Thursday. So I wanted to give the Court a
16 heads-up that we may have some slight downtime on Thursday,
17 which I presume we could use, perhaps, to settle jury
18 instructions on the medical malpractice part of the case.
19 But I wanted the Court to know that there might be a break in
20 the schedule if Dr. Calkins is flying in that night.

21 THE COURT: Well, we'll start 9:30 on Tuesday, the
22 17th. That's when the Jury Commissioner releases the jury
23 pool to us. I generally am able to get a jury by about 11:00
24 in the morning. If there's any voir dire questions that are

1 somewhat sensitive you want the Court to ask, as opposed to
2 counsel, just submit them to me. After I do the general voir
3 dire, I turn it over to the attorneys to do individual voir
4 dire as they see fit.

5 I'll look for opening statements about 1:15 and
6 we'll just start with the first witness. I notice that both
7 counsel have agreed to 24-hour notice of the witnesses. That
8 helps the Court as well. And, Mr. Kozak, I'm not going to
9 hold you to it, but how long do you think your case in chief
10 might last on the week of the 17th?

11 MR. KOZAK: I anticipate we should be completed by
12 the end of Wednesday. Dr. Seifert will be coming in on
13 Tuesday evening and he'll be testifying. We're going to call
14 him the first witness. He has to leave and get back to his
15 practice as soon as possible. We'll have him testify Tuesday
16 morning and then we will Ms. Dechambeau testify and then
17 we're going to be through with the medical end of it.

18 So I don't know how long that will take, depending
19 on cross examination of Dr. Seifert, and, of course, cross
20 examination of Mrs. Dechambeau, but that's the only two
21 witnesses we're going to call, unless they want to go into
22 damages in the medical side. I'm open to that, if that's
23 what defense wants to do. If they don't, we'll put it over
24 to the legal malpractice side if we get that far.

1 THE COURT: Let's reserve that for the end of the
2 case. All right.

3 MS. POLLARA: Your Honor, if I could please be
4 heard on that?

5 THE COURT: Certainly.

6 MS. POLLARA: I believe, technically, that counsel
7 has to prove the entire underlying case. So he must prove
8 negligence, causation, and the nature and extent of damages,
9 because it is only by doing that that then the further
10 decision can be made with regard to the legal malpractice
11 claim.

12 THE COURT: All right.

13 MS. POLLARA: At least that's my understanding of
14 the way it should work. So there has to be a verdict for
15 plaintiff, and the nature and extent of damages are what the
16 jury consider with regard to the case. I don't know if the
17 Court has had -- I mean, there's a difference in the damages
18 between a medical malpractice case and a legal malpractice
19 case.

20 As you know, in a medical malpractice case, pain
21 and suffering, grief and sorrow, those things are
22 recoverable, and, of course, there's a cap and there's other
23 issues with regard to the admissibility of bills and things
24 like that with regard to the statute. So it's my position

1 they need to put on their entire case.

2 THE COURT: All right. That's fine. All right.
3 Let's go through the motions in limine.

4 MS. POLLARA: Your Honor, I know that we received
5 some motions in limine from Mr. Kozak. They were untimely
6 filed and our time to oppose them has not yet come. So we
7 did not -- I don't believe those are properly before the
8 Court. I don't even know if the Court has those.

9 THE COURT: I don't know if we do either. Let's
10 go through the ones that we've received and to which there
11 have been responses. These are defendant's motions in limine
12 that were filed on December 8th, 2016.

13 MS. POLLARA: Yes, your Honor.

14 THE COURT: On December 19th, the plaintiff filed
15 their opposition. The motion in limine number one seeks
16 to --

17 MS. POLLARA: Your Honor, may I interrupt? I
18 apologize. Did you receive our replies that were filed on
19 December 30th?

20 THE COURT: I don't have them here, no.

21 MS. POLLARA: We electronically filed them on the
22 30th.

23 THE COURT: Ms. Clerk.

24 THE CLERK: I have on December 30th, reply to

1 opposition, defendant's reply to plaintiff's opposition to
2 defendant's motion in limine.

3 THE COURT: I don't know why we haven't -- can you
4 print those out?

5 THE CLERK: I can.

6 THE COURT: Let me just take about 15 minutes to
7 look at the reply and then I'll come back.

8 MS. POLLARA: Thank you, your Honor.

9 THE COURT: I'll come back on the bench and we'll
10 reengage. All right. Court's in recess.

11 (A short break was taken.)

12 THE COURT: All right. Thank you, counsel, for
13 your consideration. This Court has had an opportunity to
14 review the defendant's reply to plaintiff's opposition to
15 defendant's motion in limine filed December 30th, 2016.

16 The Court makes the following rulings. As to the
17 motion in limine number one, which seeks to exclude
18 references to the personal opinions of or preferences of the
19 plaintiff's experts. An expert is permitted to testify as to
20 their personal opinions so long as it is expressed to a
21 reasonable degree of medical certainty or probability.

22 However, a personal opinion as to what the
23 testifying expert regards as his personal preference for a
24 particular standard of care shall be excluded. So,

1 therefore, the motion is granted.

2 As to motion in limine number two requesting
3 24-hour notice of each witness called at the time of trial,
4 the parties have stipulated to this. So that motion is
5 granted.

6 As to motion number three, precluding a discussion
7 of the statutory limitations on damages in evidence of the
8 financial conditions of the plaintiff. Although the parties
9 agree that the Court should preclude any discussion of the
10 statutory damages, plaintiff argues that their claim for lost
11 wages requires the disclosure of the plaintiff's financial
12 condition.

13 Generally speaking, plaintiffs in a wrongful death
14 action are entitled to put on evidence through the
15 appropriate means of loss of financial support engendered by
16 the decedent's death. However, evidence of a party's
17 financial condition is not admissible in a negligence action.
18 And, therefore, motion number -- motion in limine number
19 three is granted.

20 Motion number four, precluding reference to
21 liability insurance carried by the defendants. Under NRS
22 48.135, evidence that a person was or was not insured against
23 liability is not admissible as to whether the person acted
24 negligently, wrongfully, or for any such purpose such as

1 agency, ownership, or control, or bias, or prejudice of a
2 witness. Therefore, motion number four is granted.

3 Motion in limine number five, precluding the
4 plaintiff from inquiring of perspective jurors during voir
5 dire as to whether or not the juror would hesitate to return
6 a large verdict or suggesting an amount of verdict.

7 It is reversible error to seek a commitment or
8 pledge from a juror of a certain amount for a verdict. And
9 the parties appear to stipulate that there should not be a
10 reference to a specific jury verdict during voir dire, but
11 I'll certainly permit the attorneys to discuss the issue of
12 damages in terms of a large verdict should the evidence
13 support such a verdict, but not a specific amount. As to
14 motion in limine -- so with that carveout, the motion number
15 five is granted.

16 Motion number six, precluding the plaintiff from
17 using any demonstrative evidence during the plaintiff's case,
18 unless such evidence has been previously produced to the
19 defendants, and unless relevancy and proper foundations have
20 been established and a sufficient offer of proof has been
21 made. It's generally the Court's practice that any
22 demonstrative evidence must be relevant and be supported by
23 proper foundation. Therefore, that motion is granted.

24 Number seven, precluding lay witnesses, including,

1 but not limited to, either plaintiff from offering testimony
2 as to any conversations they've had with Dr. Smith.
3 Dr. Smith is a nonparty to this case and thus any
4 conversation with Dr. Smith is hearsay. And, therefore, that
5 motion number seven is granted.

6 Motion number eight, precluding the plaintiffs
7 from offering testimony as to any conversations with any
8 personnel from the medical examiner's office. Apparently,
9 that has been stipulated to. And, therefore, that motion is
10 granted.

11 Motion number nine, precluding the plaintiff or
12 plaintiffs from testifying as to their belief that the
13 decedent died in the operating room. An individual is
14 permitted to testify as to their firsthand knowledge and
15 observation of a particular incident. Plaintiff should be
16 precluded or are precluded as to conclusory statements, but
17 may be permitted to testify as to their percipient knowledge.
18 Therefore, that motion is denied.

19 Motion number ten, precluding the plaintiffs from
20 referring to any, quote, Internet, close quote, research on
21 any medical or legal issue. Plaintiffs will be permitted to
22 discuss their actions in conducting an Internet search,
23 however, it's limited to just that. Any discussion as to the
24 results of any medical or legal issues are precluded. So

1 that motion is granted in part.

2 Number 11, precluding the plaintiff's expert
3 witness from testifying as to opinions that they are -- that
4 they cannot state to a reasonable degree of medical and/or
5 legal probabilities. The parties have stipulated to this,
6 and, therefore, that motion number 11 is granted.

7 Number 12, excluding evidence of other claims or
8 lawsuits to which the defendants are or were named as a
9 party. For evidence to be admissible, it must be relevant.
10 Evidence if deemed relevant, it tends to make a fact more or
11 less probable. Other claims or lawsuits involving the
12 defendants are not relevant. And, therefore, this motion
13 number 12 is granted.

14 Number 13, precluding the plaintiffs and/or any of
15 their experts from alluding to any claim or lawsuit against
16 Renown Regional Medical Center, and/or any anesthesiologist,
17 or that Mr. Balkenbush should have investigated the code or
18 Renown. It is not the province of even the most skilled
19 medical practitioner to determine the validity of a medical
20 malpractice suit. Under NRS 41 A, a medical malpractice suit
21 must be supported by a medical professional's written
22 affidavit. Therefore, Mr. Gillock is precluded from
23 testifying that Mr. Balkenbush should have brought suit
24 against Renown or any anesthesiologist.

1 However, he can opine that he would have
2 investigated Renown and the code if in a similar position.
3 Therefore, the motion number 13 is granted.

4 Number 14, precluding the plaintiffs from
5 referring to medical specials not in evidence. That motion
6 is granted.

7 Number 15, precluding the plaintiffs from
8 testifying as to their impression that Dr. Morady trained
9 other physicians in this case, including Dr. Smith. An
10 impression does not constitute personal knowledge, therefore,
11 it is improper to testify to this. The Court finds it's
12 likely to confuse the jury. And, therefore, motion in limine
13 number 15 is granted.

14 Motion in limine number 16, precluding Mr. Gillock
15 from offering medical opinions. Mr. Gillock is not a trained
16 medical expert, and, therefore, he will not be able to
17 testify as to his medical opinions. Motion in limine number
18 16 is granted.

19 Number 17, precluding plaintiff's expert,
20 Mr. Gillock, from testifying and/or insinuating that the way
21 he practices defines the standard of care. Mr. Gillock's
22 personal practice does not define the standard of care.
23 Personal preference is not the definition of the standard of
24 care required for practicing professionals, thus,

1 Mr. Gillock's preference to employ written interrogatories
2 where interrogatories are discretionary does not define the
3 standard of care and the prejudice that testimony would have
4 outweighs its probative value. Therefore, motion in limine
5 number 17 is granted.

6 Number 18, precluding the plaintiff's expert,
7 Mr. Gillock, from asserting the standard of care required by
8 Mr. Balkenbush to depose his own expert witness. Again,
9 Mr. Gillock's personal preference does not define the
10 standard of care. It is irrelevant and should be excluded.
11 Therefore, motion in limine number 18 is granted.

12 Number 19, precluding Mr. Gillock from expressing
13 any criticism of Mr. Balkenbush's communications with the
14 plaintiff. Mr. Gillock testified during his deposition that
15 the lack of communication between plaintiff and Mr.
16 Balkenbush was not in violation of the standard of care.
17 Thus any insinuation that he criticized the lack of
18 communication would be more prejudicial than probative.
19 Therefore, motion in limine number 19 is granted.

20 Number 20, precluding the plaintiff or their
21 experts from utilizing or testifying about or concerning a
22 stat echo photograph not disclosed or produced by plaintiff
23 during discovery.

24 I'd like to hear some argument on this, because it

1 appears as if the stat echo photographs had been disclosed in
2 2013 and in 2016. So, Ms. Pollara, I'll start with you.

3 MS. POLLARA: Thank you, your Honor. It is
4 accurate that in the plaintiff's pretrial disclosure back in
5 2013, that they left as an exhibit or as a pretrial exhibit a
6 stat echo photograph. At that time, there was, to my
7 understanding, Ms. Piscevich was involved in the case at that
8 time, but reconstituting what occurred, it is my
9 understanding that she objected to that pretrial disclosure,
10 because the stat echo photographs were not properly produced
11 at that time, nor were they provided to Dr. Seifert before
12 Ms. Piscevich took his deposition in July of that year.

13 My further understanding is that they were at no
14 point even up until today were they actually disclosed
15 pursuant to 16.1 formally.

16 Now, it is correct that in October of this year, I
17 asked Mr. Kozak to produce or provide me with the optical
18 disk, which is a different, a different part of the record,
19 and which had been instrumental to Dr. Morady's opinions in
20 the case. And when my partner picked up the disk, it was not
21 the optical disk. It was the stat echo images, which I did
22 not appreciate at the time. So I would agree that in
23 October, they did produce a disk to me. I did not know until
24 recently what it was. I was holding on to the disk to review

1 it with Dr. Morady. But, yes, they did disclose it in
2 October in the way that I described it in my documents.

3 THE COURT: Mr. Lusiani. Mr. Kozak.

4 MR. KOZAK: Well, there are a great many records
5 in this case and it was disclosed. I don't think there's any
6 doubt about its authenticity. So I just don't see any real
7 prejudice here to using this stat echo. I mean, it is what
8 it is. It was produced and so, apparently, I have a feeling
9 it's probably relevant.

10 THE COURT: Thank you. I'll give you --

11 MS. POLLARA: May I be heard briefly?

12 THE COURT: Yes.

13 MS. POLLARA: I do think there is prejudice,
14 because Ms. Piscevich when she deposed Dr. Seifert in July of
15 2013, he was asked to produce his entire file. He did not
16 have the stat echo images at that time, nor did she have the
17 opportunity to question him regarding them. So I would just
18 add that there is prejudice in that she never had the
19 opportunity to depose him on that issue.

20 THE COURT: All right. I think that's fertile
21 ground for cross examination, but I think it will go to the
22 weight of the evidence, not its admissibility. And,
23 therefore, the motion in limine number 20 is denied.

24 Number 21, excluding nonparty witnesses from the

1 courtroom. That will be granted with the exception of expert
2 witnesses. And, therefore, that motion, Ms. Clerk, is it 21?

3 THE CLERK: 21, your Honor.

4 THE COURT: Is granted. Let's talk about the
5 motion to strike Dr. Calkins. Mr. Kozak.

6 MR. KOZAK: Yes, your Honor.

7 THE COURT: Filed a motion to strike on
8 November 15th. Plaintiff argues that the pretrial motions
9 were bound by the August 17th, 2012 joint case conference
10 report, and, therefore, any additional pretrial discovery
11 motions are untimely.

12 Further, the plaintiff argues that this Court's
13 February 21st, 2016 scheduling order should be vacated. On
14 December 21st, this Court found otherwise and held that the
15 February 1st, 2016 scheduling order was valid. That was
16 followed by an emergency writ of mandamus to the Nevada Court
17 of Appeals, which denied it.

18 I've had an opportunity to revisit this issue and
19 I'm inclined to reverse myself and grant the motion to strike
20 Dr. Hugh G. Calkins as being untimely disclosed. It's my
21 understanding that Dr. Rule Doshi, Dr. Anil Bendari and
22 doctor -- I'm sorry -- Tom Vallis, a lawyer, are percipient
23 witnesses, and, therefore, this doesn't affect them. But,
24 Ms. Pollara, let me hear from you.

1 MS. POLLARA: Well, your Honor, I would encourage
2 you, if I may, to remain with your original decision and
3 from -- and let me address this from a couple of different
4 points.

5 Number one, at the point that the Court issued its
6 scheduling order in February 2016, we had every reason to
7 rely on that order. And at that point, there was no issue or
8 concern raised by plaintiff's counsel about it.

9 In fact, Dr. Calkins has been identified, as we
10 describe in our papers, throughout as a witness who has been
11 known, who has expressed expert witness questions in this --
12 expert witness opinions in this case from the outset from the
13 medical malpractice case.

14 And so from my standpoint, it was proper for us to
15 identify him additionally as an expert, although, frankly, I
16 could have left him as a percipient witness and called him in
17 the same vein, but I wanted to be -- I wanted to make sure I
18 was fully disclosing my intentions.

19 So I believe that the Court's ruling was correct
20 from the outset, and because there was no issue raised with
21 it for many months, we had the right to rely on it.

22 I would also state for the Court to now reverse
23 itself on this point, I would need clarification from the
24 Court as to whether the Court is now going to preclude Dr.

1 Calkins from testifying with regard to the opinion that he
2 formed and held at the point that he reviewed this case for
3 Mr. Lemons. Because if the Court was inclined to permit him
4 to testify with regard to the opinions that he has and that
5 he formed, then there may be no prejudicial error.

6 But for the Court to now reverse itself on this
7 point, the week before trial, particularly given the issue
8 with Dr. Morady, which we've discussed already, would work
9 irreparable prejudice upon the defendants in this case.

10 THE COURT: Ms. Pollara, explore two things. One,
11 Dr. Calkins' testimony as a percipient witness. And, two,
12 the opinion he provided to Mr. Lemons and how do you think
13 that would fit?

14 MS. POLLARA: Well, because of the case within the
15 case, your Honor, Dr. Calkins was retained by Mr. Lemons in
16 the medical malpractice case. And Mr. Lemons forwarded to
17 him documents and various materials, which he would use. And
18 based upon those documents and the review that he did and his
19 discussions with Mr. Lemons, he formed opinions that he was
20 supportive of Dr. Smith with regard to how this procedure was
21 performed, including the timing of this cardiocentesis. And
22 there was a declaration that set forth in summary his opinion
23 with regard to those issues.

24 He was disclosed in that underlying case as an

1 expert who was supportive of Dr. Smith and so he was
2 identified as an expert witness in that case. And so, you
3 know, I guess he's kind of a mixture of an expert and a
4 percipient witness, because his percipient involvement was as
5 an expert in the case.

6 I don't know if that explains it clearly enough,
7 but that was his involvement. So he has very strong opinions
8 about the fact that Dr. Smith complied with the standard of
9 care and that is what I intend to produce him to testify
10 about. Those opinions are not new. They have been known
11 since back in 2010, I believe, when his expert declaration
12 was disclosed in the underlying case.

13 THE COURT: All right. Mr. Kozak.

14 MR. KOZAK: Yes. Dr. Calkins, it seems to me, is
15 a witness in the legal malpractice case. He rendered his
16 opinion and I suppose this would weigh into Mr. Balkenbush's
17 decision to dismiss the case.

18 As far as the medical malpractice case, now we're
19 getting into completely new ground. He wants to come in and
20 give expert witness opinions that we have no idea what they
21 are. He did submit an affidavit in the underlying case, and,
22 you know, if they want to produce that and use it in the
23 legal malpractice case, knock yourself out. We're fine with
24 that.

1 We don't think he should be able to come in now
2 and start giving all different opinions hither and yon about
3 what he thinks happened in the operating room, because he
4 wasn't there. And he's now, and we told Ms. Pollara early on
5 we were going to strenuously object to any expert testimony
6 that was new that was going to be given by the doctor. And I
7 must have sent her about three letters saying we're just not
8 going to put up with that.

9 If you want to use him in the legal malpractice
10 case and show there was an expert opinion by Dr. Calkins,
11 that's fine with us, but not in the medical malpractice case.
12 That, I think is -- and if you look at his affidavit, there's
13 really not much in there that we can rely on to show what
14 he's going to testify to.

15 And, furthermore, he didn't submit an expert
16 witness report under the new scheduling order. If they want
17 to go by that, then he should have come in with an expert
18 witness disclosure that was detailed and told what the basis
19 of his opinion was.

20 If you read the affidavit, he just says, I don't
21 think there was any negligence, everything went according to
22 the stand of care. That's all he says. There's no basis for
23 that opinion. So now he wants to come in and give us all
24 kinds of bases for his opinion in the medical malpractice

1 case and that's our complaint. That's just unfair.

2 THE COURT: Ms. Pollara.

3 MS. POLLARA: Well, your Honor, first of all,
4 expert witness reports in this case were waived and there's
5 never been any indication, your Honor, that expert witness
6 reports were requested or required. And, in fact, if you
7 look at the original joint case conference report, it says
8 that expert witness reports were waived. So that is the
9 response to that.

10 Number two is that this Court -- well, I would say
11 that if Mr. Kozak is trying to imply that prior to receipt of
12 our expert witness disclosure, that he put me on notice that
13 he was not going to allow or he was going to object to Dr.
14 Calkins being called as an expert in the case, that is
15 absolutely incorrect.

16 The letters that I received from him occurred
17 after and the Court has those. But, in fact, there's
18 absolutely no indication that Mr. Kozak contacted me at any
19 point after he received the discovery order and said
20 discovery does not remain open or there was an issue with
21 this Court's order with regard to the disclosure of experts.
22 And I believe we had a right to rely on the Court's order in
23 that regard.

24 Third, with regard to Dr. Calkins' declaration, it

1 is a detailed declaration, but as with all of these
2 declarations, and that was in the underlying -- that was in
3 the underlying medical malpractice case where expert witness
4 reports were not waived, Mr. Lemons put together a report
5 that had Dr. Calkins' opinions in it. So it is not a
6 surprise and his opinions are relatively detailed. So I
7 disagree with Mr. Kozak's description of all of those events.

8 THE COURT: Do you see a limited use of Dr.
9 Calkins' testimony?

10 MS. POLLARA: Well, I don't know what the Court
11 means by a limited use. I believe that he should be able to
12 testify with regard to his opinions regarding Dr. Smith's
13 actions, with regard to his opinions that he complied with
14 the standard of care in how he did the procedure, and he
15 should be allowed to explain that.

16 Those were opinions that he formed during the time
17 frame of the medical malpractice action and those are
18 opinions that he continues to maintain. And he should be
19 able to in the medical malpractice case testify that
20 Dr. Smith complied with the standard of care and why he
21 believed he did so.

22 THE COURT: Mr. Kozak.

23 MR. KOZAK: I think your Honor is on the right
24 track. I think maybe he should be allowed to or he should

1 have his affidavit submitted that he believes that Dr. Smith
2 comported with the standard of care, but that's it. He's got
3 his affidavit there. It gives his opinion. But now to come
4 in and try to expand on that and give a whole bunch of other
5 opinions, which he feels provide a basis for that, I think is
6 improper.

7 And I think we are at a complete disadvantage. We
8 haven't had a chance to depose him and we notified counsel
9 that we did not feel it was proper that she bring any note of
10 expert. If she wants to go by the old case conference report
11 that says that we waive the expert reports, then let's go by
12 the old case conference all the way through about when the
13 close of discovery was.

14 But if she wants to go by the new scheduling
15 order, she's got to comply with the rules of discovery in
16 16.1 A, B and C, which she didn't do, which Dr. Calkins
17 didn't do.

18 And we have another complaint we'll be making,
19 which is that he can't come in and testify, because his
20 expert witness report that she's relying on just doesn't give
21 any basis for his opinions. So, you know, he shouldn't be
22 allowed to come into court now and testify as to the basis of
23 those opinions.

24 MS. POLLARA: Your Honor, if I may be heard?

1 THE COURT: Go ahead.

2 MS. POLLARA: First of all, if the Court's ruling
3 is to simply allow me to use his declaration, that decision
4 would entirely place the defense in this case at a completely
5 prejudicial position. If Mr. Kozak had wanted to, typically,
6 what occurs, if I may go back to this, so if Mr. Kozak had a
7 complaint that we did not produce a sufficient report, or a
8 report by Dr. Calkins, he could have brought that to my
9 attention after he received the expert witness disclosure,
10 and he could have addressed that with me at that time, and I
11 would have gotten him a report.

12 Alternatively, he had every opportunity to notice
13 Dr. Calkins' deposition and take his deposition. He did not
14 do that. Rather, what he did was he sat back and
15 subsequently filed a motion to strike Dr. Calkins. And the
16 Court ruled on that, we believe properly, but he did have the
17 opportunity to depose him, he did have the opportunity to
18 have that conversation with me if he wanted a detailed
19 report, and he did not do that.

20 So now at this point to exclude Dr. Calkins would
21 completely take away any defense that doctor -- that my
22 client has with regard to the medical malpractice case and
23 Mr. Kozak obviously knows that.

24 THE COURT: Well, the sticking point is the

1 pretrial order, which states that a continuance of the trial
2 date does not modify, alter, or change the discovery schedule
3 absent an agreement in writing by counsel and approved by the
4 Court.

5 MS. POLLARA: But, your Honor, speaking to that
6 point, the Court then subsequently issued a new scheduling
7 order. And, you know, I am not someone, as an officer of the
8 Court, I do not ignore scheduling orders and I calendar those
9 documents accordingly and I adhere to them. So it is my
10 position that I relied properly on the Court's scheduling
11 order.

12 If I had thought that this was an issue, then I
13 would have much earlier brought a motion to the Court to
14 reopen discovery or to address this issue. But now to do
15 this a week before trial works an incredible disadvantage on
16 the defense.

17 THE COURT: All right. Thank you, Ms. Pollara.

18 MS. POLLARA: Thank you, your Honor.

19 THE COURT: Well, this Court is going to stand on
20 its previous order and permit Dr. Calkins to testify and
21 we'll see where it goes from here. All right. Do we need to
22 address anything? I understand you've spoken to my clerk
23 about exhibits and jury instructions?

24 MR. KOZAK: Yes, your Honor.

1 MS. POLLARA: Yes, your Honor, we have done that.

2 THE COURT: We'll see you on --

3 MS. POLLARA: Your Honor, could I just ask as a
4 point of knowledge, because I haven't had the pleasure of
5 trying a case in your court, could you give us a brief
6 thumbnail as to how you proceed with jury selection? For
7 example, do you like challenges for cause to be done at a
8 certain point of the event? How do you typically seat a
9 number of people and then how do you fill the empty seats?
10 Could you just review that with us so we don't have any delay
11 on Tuesday?

12 THE COURT: Certainly. Counsel will receive a
13 packet of the jury questionnaires on Thursday.

14 THE CLERK: Your Honor, they're meeting to mark
15 exhibits Thursday afternoon and their questionnaire should be
16 available then.

17 THE COURT: We will call 19 potential jurors and
18 we'll seat them in the box. I'll introduce the parties. The
19 clerk will read the complaint, unless the parties wish to
20 provide a summary of the allegations and the defense. I'll
21 do the general voir dire, ask them to stand, introduce
22 themselves, tell us what you do, if you're married, your
23 spouse, what your spouse does. I'll ask them if they have
24 any previous jury experience, whether it's civil or criminal,

1 whether they were the foreperson of the jury, whether or not
2 a jury returned a verdict.

3 I'll explain to them this is a civil trial. I'll
4 ask them if -- I'll tell them that this case, potentially,
5 could last two weeks, whether or not that imposes a hardship
6 on them, whether there are other circumstances that would
7 create a hardship that service on this jury would create as a
8 hardship to them.

9 If we get one, let's just say, Ms. Pollara, it's
10 juror number four, who says, I can't serve for two weeks, I
11 will then ask counsel if they have any objection. If there's
12 no objection, you know, perhaps the juror is a sole provider,
13 care provider for a disabled child or adult. Generally, in
14 those cases, I'll excuse that juror and then ask Ms. Clerk to
15 call another name from the jury pool and then that person
16 will be seated in juror number four's seat.

17 I'll then ask if their answers would have been
18 different. And then I'll continue the voir dire. Do they
19 know anything about the case? Do they know anything about
20 the parties? Do they know the attorneys? Do they know the
21 witnesses? I'll ask them if they had, as I said, previous
22 jury service.

23 If there is a challenge for cause, we have a
24 little white noise box, I think it's called pink noise, at

1 which point I'll ask counsel to come up to the bench, state
2 your objections on the record, and I generally tend to ask
3 the potential juror questions that would determine whether or
4 not they have a sufficient basis to be excused for cause.

5 If they do, then we do -- then I'll grant the
6 motion and we'll call the name from the jury pool and that
7 person from the gallery will come up and take juror number
8 seven's slot.

9 And we'll continue to go through until I've gone
10 through the general, as you sit there now, can you be fair to
11 both sides? If you were either the plaintiff or the
12 defendant, would you be satisfied with being tried by a
13 person of your presence state of mind, et cetera? And then
14 I'll turn it over to counsel.

15 And then once we've cleared the panel of 19, we'll
16 go back into chambers, I'll send the jury out on a break and
17 we will go back into chambers and exercise the peremptory
18 challenges. Both sides get five and we end up with eight
19 jurors and one alternate.

20 And then we come back out, the jury pool is out in
21 the gallery. Ms. Clerk will call the names of those jurors
22 who have not been struck. And we will swear them in as the
23 jury who will try this case. Does that help you at all,
24 Ms. Pollara?

1 MS. POLLARA: It's very helpful. Thank you, your
2 Honor.

3 THE COURT: Mr. Kozak.

4 MR. KOZAK: That's fine, your Honor.

5 THE CLERK: Your Honor, would you like Ms. Pollara
6 to prepare the order with respect to the motions in limine?

7 THE COURT: That's fine.

8 THE CLERK: Ms. Pollara, did you hear that?

9 MS. POLLARA: No, I did not.

10 THE CLERK: Judge Flanagan is asking that you
11 prepare the proposed order in accordance with the motions in
12 limine.

13 MS. POLLARA: Yes, I will do that.

14 THE COURT: All right. Anything further, Mr.
15 Kozak?

16 MR. KOZAK: No, your Honor.

17 THE COURT: Ms. Pollara, anything further?

18 MS. POLLARA: No, thank you.

19 THE COURT: Be safe driving over the hill.

20 --oOo--

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22

23

24

1 STATE OF NEVADA)
2 County of Washoe) ss.
3)

4 I, STEPHANIE KOETTING, a Certified Court Reporter of the
5 Second Judicial District Court of the State of Nevada, in and
6 for the County of Washoe, do hereby certify;

7 That I was present in Department No. 7 of the
8 above-entitled Court on January 10, 2017, at the hour of 2:00
9 p.m., and took verbatim stenotype notes of the proceedings
10 had upon the pretrial conference in the matter of ANGELA
11 DECHAMBEAU, et al., Plaintiff, vs. STEPHEN C. BALKENBUSH, et
12 al., Defendant, Case No. CV12-00571, and thereafter, by means
13 of computer-aided transcription, transcribed them into
14 typewriting as herein appears;

15 That the foregoing transcript, consisting of pages 1
16 through 34, both inclusive, contains a full, true and
17 complete transcript of my said stenotype notes, and is a
18 full, true and correct record of the proceedings had at said
19 time and place.

20 DATED: At Reno, Nevada, this 30th day of May 2017.
21

22 S/s Stephanie Koetting
23 STEPHANIE KOETTING, CCR #207
24

EXHIBIT 2

EXHIBIT 2

1 4185
2 STEPHANIE KOETTING
3 CCR #207
4 75 COURT STREET
5 RENO, NEVADA
6

7 IN THE SECOND JUDICIAL DISTRICT COURT
8 IN AND FOR THE COUNTY OF WASHOE
9 THE HONORABLE PATRICK FLANAGAN, DISTRICT JUDGE

10 --oOo--

11 ANGELA DECHAMBEAU, et)
12 al.,)
13 Plaintiffs,) Case No. CV12-00571
14 vs.) Department 7
15 STEPHEN C. BALKENBUSH, et)
16 al.,)
17 Defendant.)

18 TRANSCRIPT OF PROCEEDINGS
19 TRIAL
20 VOLUME I
21 January 17, 2017
22 9:30 a.m.
23 Reno, Nevada

24 Reported by: STEPHANIE KOETTING, CCR #207, RPR
Computer-Aided Transcription

1 APPEARANCES:

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1 RENO, NEVADA, January 17, 2017, 9:30 a.m.

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3 --oOo--

4 THE CLERK: Case number CV12-00571, A. Dechambeau
5 versus S. Balkenbush, et al.. Matter set for jury trial.

6 (Jury voir dire was conducted.)

7 (The following proceedings were had outside the
8 presence of the jury.)

9 THE COURT: Please be seated. Do we need to
10 address anything before we take our lunch break, Mr. Kozak?

11 MR. KOZAK: Your Honor, Mr. Lusiani would like to
12 address the whole issue regarding the testimony of the
13 plaintiff. We have filed a motion for reconsideration on
14 that issue.

15 THE COURT: All right. Mr. Lusiani.

16 MR. LUSIANI: Thank you, your Honor. The two
17 items that we have filed a motion for reconsideration on
18 involve the motion in limine of the defendant, motion in
19 limine number seven and number 19, number seven as it relates
20 to communications to and from Dr. Smith. We submitted a
21 brief in support of these, the motion.

22 THE COURT: You did, but you didn't identify what
23 those statements were. I recall Ms. Dechambeau's deposition
24 where she referenced something Dr. Smith saying, I killed

1 him, or something like that. What are the statements?

2 MR. LUSIANI: The motion in limine includes any
3 and all, as I understand it.

4 THE COURT: Okay.

5 MR. LUSIANI: And the situation is such,
6 especially considering in a case within a case situation
7 we're facing here, we have to be able to -- we respectfully
8 submit, we must be able to provide evidence that would
9 establish the first part of that, which would be the medical
10 malpractice.

11 The statements of Dr. Smith, regardless, would
12 be -- well, within the proper context, would be admissions
13 against interest, and that's a major basis upon which we're
14 asking for your consideration to allow us to get into that
15 area.

16 THE COURT: What are the statements?

17 MR. LUSIANI: The statement would be -- one would
18 be the admission of Dr. Smith when he first came out
19 indicating to Ms. Dechambeau that he had killed her husband.

20 THE COURT: Okay. That's one. What's the next
21 statement?

22 MR. LUSIANI: There's also a conversation that was
23 had subsequently after Mr. Dechambeau's demise wherein he's
24 apologizing and expressing sorrow and concern about the

1 situation and how it was handled. Those are the two things
2 that we're mainly concerned with at this point, your Honor.

3 And in order to provide proper direct examination
4 of Ms. Dechambeau, we would like some further direction from
5 the Court in that regard.

6 THE COURT: Okay.

7 MR. LUSIANI: The other item -- you want me to
8 address the other item?

9 THE COURT: No. Let's just stick with one at a
10 time. Ms. Pollara.

11 MS. POLLARA: Thank you, your Honor. I think the
12 Court's ruling originally was correct and I have nothing
13 further to add from my briefing, except I would note that
14 counsel cited to an unpublished opinion in their motion for
15 reconsideration, which I don't believe is proper. And that
16 is the Walsh versus Peele and Grumley case, which they cite
17 to extensively in their motion and that is not a published
18 opinion.

19 THE COURT: Anything else on that?

20 MR. LUSIANI: No, your Honor.

21 THE COURT: Well, I think as to the first
22 statement of Dr. Smith in which he allegedly said, I killed
23 him, I just find that is more prejudicial than probative.
24 Clearly, this was a tragedy and everybody was emotional. I

1 don't believe it -- I'll just say it is just far more
2 prejudicial than probative. As to the second -- so I'll
3 preclude that statement.

4 As to the second statement in which he was
5 apologizing for the situation, I think that's natural. Let
6 me hear, Ms. Pollara, what are your thoughts there?

7 MS. POLLARA: Your Honor, I don't have a strong
8 opinion about that. I mean, I think it's a matter of the
9 Court's judgment as to whether to admit that or not and I
10 would defer to the Court.

11 THE COURT: All right. I'll permit that, then. I
12 think that's a natural and human response to the situation.
13 Next item?

14 MR. LUSIANI: The next item, your Honor, deal with
15 communications between Mr. Balkenbush and his then client,
16 our clients at this point. And the only thing I can suggest
17 in addition to what the points and authorities are in support
18 of our motion here is that communications are the essence of
19 services provided by an attorney. And to cross the board
20 preclude communications that were made and/or communications
21 that were not made takes away the entire basis and ability of
22 our client to be able to establish what was actually done
23 versus what should have been done under the proper standard
24 and duty of care.

1 THE COURT: How do you get around Mr. Gillock's
2 testimony that he had no criticism of the level of
3 communications between Ms. Balkenbush and Ms. Dechambeau?

4 MR. LUSIANI: Well, the level of communications, I
5 think, can be distinguished between what the communications
6 actually were. And the other part of that, your Honor, is
7 that we don't know -- again, there are actual communications
8 and there are lack of communications, both of which are
9 relevant as it relates to what was done and what wasn't done
10 in terms of services by the defendant.

11 And if Mr. Gillock is still of that mind, then,
12 that's fine, and of course, anything that he might change in
13 that regard certainly is subject to cross examination by Ms.
14 Pollara and can go from there.

15 But, again, we don't know exactly what we're
16 talking about until it actually comes out in terms of
17 communications that were had or not had.

18 THE COURT: We know what was had.

19 MR. LUSIANI: We know what ultimately was had, but
20 in the meantime, you're precluding us from showing what the
21 communications were or were not between the attorney-client,
22 and this is in fact what the issues are before the Court.

23 It's what communications were or were not that led to
24 whatever action may or may not have been taken. And, again,

1 to take away our ability to produce that for you or for the
2 jury seriously hampers and prejudices us in a way that can't
3 be rectified in any other manner.

4 THE COURT: Well --

5 MR. LUSIANI: Certainly, Mr. Balkenbush can get up
6 and say anything he wants to say about what he did or what he
7 didn't do in the way of communications.

8 THE COURT: I'm still struggling with the
9 professional standard. If you have no expert that will
10 testify that the communications between Mr. Balkenbush and
11 Ms. Dechambeau fell below the standard, the professional
12 standard, then why -- how is it relevant?

13 MR. LUSIANI: Why or how do we get to a point
14 where certain things we feel should have been, Mr. Gillock
15 has in fact indicated should have been communicated, and
16 weren't.

17 THE COURT: That's fair game. I mean, if you have
18 Mr. Gillock up here on his -- and he testifies that he should
19 have done X in order to meet the professional standard,
20 that's all well and good, but if you have Mr. Gillock
21 testifying that I have no complaint about the level of
22 communication, then why should this Court permit that
23 testimony to come in if it doesn't impact the standard?

24 MR. LUSIANI: Again, your Honor, I think we're

1 dealing with things that can't really be defined, I mean,
2 until we actually know what they are, and what the testimony
3 might be as it relates to communications that were or were
4 not provided.

5 Certainly, services not provided, communications
6 and information not provided to our client should be relevant
7 and should be allowed to be testified to by Ms. Dechambeau in
8 setting a standard, in looking to the standard in terms of
9 what should have been done.

10 THE COURT: Are you going to put Ms. Dechambeau up
11 there as an expert?

12 MR. LUSIANI: No, your Honor. But she certainly
13 can testify as it relates to what wasn't told to her. And my
14 understanding of what this motion in limine is, is that it
15 precludes us from even doing that.

16 THE COURT: Well, how are we going to know -- how
17 is she going to know what was not told to her? What would
18 she testify to?

19 MR. LUSIANI: Mr. Gillock will testify as what
20 should have been done, what should have been said.
21 Ms. Dechambeau will provide information as it relates to what
22 wasn't within that same area.

23 THE COURT: All right. Let me hear from Ms.
24 Pollara.

1 MS. POLLARA: So, your Honor, I was looking for my
2 original motion and I'm not able to find it right now. But I
3 feel very strongly about this. Mr. Gillock is an experienced
4 trial lawyer who knows and understands the significance of
5 giving a deposition under oath. Ms. Piscevich took his
6 deposition, a very thorough deposition under oath, and he
7 indicated that he was prepared to give that deposition and
8 that he reviewed what he needed to in order to render his
9 opinions in that case, in that deposition.

10 And, in fact, what he testified to is that he had
11 no standard of care criticisms of the level of communication
12 that was between my client and the plaintiffs in this case.

13 Clearly, he could have said, well, I do have a
14 standard of care criticism of it and he could have outlined
15 it, but he did not. He said, I don't have any standard of
16 care criticisms about that.

17 So to now suggest that he's going to come into
18 court and we're just going to see what happens, I mean,
19 that's the purpose of a motion in limine, so that we can make
20 sure that he is held to his deposition testimony. And I've
21 known Mr. Gillock for many years and I know he's an
22 experienced trial lawyer, I've tried cases against him, I
23 know he understands the oath that he gave when he was deposed
24 and the significance of it. And it is shocking for me to now

1 hear that he's going to come in and say something different
2 than he did when he gave his deposition in 2013.

3 THE COURT: Do we know if that's going to happen?

4 MS. POLLARA: They're suggest that it is and so
5 that's the reason I filed this motion in limine, because he
6 clearly testified under oath that he had no standard of care
7 criticisms of the level of communication between
8 Mr. Balkenbush and the Dechambeaus.

9 To now suggest that he's going to come in and say
10 something different, this Court should preclude that. It's
11 not appropriate for him to be permitted to do that in this
12 case. And so there's a distinction.

13 Now, Mrs. Dechambeau can testify about the
14 relationship or lack thereof, if she feels that way, with
15 Mr. Balkenbush. And she can talk about that experience. But
16 then to go the next step and say that Mr. Gillock should be
17 able to -- because Mr. Gillock read her deposition. He read
18 both of them. He had that information at the point that he
19 gave his deposition and he knew what she said and what I
20 would presume she's going to say in the context of the trial
21 in this case.

22 So you now to -- first of all, I don't think
23 there's anything for this Court to reconsider on that point.
24 His testimony is clear. This Court should affirm its prior

1 ruling. And it would be inappropriate to allow Mr. Gillock
2 to now get up on the stand and testify differently when he
3 gave an opinion without question at the time of his
4 deposition. That was the whole reason for filing that
5 motion.

6 THE COURT: Well, this is what I'm going is I'll
7 deny the motion for reconsideration. But I want to listen to
8 Mr. Gillock on that point outside the presence of the jury.
9 If he's going to change his testimony, I want to know about
10 it before he testifies about it.

11 As far as Ms. Dechambeau is concerned, she can
12 certainly testify as to the conversation she had and the
13 relationship she had with Mr. Balkenbush. But she can't get
14 up there and say that fell below the standard of practice.
15 She's not an expert. She can certainly testify as to what
16 did happen or what her expectations may have been.

17 But Mr. Gillock is the expert here and he was
18 unequivocal in his testimony in the deposition. If he's
19 going to change it, I want to know before it gets in front of
20 the jury. But I'm not going to change my mind at this point.

21 All right. Court's in recess.

22 (A lunch break was taken.)

23 THE COURT: We are convened outside the presence
24 of the jury in CV12-00571. It's my understanding that

1 counsel wants to use some exhibits in opening statements. We
2 have not admitted them, but we have a number of them that
3 have been stipulated to. I'd like to just admit those that
4 you intend to use, unless there's objections.

5 MS. POLLARA: Your Honor, I don't have any
6 objection.

7 THE COURT: Thank you. So, Ms. Clerk, Exhibits 2
8 through 11 are admitted. Wait. 2, 4, 5, 6, 7, 8, 9, 10, and
9 11 are admitted. Counsel, do you want any others admitted?

10 MR. KOZAK: 11 is fine, your Honor. That's the
11 only one we're going to use.

12 THE COURT: Let's bring in the jury. Thank you,
13 counsel.

14 (The following proceedings were had in the
15 presence of the jury.)

16 THE COURT: Will counsel stipulate to the presence
17 of the jury?

18 MS. POLLARA: Yes, your Honor.

19 MR. LUSIANI: Yes, your Honor.

20 THE COURT: Ladies and gentlemen, this is the time
21 for opening statements. Opening statements are like a road
22 map that the attorneys will draw for you so you can get an
23 idea of what to expect and the context in which the evidence
24 comes in. So because the plaintiff bears the burden of

1 proof, the plaintiff gets to go first. Counsel.

2 MR. KOZAK: Thank you, your Honor. Well, as your
3 Honor stated, we get to give you a summary of what we think
4 the evidence is going to show in this case and what we think
5 will justify a compensation award to our clients based on the
6 conduct of two people, Dr. David Smith and Stephen
7 Balkenbush, an attorney.

8 As you know now, we represent Angela Dechambeau
9 and Jean Paul Dechambeau. They are the son and the widow of
10 Neil Dechambeau. At the time of his death, he was a
11 57-year-old accountant and also he was a Fed Ex driver.
12 We're going to hear a lot of talk -- I should say he was
13 57 years old, too.

14 You're going to hear a lot of talk in this case
15 about some methodologies. This is called electrophysiology.
16 Before I got involved in this case, I'd never heard of it,
17 but what it is is the use of electricity to treat heart
18 conditions.

19 And what they do is they take wires and they go
20 into the groin and the wires run up into the heart chamber,
21 and then if someone has an arrhythmia, what they call atrial
22 fibrillation, they map that heart when they put those wires
23 up into the heart chambers. And when they determine where
24 those nerve impulses are coming from that cause the irregular

1 heartbeat, they shot an electric pulse through there and they
2 zap it. So they try to eliminate that nerve ending where
3 that arrhythmia is originating in the heart.

4 What happened in this case? Neil Dechambeau had
5 that condition. He basically had arrhythmia. They tried to
6 treat it with drugs. Couldn't do it. So he consented to
7 have what they call a catheter ablation. What that is is the
8 methodology I just described.

9 So he went into Reno Heart and he got hooked up,
10 all the preop was done properly, there's no argument with
11 that. And he began have been the ablations. There's a
12 series of them. He had gone through maybe 157 of them.

13 All of a sudden, this was October 7th, 2016, there
14 was what is called a code blue, which means that the heart
15 stopped beating. So immediately there's consternation in the
16 catheter lab where this procedure was being done and it was
17 being done by Dr. Smith.

18 When that happens, there's a certain standard of
19 care that has to be executed, and, unfortunately, Dr. Smith
20 made a series of mistakes that violated the standard of care,
21 and, unfortunately, led to the demise of Neil Dechambeau.

22 The code blue was first sounded at 12:39 p.m.. So
23 what Dr. Smith ordered immediately at 12:41 was CPR and what
24 they call pressor drugs. These are drugs like epinephrine,

1 which they insert into the heart in order to stimulate it and
2 try to get it beating. Of course, CPR is intended to cause
3 the same effect, they want to get the heart started again.

4 The next thing he did, which was also a mistake,
5 is he ordered a cardiac echogram from outside the catheter
6 lab. Well, it took approximately four minutes for that
7 machine to get into the catheter lab, because it wasn't
8 there.

9 By the time they finally got there, it was 12:49.
10 By the time they got the echocardiogram hooked up and they
11 got the -- he got to look in there to see what was happening,
12 he observed a large effusion, which is bleeding into the
13 pericardium, and this is caused by what they call a cardiac
14 tamponade, which is a hole in the heart. That causes
15 bleeding into the pericardium and that swells around the
16 heart and it freezes it so the heart can no longer clear the
17 chamber. So what you have is cardiac arrest.

18 The problem with that is by the time he finally
19 got the echocardiogram hooked up, at least 15 minutes had
20 elapsed between the initial code blue and the time that they
21 were able to get the pulse started again.

22 Now, the way they get the pulse started again, and
23 what the standard of care is, you put a needle into the heart
24 and the pericardium and you extract the fluid that's in there

1 and that frees up the heart so it will begin beating again
2 and it will begin beating almost immediately. You don't even
3 have to extract all the blood from that pericardium. If you
4 just get a certain percentage of it out, your heart is going
5 to start beating again, which it did at approximately 12:54.

6 Unfortunately, the gap in time 12:39 and 12:54 was
7 15 minutes. Well, if your brain is without oxygen for
8 15 minutes, you're basically going to be under serious risk
9 of brain damage and death and that's exactly what happened.

10 Well, how do we know that this is true? We have
11 one of the best electrophysiologists in the country, Dr. Mark
12 Seifert. He's going to come in here and testify tomorrow
13 morning. He is an absolute expert in this. He's done
14 literally thousands of these procedures.

15 And he's going to testify as to what standard of
16 care was in the care of Neil Dechambeau. He's going to tell
17 you that the standard of care was to have an immediate
18 pericardiocentesis, which means as soon as that code blue was
19 sounded, boom, in goes that needle, out comes the fluid from
20 the heart, the heart will begin beating in two minutes, maybe
21 a minute, maybe seconds. But if you don't do that right away
22 and you don't assume that you have a cardiac tamponade right
23 away, you violated the standard of care.

24 Dr. Seifert is also going to testify that CPR was

1 contraindicated. You don't do CPR when you have a cardiac
2 tamponade. Why not? Because pushing on that chest and
3 trying to shove that blood out the pericardium isn't going to
4 work. It's not going anywhere. The heart is frozen. And
5 the injection of the epinephrine and all these other drugs
6 isn't going to stimulate the heartbeat either.

7 Well, what is the reason that Dr. Smith gives for
8 not doing the pericardiocentesis at the time it was supposed
9 to be done? He's come up with a story that what he did was
10 he did the pericardiocentesis as he should have while CPR was
11 being administered. And then he's going to say he sent for
12 the echocardiogram, not for the purpose of viewing what was
13 going in the heart to get an image to see if there was
14 bleeding in the heart, but only to see if the
15 pericardiocentesis procedure was going smoothly.

16 And, therefore, when he finally did the
17 pericardiocentesis or when the heart finally did start
18 beating, he has no reason why the heart, basically, wasn't
19 freed up earlier and why Neil Dechambeau was out of oxygen
20 for 15 minutes.

21 The problem with Dr. Smith's story, as Dr. Seifert
22 will testify, in the first place, you shouldn't be doing
23 pericardiocentesis with a needle while someone is on top of
24 his chest, pumping his chest, because you have an extreme

1 risk of lacerating the heart with the needle.

2 Number two, he's going to tell you that there was
3 no reason to call for a stat echo, because Dr. Smith already
4 had what they call an intracardiac echo catheter in the heart
5 cavity that was put in way before the cardiac arrest was
6 called. And all he had to do was adjust that catheter a
7 little bit, he could have looked in there, he could have seen
8 that he had a cardiac tamponade, and then he should have done
9 the pericardiocentesis within seconds. But he says by
10 ordering the stat echo, it was totally unnecessary, and
11 that's why the story starts to fall apart.

12 We're going to see that also Dr. Smith has what
13 they call a progress report and we'll show you that progress
14 report. It's Exhibit 11. And this is what he said right
15 after the operation.

16 Can't make it any bigger? There you go. At the
17 end of the ablation, the patient had evidence of some
18 hemodynamic compromise, that means cardiac arrest, with
19 hypotension and some brachycardia. Stat echogram was
20 performed, which showed a fairly large pericardial effusion.
21 CPR was also performed for approximately ten minutes. We
22 removed approximately 300 milliliters from frank blood from
23 the pericardial space after doing a pericardiocentesis.
24 Please note that there was approximately 5 to 10 minutes of

1 CPR. The patient also received pressors from the
2 anesthesiology, including epinephrine, atropine, bicarbonate.
3 Patient also received reversal of his heparin. CT surgeon
4 was consulted, who felt that the patient was having no
5 further bleeding, and there no significant pericardial
6 effusion seen on the transthoracic echocardiogram. That's
7 the one he sent out for in the end.

8 You can see right after the operation, Dr. Smith
9 is giving this a sequence of events, and the last event there
10 is a pericardiocentesis after he observed the effusion in the
11 pericardium.

12 If that is true, and that is what Dr. Smith said
13 in his report, then he was negligent. He needed to get that
14 pericardiocentesis done prior to looking into that
15 echocardiogram and getting an image of a pericardial
16 effusion.

17 So I think you'll see that there's other experts
18 that agree with Dr. Seifert. You'll be hearing something
19 from them, too. And after all the evidence is in, I think
20 you'll see what happened was Dr. Smith simply didn't pay
21 attention. He didn't know what he was doing.

22 You'll hear him testify that this was the first
23 time this had ever happened to him. So he really wasn't
24 prepared for this kind of an emergency.

1 If you agree with us, we'll be asking you to
2 compensate us for a number of items, one of which is the loss
3 of earnings of Mr. Dechambeau as a truck driver and also as
4 an accountant. And we'll be asking for the loss of
5 consortium, love and affection that Mr. Dechambeau would have
6 provided to his wife of 25 years and his son Jean Paul.

7 Insofar as the -- do we want to address the legal
8 aspect of this will now? I'll be happy to do that.

9 MS. POLLARA: Your Honor, I don't think that's
10 appropriate at this point.

11 MR. KOZAK: Okay. I agree. That's all we have.

12 THE COURT: Thank you very much, Mr. Kozak. Ms.
13 Pollara.

14 MS. POLLARA: Thank you, your Honor. Ladies and
15 gentlemen, thank you very much for your attention. And as
16 Judge Flanagan touched upon this morning, and as you've
17 heard, this is a legal malpractice case against my client,
18 Steve Balkenbush, who is here with me, and his law firm.

19 And by way of brief introduction, Mr. Balkenbush
20 has been a lawyer in Reno since 1978. He began first working
21 for the State of Nevada and then worked as an assistant DA in
22 Douglas County before he went into private practice with the
23 firm that he's with. And I won't say anything more about
24 that. You may hear from him next week.

1 In 2006, Mrs. Dechambeau came to Mr. Balkenbush,
2 because her husband had died at Renown following a heart
3 procedure that was performed on him by Dr. Smith and she
4 asked him to investigate that case with regard to a possible
5 lawsuit against him, against Dr. Smith, and perhaps others
6 who were involved in that procedure.

7 So we're not going to get into the details of that
8 representation now, except to say that Mr. Balkenbush did
9 bring a lawsuit and Mrs. Dechambeau and her son Jean Paul
10 Dechambeau are upset with him as to the manner in which he
11 handled that case.

12 However, as you know, the first part of this case,
13 the reason that we're here now is to talk with you about the
14 medical malpractice lawsuit with regard to Dr. Smith. And so
15 as the judges of the facts in this case, it is your job first
16 to focus on that part of the case and really look at what I
17 would say is what's going to go into the box of evidence with
18 regard to the -- is it on?

19 What we're going to do first is we're going to
20 focus on this box of evidence with regards to the medical
21 malpractice case. And at the end of the evidence in this
22 case, you're going to hear from some witnesses, and when
23 you're done with collecting all of that evidence here in the
24 box, then Judge Flanagan will instruct you as to the law and

1 you will go back and deliberate on the medical malpractice
2 case and you'll apply the law that the judge gives you to the
3 facts as you find them in the medical malpractice case.

4 So you'll basically take that box of evidence into
5 the deliberation room and you'll consider this part of the
6 case and hopefully arrive at a verdict.

7 And then depending on that verdict, you may or may
8 not get to the legal malpractice part of the case. And that,
9 of course, is up to you. If you conclude in this case that
10 Dr. Smith wasn't a reasonable, prudent physician, that he's
11 guilty of malpractice, then you proceed to the second part of
12 the case. And we'll have another chance to talk with you
13 before we start that part of the case, if it makes sense.

14 And in that second trial, you'll hear from
15 witnesses, including, I'm sure, Mrs. Dechambeau and her son.
16 You'll hear from Mr. Balkenbush. You'll hear from various
17 experts with regard to that. And so really right now we're
18 going to focus on the first job that you have, which is the
19 medical malpractice part of the case.

20 So this is my opportunity now to just focus on
21 that and tell you what I think the evidence will show. And,
22 ladies and gentlemen, I believe the evidence will show you in
23 this case that Dr. Smith acted as a reasonable, as a prudent
24 cardiologist practicing under similar circumstances. And

1 while there is no question and there is no dispute here that
2 this is a very tragic situation, it's not one that anyone
3 would want to have happen to anyone, but I believe the
4 evidence will show you that in fact Dr. Smith is not at fault
5 for Mr. Dechambeau's death. And this was just an
6 unfortunate, unfortunate situation that occurred despite
7 everybody's best efforts, including by Dr. Smith.

8 Now, what I want to do is step back for a moment
9 and talk about some concepts and some terms that you're going
10 to hear over the next few days. Mr. Kozak mentioned a couple
11 of them, but I want to go back and really lay out some of the
12 chronology for you.

13 First of all, some of you may be familiar, this is
14 a case about cardiology or the heart. And the experts will
15 talk with you about this. I'm not a doctor, so I'll leave it
16 to them to describe it to you.

17 But your heart is basically made up of four
18 chambers. You have a left atrium and a left ventricle, you
19 have a right atrium and right ventricle. And there is an
20 electrical sensor, I will call it, it's call the sinoatrial
21 node, which, I believe, is in the right atrium and that
22 basically will trigger an electrical current through the
23 heart, which causes it to beat. And it causes the different
24 components of the heart to beat in a certain rhythm normally.

1 So everything depends on that current flowing
2 correctly through the heart in order to initiate the
3 heartbeat. And the reason that's so important is that if the
4 electrical current isn't working correctly, it can cause
5 problems.

6 So, normally, the heart will pump blood to your
7 lungs and the lungs will then provide oxygen to the blood and
8 then the heartbeat brings the blood back to the heart, and
9 now it's full of oxygen, and then another heartbeat occurs,
10 and it goes out to the body. It's a circuit, in essence, but
11 it depends on this electrical system working properly.

12 Now, there is a sack, you're going to hear a term
13 called the pericardium, it's also called the pericardial
14 sack. And peri just means around, cardium means the heart.
15 So it is a sack around the heart. And this is a thin
16 membrane, it's a tough membrane, and it basically is a sack
17 that the heart sits in. So you're going to hear that term
18 and that's a picture of the pericardium.

19 Now, you're also going to hear, and this is a
20 little bit hard to see, but really when the heart is beating
21 the right way, when it's beating effectively, you get oxygen
22 to the blood and then the blood goes out and it perfuses
23 everything so that you have oxygen going to all of the
24 tissue.

1 But as you can see in the right hand diagram, that
2 if that current isn't working properly, if it's like all over
3 the place or dysfunctional, then what happens is the atrium
4 then don't beat regularly like we can feel in our neck or you
5 can feel sometimes in your chest. What happens is the atrium
6 start beating too fast, and what happens, then, is the blood
7 is not effectively pumped out and so it becomes static in the
8 atrium so you have a very rapid heartbeat and the blood is
9 not moving effectively.

10 This is something that is uncomfortable at a
11 minimum. It is potentially dangerous if it is persistent and
12 it's not treated. The blood can clot in the atrium and those
13 clots can break off and go up to the brain and cause strokes
14 and other problems. So it is something that you want to pay
15 attention to. It is something that can be bad if it's not
16 treated appropriately.

17 So, now, let's talk about Mr. Dechambeau and what
18 I think the evidence will show you to him and his medical
19 condition leading up to September 7th of 2006.

20 Mr. Dechambeau, I think the evidence will show,
21 had suffered from atrial fibrillation for about 35 years.
22 This had been something he had had for as long as
23 Mrs. Dechambeau had known him. And what we know is that in
24 late 2005, and early 2006, his atrial fibrillation was

1 getting a lot worse.

2 And so he went to his primary care doctor,
3 Patricia Levan, and she referred Mr. Dechambeau to Reno Heart
4 Physicians in the early -- actually, it was in December of
5 2005 and then he began treatment at Reno Heart Physicians.
6 He first saw a cardiologist by the name of Ted Berndt. And
7 Dr. Berndt evaluated him, did a thorough evaluation. He was
8 very concerned about him.

9 He sent him to Dr. John Grinsell for additional
10 testing, including a stress echo, which looked at the heart
11 and the pumping mechanism. There were problems getting that
12 done, because when they hooked him up to the machine, he was
13 in atrial fibrillation and you wouldn't want to do anything.
14 So there were some delays.

15 But they also tried adjusting his medications,
16 tried putting him on other medications. They actually put
17 him on a medication called Coumadin, which is a blood
18 thinner, because they wanted to try to keep him from
19 developing these clots. That was not something that
20 Mr. Dechambeau or his wife were happy with, because they has
21 potential side effects. When those medical management
22 attempts failed, then Dr. Berndt then referred Mr. Dechambeau
23 to Dr. Smith.

24 Now, Dr. Smith is not just a cardiologist, but he

1 also has specialized training in electrophysiology. So he is
2 a subspecialist in that area of medicine. And we'll talk a
3 little bit more about his background in a bit, but what
4 Dr. Smith did is he saw Mr. Dechambeau. They tried
5 additional medications. They tried to help him. Because
6 sometimes this can be treated adequately with medication.
7 And Mr. Dechambeau had terrible side effects from the
8 medication and caused a lot of fatigue, it was causing
9 problems with his truck driving, and so that was not working.

10 So after they tried altering the medications and
11 lowering the levels and his arrhythmia were happening at this
12 point sometimes every three days and sometimes up to 30 hours
13 at a time.

14 So at that point, Dr. Smith talked with
15 Mr. Dechambeau about having an atrial ablation. They
16 discussed the potential risks of that procedure, the benefits
17 of that procedure, the alternatives to that procedure. And
18 eventually Mr. Dechambeau decided he wanted to go through
19 with that procedure in an effort to try to deal with this
20 problem.

21 The surgery was scheduled for September 7th of
22 2006 and it was a procedure that happened in the cath lab at
23 Renown. So what is done is that this isn't a surgery where
24 they crack open your chest like they do with bypass surgery.

1 But they basically thread the small instruments up through
2 your femoral vasculature, which are the larger veins in your
3 legs and arteries in your legs, up and they thread them up
4 through the heart, it's pretty amazing. And then they work
5 in that way.

6 So they don't have the chest open where they're
7 looking with the heart, but they're working really looking at
8 electric pulses and electric mapping of the heart as they're
9 then locating where the abnormal signal is coming from. And
10 then they are cauterizing those different areas very
11 carefully to try to stop the abnormal pulse from going
12 through the heart muscle to make it so -- they try to get it
13 back on track, in essence.

14 And so what occurred in this case is that the
15 ablation procedure proceeded uneventfully. At the end of the
16 procedure, Mr. Dechambeau's blood pressure suddenly dropped,
17 his pulse rate disappeared, and at that point, the evidence
18 will show, ladies and gentlemen, that Dr. Smith recognized
19 that there would be possibly a cardiac tamponade.

20 So what I want to do now is let's talk about what
21 that means. So, normally, you can see on the left hand
22 picture the pericardium is around the heart and that sack
23 around the heart. But if there's fluid that gets around the
24 heart and that sack, that causes a pericardial effusion.

1 Now, a pericardial effusion is nothing more -- it
2 just simply means fluid around the heart. That's what a
3 pericardial effusion is. Depending on the person, you can
4 have a little bit of fluid and have too much pressure in that
5 sack, which makes the heart have problems beating, or with
6 other people, their sack may be larger, everybody is
7 different, so you can have actually much more blood in that
8 sack and have the heart still be able to beat for a period of
9 time before it stops.

10 But what happens is that pressure builds up in
11 that sack, because you have blood there, and it keeps the
12 heart from beating effectively. That's what a cardiac
13 tamponade is. So a cardiac tamponade can be caused by a
14 pericardial effusion. The fluid in that sack builds up the
15 pressure so the heart can't beat properly. All right.

16 So what you will hear, you've heard another term,
17 and I like to keep my diagrams so they're showing real life
18 stuff here. But, basically, the other term you're going to
19 hear is a pericardiocentesis.

20 And what that is, is the physician when they
21 diagnose a cardiac tamponade, they will take a needle, and
22 they will direct it into the pericardial sack, hopefully, to
23 draw blood out or fluid out of the sack to alleviate the
24 pressure.

1 So the pericardiocentesis is done to try to remove
2 that fluid from the pericardial sack and relieve that
3 pressure so that the heart can then beat more normally or
4 hopefully it's normally.

5 So those are the different terms that I believe
6 you're going to hear from the witnesses that may be helpful
7 for you to get just a little visual picture of now.

8 So the evidence will show in this case, ladies and
9 gentlemen, that Dr. Smith immediately recognized that there
10 was a cardiac tamponade. And I believe the evidence will
11 show that he immediately took steps to perform a
12 pericardiocentesis in this case.

13 Unfortunately, by the time enough fluid was
14 removed from that pericardial sack, enough time had gone by
15 that he did not have enough oxygen circulating and he
16 suffered a serious severe neurologic injury and,
17 unfortunately, he passed away the next day.

18 Now, what you may be surprised to hear is that
19 before we get here, before we end up bothering all of you and
20 taking time out of your life to be here, the lawsuit has been
21 going on for quite some time.

22 And what occurs during the pendency of a lawsuit,
23 particularly in a medical malpractice lawsuit, is that
24 records are collected and those records are examined, experts

1 are hired for input and expertise with regard to what the
2 records show. Sometimes depositions are taken to discover
3 more information. And through that process, there are
4 determinations that are made as to what is in dispute and
5 what is not in dispute in the case.

6 And so as judges of the facts, it may be helpful
7 for you to know that although the chronology of events that I
8 just gave you is super long and you're probably going, oh, my
9 gosh, how do I follow this? There really are many things
10 about this case about which there is no dispute. In other
11 words, there's agreement between the parties about many
12 things in this case.

13 And so I think it might be helpful to tell you
14 what I think the evidence will be about which there's no
15 dispute or no beef. All right.

16 So there is no dispute in this case that Dr. Smith
17 is a well-trained cardiologist and a well-trained
18 electrophysiologist. There's no dispute about that in this
19 case, ladies and gentlemen.

20 There is no dispute in this case that
21 Mr. Dechambeau was an appropriate candidate for the atrial
22 ablation surgery. The parties agree that he was an
23 appropriate candidate.

24 There is no dispute in this case that

1 Mr. Dechambeau was provided with appropriate informed
2 consent. That he knew going into this what the potential
3 risks, what the benefits of the procedure was, what the
4 alternatives were, and that he consented after he knew those
5 things.

6 There is no dispute in this case that the
7 procedure itself, the atrial ablation procedure performed by
8 Dr. Smith was performed appropriately. And I believe you
9 will hear the plaintiff's expert tomorrow admit all of these
10 things. So I don't think there's going to be any dispute
11 about that.

12 And, lastly, there will be no dispute that cardiac
13 tamponade, which is what Mr. Dechambeau eventually had at the
14 end of this procedure, that complication, there is no dispute
15 that is a recognized complication of this procedure and it
16 happens to physicians with the best of hands. It's
17 something, unfortunately, that is known to happen.

18 So you're probably sitting there, and you might be
19 asking yourself, well, why are we here? And you did hear a
20 little bit from Mr. Kozak about this, but, in fact, I believe
21 that the only material issue that is in dispute in this case
22 is that the plaintiffs, Mrs. Dechambeau and her son, contend
23 that in this emergency situation, Dr. Smith did not perform
24 the pericardiocentesis in a timely fashion, that he didn't

1 perform it rapidly enough after the cardiac tamponade
2 occurred. I think that's what you're going to hear is the
3 only issue in this case as judges of the facts that you're
4 going to be faced with regard to the standard of care. And
5 so that, ladies and gentlemen, is the entirely focus of this
6 lawsuit.

7 Now, we believe, obviously, that the evidence is
8 different, and so, obviously, as judges of the facts, you are
9 the ones that will be finding those facts. But I would
10 contend and offer that the evidence will show that Dr. Smith
11 timely and appropriately recognized the fact that
12 Mr. Dechambeau had a cardiac tamponade and that he
13 immediately undertook to perform a pericardiocentesis in this
14 case.

15 I just wanted to take a moment and give you a
16 brief time line in this case so just focus a little bit more.
17 So what we know in this case is that Mr. Dechambeau was taken
18 into the cath lab shortly before 8:00 in the morning. And as
19 I explained to you before, I believe the evidence will show
20 that the procedure, there's a lot of things that need to
21 happen, they have to put catheters in and things like that
22 before they start to do the ablation. But throughout the
23 entire course of that time up until shortly before 1:00,
24 there's no dispute that everything was done appropriately,

1 that everything was done properly for Mr. Dechambeau.

2 So really what we're focusing on here is we're
3 focusing on a time frame starting at 12:39 p.m., which is
4 when the record shows, the code sheet shows that
5 Mr. Dechambeau lost his blood pressure, there was no pulse
6 detected, and the notation that is on the record says, CPR
7 started, no pulse detected. You'll see that record. That's
8 on the cath lab log, which is one of the records you will
9 see.

10 You will see on the code sheet, and the code blue
11 sheet is a separate sheet. I want to take a moment and talk
12 to you about that. So when there is a code that is called,
13 what happens in that case is everybody in the room jumps in
14 to help, except one person. There is a scribe. That scribe
15 is simply someone who is writing things down, because
16 everybody has their hands full, everybody is doing everything
17 they can for that patient as quickly as they can.

18 They're not saying, I'm sorry, Mr. Dechambeau, I
19 need to write this down. Right. They are doing everything
20 they can and they're not looking at the clock. But there is
21 one person there who is a scribe who is writing on the code
22 blue sheet. And you'll see that document in this record and
23 you'll see the handwritten notations from that person.

24 So on that code blue sheet, there is a notation up

1 at the top, and we'll show it to you, that says, cardiac
2 tamponade, 12:41. And, ladies and gentlemen, I believe the
3 evidence will show the only way that one would know that is
4 for Dr. Smith to call out or make some comment about that,
5 because the person who is writing things down doesn't have
6 the ability to make that type of diagnosis. So we know, and
7 I believe the evidence will show, that is when it was
8 diagnosed.

9 We know from other records, from the cath lab
10 records and from the code sheet that a pulse was detected at
11 12:54 and a few seconds. And so, really, when you're
12 focusing your attention as judges of facts in the case, this
13 is the time frame that you will be focusing on, all right,
14 during those moments.

15 Now, I know when we were talking this morning
16 about being on this jury and being judges of the facts, one
17 of the things we talked about, and I know Judge Flanagan has
18 mentioned it to you, is making sure to keep an open mind and
19 waiting until you've heard all of the evidence in this case,
20 because I don't get to go before the plaintiffs. As the
21 defense, we have to wait. We have a protocol that we follow.

22 And so you are going to hear from their experts
23 first. I believe it's Dr. Seifert tomorrow. And then after
24 they have rested their case, then we have the ability to call

1 people, witnesses and so forth. And why is it important for
2 you to wait until you hear all the evidence before you form
3 any opinions in this case? On Thursday morning, if
4 everything goes as planned and we don't end up getting
5 flooded here in the Courthouse, because I think there's
6 another weather front coming in, you're going to hear from
7 Dr. Smith.

8 Dr. Smith is going to come in and testify on
9 Thursday morning and you're going to hear from him. He's
10 going to talk with you about a number of different things,
11 about the chronology of events and about Mr. Dechambeau. And
12 there is no dispute, ladies and gentlemen, that's probably a
13 younger picture of him, but you'll hear from him that he
14 graduated from New York University Medical School in 1988.
15 He then completed -- and I'm sorry that's a little bit small
16 for you to see. He completed a three-year internship
17 residency in internal medicine. He did that at University of
18 California, San Diego.

19 He then went and did a fellowship, which is
20 additional special training in cardiology. He did that at
21 Harbor UCLA Medical Center. He completed that in 1995. And
22 then on top of that, he did an electrophysiology fellowship,
23 that's more training, especially in electrophysiology, he did
24 that at Stanford and he finished that in 1996.

1 I believe he will testify here in court like he
2 did in his deposition that he immediately diagnosed
3 Mr. Dechambeau as having a cardiac tamponade. He immediately
4 asked the entire team that was there helping him to jump into
5 action. He immediately asked for the pericardiocentesis
6 tray, which is there in the cath lab. It's a tray that has
7 certain equipment on it. So it's there, it's available. And
8 that he will testify that he immediately took steps to
9 perform the pericardiocentesis.

10 And I ask you, ladies and gentlemen, to listen
11 very carefully to what he says and what he says about what he
12 did, when he did it, why he did it, during the course of this
13 procedure. And, you know, ladies and gentlemen, he's the
14 only person that you're going to hear from that was actually
15 there, that was in that room taking care of this patient.

16 Now, you're also going to hear from Dr. Hugh
17 Calkins in this case. He's an expert witness from Maryland.
18 He is a cardiologist and electrophysiologist, like Dr.
19 Seifert, like Dr. Smith. He graduated from Harvard Medical
20 School in 1983.

21 He then completed his internship residency in
22 internal medicine at Massachusetts General in 1986. And then
23 he did a fellowship in cardiology at Johns Hopkins where he
24 is back practicing now. He completed that in 1986. And then

1 he did a fellowship in electrophysiology at the University of
2 Michigan. He completed that in 1990.

3 He is board certified in all of those specialties,
4 as is Dr. Smith, and he's the professor of cardiology, and
5 he's the director of the arrhythmia service in the
6 electrophysiology lab at Johns Hopkins. He's actually
7 authored a number of different guidelines and so forth in the
8 area.

9 Dr. Calkins will testify that Dr. Smith met the
10 standard of care in all respects, that he acted reasonably
11 and prudently in how he cared for Mr. Dechambeau up to the
12 code and through the code and everything he did in taking
13 care of him. He will testify that Dr. Smith did not delay in
14 performance a pericardiocentesis, that he did everything in
15 his power to try to help Mr. Dechambeau.

16 He's going to talk with you in detail about his
17 opinions. I'm not going to get into the details now. But he
18 will explain to you why in his opinion to a reasonable degree
19 of medical probability Dr. Smith is not guilty of medical
20 malpractice in this case and that he acted reasonably and
21 prudently.

22 And, ladies and gentlemen, I believe when we're
23 done here, I'm going to come back and talk with you again,
24 and at that point, I will ask you to go back and deliberate

1 and I believe when you review all the evidence, you will
2 conclude that the weight of the evidence is that Dr. Smith
3 acted appropriately in this emergency situation and he was
4 not negligent. Thank you, your Honor.

5 THE COURT: Thank you, Ms. Pollara.

6 Ladies and gentlemen, you've had a long day and
7 we're going to break tonight right here. That will give me
8 an opportunity to talk with counsel a little bit. We'll
9 start at 9:00. Remember the admonition. Don't talk about
10 this case amongst yourselves or anybody else. Don't allow
11 anybody else to talk to you about the case. Don't form any
12 conclusions until the case has been submitted to you. Don't
13 conduct any independent investigation, any independent
14 experiments. Don't read any newspaper account, listen to any
15 radio, television, engage in any social media. Keep an open
16 mind. I'll see you tomorrow at 9:00.

17 (The following proceedings were had outside the
18 presence of the jury.)

19 THE COURT: We've got some time. I thought I'd go
20 over our calendar. Who do we start off with tomorrow, Mr.
21 Kozak?

22 MR. KOZAK: Dr. Seifert.

23 THE COURT: How long do you think he could be?

24 MR. KOZAK: He could be quite a while. I think

1 probably a couple of hours with him.

2 THE COURT: Okay. And let's just say it takes us
3 to noon. Let's say it's about three hours. Who is next
4 after that?

5 MR. KOZAK: It will be Angela Dechambeau or Jean
6 Paul.

7 THE COURT: All right. Who else?

8 MR. KOZAK: It will be Richard Teichner on
9 damages. He's the damage expert.

10 THE COURT: I saw that. So let's say that might
11 be Thursday morning?

12 MR. KOZAK: Right.

13 THE COURT: Do you think he'll take all morning?

14 MR. KOZAK: It depends. He's been disposed. I
15 don't know how much more they want to cross examine him.

16 THE COURT: Okay. Anybody after that?

17 MR. KOZAK: I don't think so.

18 THE COURT: Okay.

19 MS. POLLARA: Your Honor, when I had previously
20 spoken with counsel, it's my understanding they thought they
21 would be done by the end of the day on Wednesday. Dr. Smith
22 has blocked his morning on Thursday morning. I think he has
23 patients all afternoon. So if counsel is going to be done
24 with their case with the exception of Mr. Teichner, I would

1 ask the Court's indulgence in taking Dr. Smith out of order
2 so that we can accommodate Dr. Smith. I did serve him with a
3 subpoena to be here in the morning on Thursday.

4 THE COURT: Any problem with that, Mr. Kozak?

5 MR. KOZAK: No.

6 THE COURT: Do you think he'll take all morning?

7 MS. POLLARA: I believe he'll take at least
8 several hours. And then as we discussed at the pretrial
9 conference, I do not have any other witnesses until Friday
10 morning when Dr. Calkins will be here first thing.

11 THE COURT: We can perhaps target Thursday evening
12 to work on jury instructions.

13 MR. KOZAK: I think we might have a problem with
14 Mr. Teichner.

15 MR. LUSIANI: He's not available Thursday
16 afternoon, your Honor.

17 MS. POLLARA: Is there any way they could call him
18 tomorrow afternoon?

19 THE COURT: Can we substitute him in for perhaps
20 Jean Paul?

21 MR. KOZAK: Tomorrow afternoon. He is not
22 available tomorrow afternoon. He can be here, but it would
23 be after 2:00.

24 THE COURT: Let's see if we can squeeze him in

1 there. We'll get a jury instruction packet to you tomorrow.
2 Let's go through it Thursday afternoon or evening. And that
3 will give us Friday morning with Dr. Calkins. Can we get to
4 closing arguments by 1:00 Friday afternoon?

5 MS. POLLARA: I believe we should be able to get
6 to closings in the morning, your Honor. I don't belabor
7 things and I don't know what counsel has in mind for Dr.
8 Calkins, but I try to move with alacrity.

9 THE COURT: Will he be your last witness?

10 MS. POLLARA: Yes.

11 THE COURT: Okay.

12 MR. KOZAK: Do my best. We don't know what Dr.
13 Calkins is going to say. We don't know. That's been the
14 subject of much disputation in this case.

15 THE COURT: Understood. All right. We'll work
16 with counsel and we'll get that packet to you tomorrow. I
17 appreciate the hard work everybody has put in in this case on
18 behalf of your clients. I appreciate the good work you've
19 done in presenting this case to the jury so far. This is a
20 complicated case and I thought the attorneys have done a good
21 job in explaining it to the jury. All right. Do we need to
22 pick up anything before we meet tomorrow morning?

23 MR. KOZAK: Not that I can think of.

24 THE COURT: Ms. Pollara.

1 MS. POLLARA: We did meet and confer on jury
2 instructions and I believe we submitted a joint set. I
3 believe we have a dispute over three jury instructions that
4 plaintiff's counsel has requested. Hopefully, Ms. Oates has
5 a set we provided in Word format so it might make the Court's
6 job a little bit easier.

7 THE COURT: I look forward to that. Anything
8 further?

9 MR. KOZAK: No.

10 MS. POLLARA: Nothing further.

11 THE COURT: Court's in recess.

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1 STATE OF NEVADA)
2 County of Washoe) ss.
3)

4 I, STEPHANIE KOETTING, a Certified Court Reporter of the
5 Second Judicial District Court of the State of Nevada, in and
6 for the County of Washoe, do hereby certify;

7 That I was present in Department No. 7 of the
8 above-entitled Court on January 17, 2017, at the hour of 9:30
9 a.m., and took verbatim stenotype notes of the proceedings
10 had upon the trial in the matter of ANGELA DECHAMBEAU, et
11 al., Plaintiff, vs. STEPHEN C. BALKENBUSH, et al.,
12 Defendant, Case No. CV12-00571, and thereafter, by means of
13 computer-aided transcription, transcribed them into
14 typewriting as herein appears;

15 That the foregoing transcript, consisting of pages 1
16 through 45, both inclusive, contains a full, true and
17 complete transcript of my said stenotype notes, and is a
18 full, true and correct record of the proceedings had at said
19 time and place.

20 DATED: At Reno, Nevada, this 31st day of May 2017.

21
22 S/s Stephanie Koetting
23 STEPHANIE KOETTING, CCR #207
24

EXHIBIT 3

EXHIBIT 3

1 4185
2 STEPHANIE KOETTING
3 CCR #207
4 75 COURT STREET
5 RENO, NEVADA
6

7 IN THE SECOND JUDICIAL DISTRICT COURT
8 IN AND FOR THE COUNTY OF WASHOE
9 THE HONORABLE PATRICK FLANAGAN, DISTRICT JUDGE

10 --oOo--

11 ANGELA DECHAMBEAU, et)
12 al.,)
13 Plaintiffs,) Case No. CV12-00571
14 vs.) Department 7
15 STEPHEN BALKENBUSH, et)
16 al.,)
17 Defendants.)

18 TRANSCRIPT OF PROCEEDINGS

19 TRIAL

20 VOLUME II

21 January 18, 2017

22 9:00 a.m.

23 Reno, Nevada

24 Reported by: STEPHANIE KOETTING, CCR #207, RPR
Computer-Aided Transcription

1 APPEARANCES:

2 For the Plaintiff:

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1 RENO, NEVADA, January 19, 2017, 9:00 a.m.

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3 --oOo--

4 THE COURT: Good morning, ladies and gentlemen.
5 My apologies. The computer went down, so we had to work on
6 that before we started. Will counsel stipulate to the
7 presence of the jury?

8 MR. KOZAK: Yes, your Honor.

9 MS. POLLARA: Yes, your Honor.

10 THE COURT: Mr. Kozak, your next witness.

11 MR. KOZAK: Thank you, your Honor. Call Mark
12 Seifert, your Honor.

13 (One witness sworn at this time.)

14 MARK SEIFERT

15 called as a witness and being duly sworn did testify as

16 follows:

17 DIRECT EXAMINATION

18 BY MR. KOZAK:

19 Q. Good morning, Dr. Seifert.

20 A. Good morning.

21 Q. Dr. Seifert, first of all, I want to go over your
22 educational background. Can you tell us where your medical
23 training started?

24 A. I started at Johns Hopkins Medical School in

1 Baltimore, Maryland.

2 Q. Then what was your next step?

3 A. When I graduated in 1990, I went to the University
4 of Michigan Medical Center, Ann Arbor, where I did a
5 three-year internal medicine residency.

6 Q. Was there any particular doctor that was
7 supervising your residency there?

8 A. It was a variety of doctors that would change
9 typically on a monthly basis, but in one month it was
10 actually Dr. Calkins.

11 Q. Is this the Dr. Calkins we expect to see later in
12 this case?

13 A. Correct.

14 Q. And then what did you do?

15 A. After I finished the internal medicine residency,
16 I went to Boston where I was at Harvard at the Beth Israel
17 Hospital for a general cardiology fellowship, which is
18 generally a three-year program. The last year of my general
19 cardiology fellowship was essentially exclusively arrhythmia
20 training.

21 And a separate board exam for arrhythmias just
22 became required in this time frame and became the first
23 subspecialty of cardiology that required a fourth year. And
24 so I went across the street to Brigham and Women's Hospital,

1 another Harvard teaching hospital, for a fourth year of
2 training that was also exclusively electrophysiology.

3 Q. What is electrophysiology?

4 A. In a general sense, electrophysiology is medical
5 care of the heart that involves rhythm issues. So we're, if
6 you will, essentially, like electricians. If we think of
7 people who do angioplasty and stints and open arteries as
8 dealing with plumbing issues with the heart, and there are
9 people who specialize in high blood pressure medications and
10 treatments and cholesterol, one would think of someone who
11 does what I do for a living as largely taking care of the
12 electrical issues of the heart.

13 Q. What are some of those issues?

14 A. Atrial fibrillation, as in this case, is certainly
15 one of them. There are a myriad of other fast rhythms that
16 can arise from the upper chamber, which are typically not
17 life-threatening. Many of them are curable with catheter
18 ablation, where we go up into the heart and cauterize the
19 area that is causing the problem.

20 We deal with fast heart rhythms from the lower
21 chamber that can sometimes be life-threatening. We generally
22 treat those with implantable defibrillators, which shock the
23 heart, much like an ambulance crew could in a code situation.

24 For rhythms that are too slow, we often implant

1 pacemakers. And for patients with different rhythm issues,
2 we may also use medicines to treat heart rhythm issues.

3 Q. Where did you go after the University of Michigan?

4 A. After the University of Michigan was Boston for
5 cardiology training.

6 Q. And then after that?

7 A. After that, I took a job in Nevada in Las Vegas.

8 Q. What were you doing there?

9 A. I was a cardiologist and electrophysiologist with
10 a mix of general cardiology and electrophysiology.

11 Q. After that?

12 A. In the late '90s, I went to the Los Angeles area
13 and stayed there until 2004, also in private practice as an
14 employee.

15 Q. And where are you now?

16 A. Now, I'm in Phoenix, Arizona where I went in 2004
17 and I was with a large practice called Arizona Heart
18 Institute where I was an employed doctor. They unfortunately
19 went through bankruptcy and I switched to a different private
20 practice in town, which has since been purchased by a
21 hospital network. So, again, I'm employed by a hospital
22 network. And for the last 12 or 13 years, I've essentially
23 done no general cardiology at all and limited my practice to
24 solely electrophysiology.

1 Q. This case involves catheter ablation, is that
2 right?

3 A. Correct.

4 Q. Can you demonstrate what exactly is involved with
5 a catheter ablation?

6 A. Do we have a board?

7 Q. Yes, we do. Right here.

8 THE COURT: You want to put it on the easel?

9 MR. LUSIANI: May I?

10 THE COURT: Yes, you may.

11 MS. POLLARA: Your Honor, do I get your permission
12 to move to another location?

13 THE COURT: Certainly.

14 MS. POLLARA: Thank you.

15 BY MR. KOZAK:

16 Q. So to understand what happens in a catheter
17 ablation to correct an abnormal rhythm, we first have to
18 understand what the normal rhythm is. So I'm going to try to
19 draw as best I can what the heart looks like.

20 So the heart has four chambers and some of my
21 later drawings will be a little more diagrammatic, just four
22 squares for simplicity.

23 THE COURT: Doctor, just a minute. Would it be
24 easier over here, Ms. Pollara?

1 MS. POLLARA: I think it would.

2 THE COURT: We have a chair as well.

3 MS. POLLARA: Thank you.

4 THE WITNESS: With my limited artistic ability, I
5 would like to draw it a little more realistically at least
6 for the first drawing. This is the first way you would see
7 it on my body. So even though this is the left side of the
8 page, this is the right side of the heart. This is the
9 patient looking at the jury.

10 Blood runs in the veins from the head and neck and
11 arms through the superior vena cava, and from the legs and
12 abdomen and body and other organs through inferior vena cava
13 to the right upper chamber of the right atrium. This blood
14 doesn't have oxygen. So we need it to get oxygenated.

15 The right atrium squeezes and it fills the right
16 ventricle, a low pressure vessel, which is why I've drawn the
17 wall a little thinner as it is in real life. And this
18 chamber pumps to one place and one place only and that's the
19 lungs. It pumps to the lungs through the pulmonary artery,
20 which will be the front of this structure, so the blood can
21 pick up oxygen.

22 Once the blood picks up oxygen, which is what we
23 really want to pump around the body, it comes back through
24 these four veins in the left upper chamber, the left atrium,

1 now oxygen-rich. This chamber squeezes and fills the thick
2 left ventricle, the main pumping chamber of the heart. From
3 there when that squeezes, it goes out to aorta artery. Some
4 branches feed back on the heart muscle to feed the muscle
5 that is working so hard. And the rest goes to the brain, the
6 muscles and organs so that they get oxygen. And then when
7 it's drained of oxygen, it comes back through the vena cava.

8 And so that's the plumbing. Of course, I'm not a
9 plumber. I'm an electrician. So what is going on
10 electrically is a little different. The heart has its own
11 built-in pacemakers. We've heard of artificial pacemakers
12 that physicians like myself or others might implant. But we
13 come from the manufacturer with a pacemaker and it lives high
14 up in the right upper chamber. It's called the sinus node.
15 We call the normal rhythm normal sinus rhythm.

16 That will fire every second, 60 times a minute, if
17 we're healthy and relaxed and calm. If we're scared or
18 exercising or in pain or ill where our blood pressure is low,
19 it might go faster as the signals spread through both upper
20 chambers and they contract together to fill the lower
21 chambers. Even though the blood is a circuit going right and
22 then to the lungs back to the left then to the body,
23 electrically all the chambers they contract simultaneously.

24 The valves that connect the upper and lower

1 chambers, the tricuspid valve on the right, the micro valve
2 on the left, they're surrounded by some fibrous insulating
3 tissue, not muscle. So the signal can't pass by the valve.
4 It has to go through a special conduction fiber between the
5 atrium and the ventricle called the AV node. And it has a
6 small delay, a little less than a fifth of a second.

7 And so the upper chambers squeeze, there's a pause
8 while the lower chambers fill, because they have to be full
9 to do any pumping. They can't pump empty. And when the
10 signal gets to the lower chambers, they squeeze.

11 A number of different things can occur to
12 interfere with this correct pattern. So there's a number of
13 different fast rhythms, which we collectively refer to as --
14 these words are kind of long winded -- I apologize for
15 that -- but the jargon is supraventricular tachycardia. It
16 means above the ventricles. The ventricles are where we
17 sometimes see life-threatening rhythms. Supraventricular
18 tachycardias generally arise from higher up and tachycardia
19 simply means fast heart rate.

20 The most common is conduction in fibers near the
21 AV node where the signal goes slowly across the direction of
22 the fiber and it goes fast in the wrong direction around the
23 AV node. Of the seven or eight different kinds of fast
24 rhythms we might see, this probably accounts for 40 or

1 50 percent of them. So very common.

2 If this rhythm is present, we try burning higher
3 up in this circuit. But the incidence of no signals getting
4 to the lower chamber when that was first tried in the late
5 '80s, early '90s was high, patients needed pacemakers.

6 Since then, we started burning down on this area,
7 which we call a slow pathway, which seems to have a very high
8 cure rate in the range of 90 to 95 percent for this rhythm
9 with a low incidence of needing a pacemaker, perhaps one
10 percent.

11 Another less common, but more easily understood
12 way that we can have one of these SVT rhythms or
13 supraventricular tachycardia is when the fetus is developing,
14 a fiber grows across this insulation. We call this an
15 accessory pathway. This was the first rhythm that we could
16 really cure. Originally, when I was medical school, it was
17 open chest surgery.

18 So in an accessory pathway, an extra beat might
19 come down the lower chamber, conduct through the ventricle,
20 go up the accessory pathway to the upper chamber, back down
21 through the AV node and around and around in a circle.

22 In the '80s, cardiac electrophysiologists were
23 diagnostic specialists. Patients who had tried many
24 different medicines and were having lots of problems and were

1 still not well-controlled with their rhythms might elect to
2 have open chest surgery for a rhythm that is not a
3 life-threatening rhythm, basically.

4 And a physician like me would say, well,
5 Mr. Surgeon, that's where the problem is and the surgeon
6 would cut that area with a scalpel blade and then sew the
7 heart back up. It was open heart surgery, big surgery, long
8 recovery, some risks.

9 In catheter ablation, we might address this by
10 coming up the heart with a catheter, which is a plastic tube,
11 if you will, that has wires in it and applying an electrical
12 current to that area and burning it. And these procedures
13 now are often outpatient procedures.

14 So we've gone from open chest surgery, the last
15 thing that a patient with a nonlife-threatening problem might
16 really consider doing for an arrhythmia that may be
17 bothersome, but is very unlikely to kill them, to one of the
18 first things we do.

19 In atrial fibrillation, the rhythm in this
20 patient, there are many different things that can trigger
21 atrial fibrillation. But we believe the majority of the
22 triggers come from these pulmonary veins. And while the
23 drawing looks like the pulmonary veins are tubes that insert
24 into the upper chamber, in biological systems things a little

1 more complicated than they appear at first glance, and these
2 pulmonary veins are often covered in an outer sheathe of
3 muscle fibers and they can fire electrically. And they can
4 fire electrically and the signals can conduct from muscle
5 fiber to muscle fiber into the upper chamber. And it can
6 essentially pace the atrium into fibrillation.

7 So we think of these areas that are firing as
8 triggers. The atrium generally has to be a little abnormal
9 to sustain the fibrillation as well. There's a process where
10 some scar cells what we call fibrous tissue grows into the
11 atrium as we age and that's why older patients have a higher
12 incidence of the atrial fibrillation than younger patients.
13 It's about four percent over age 65, about 10 percent over
14 age 80. There can be other triggers, but we think about
15 75 percent of them come from the pulmonary veins.

16 So as a general rule in atrial fibrillation
17 patients where the rhythm comes and goes and they don't seem
18 to have a lot of structural heart abnormalities, our first
19 approach is come from the vena cava through the legs,
20 puncture the dividing wall of the heart with a long needle,
21 this has some risk, because we don't want to puncture the
22 heart, and enter the left atrium.

23 And then we make burns in circles around each of
24 these veins, which we call Y area. We don't want to be deep

1 in the vein. We want to be farther out in its broader funnel
2 like area. The reason for that is if we burn deeply in
3 there, the vein can narrow and cause very difficult to treat
4 shortness to breath, if blood can't come back from the lungs.
5 So we do what we call wide area circumferentially, which
6 means we're going around in a big circle, pulmonary vein
7 isolation.

8 What we want to do is we want to create a thin
9 circular fence of scar through which electrical signals can't
10 pass so these triggers can occur, but they get blocked. And
11 that's generally our first approach to fibrillation. That's
12 what I understand was done in this case and that's what I
13 would typically do in a patient who had intermittent
14 fibrillation in the absence of any other significant heart
15 issues that we were trying to treat, because perhaps drugs
16 weren't tolerated or perhaps drugs didn't work. Rarely,
17 because the patient simply prefers a procedure with its
18 attendant risks to long-term treatment with medications.

19 BY MR. KOZAK:

20 Q. Doctor, have you reviewed the medical records of
21 Neil Dechambeau in this case?

22 A. I have.

23 Q. Was this catheter ablation appropriate?

24 A. It was. The patient had symptomatic fibrillation.

1 We generally do not do such a procedure in patients without
2 symptoms. The patient had tried medications and was still
3 having symptoms and this is an indication for the procedure
4 that I believe to be generally accepted.

5 Q. What are the risks of this procedure, doctor?

6 A. Well, again, the left side of the heart pumps
7 blood to all the organs, including the brain. If an air
8 bubble could enter the left upper chamber, it could cause a
9 stroke. If a clot could form on our catheter, it could cause
10 a stroke. If a clot forms while making out burn, it could
11 cause a stroke.

12 For that reason, as soon as we enter the left
13 upper chamber, we aggressively anticoagulate the patient with
14 a medicine called intravenous heparin so that clots are less
15 likely to form.

16 In addition, we're taking this long needle from
17 the leg up into the heart to puncture the dividing wall of
18 the heart. I've drawn it as a two dimensional picture, but
19 of course it's a three-dimensional structure. If as we're
20 making this puncture the needle is directed too far forward,
21 too far towards the back, or maybe too high up, or too far
22 across the heart, we could puncture the heart with the
23 needle.

24 Now, the heart lives in a fibrous sack called the

1 pericardium. There's a usually a couple of teaspoons of
2 lubricant fluids so the heart moves and beats, it can wiggle
3 without friction, which would irritate it. But if there's
4 bleeding in the sack, the sack can fill up with blood. And
5 if it fills up with blood, that can apply pressures on these
6 chambers, and if you will, squash them.

7 And so now I'm drawing what pericardial tamponade
8 would look like. The heart is being squashed by blood that
9 is collected.

10 Now, the heart has to do two things as a pump to
11 work well. Obviously, it has to squeeze to eject blood, but
12 between beats it has to pause and expand and relax to fill
13 with blood. And there's a very small amount of pressure
14 coming back through the veins to fill, just a few millimeters
15 of mercury pressure. Whereas the blood pressure in your arm
16 might be 120 millimeters of mercury.

17 However, if this fluid in the heart sack, the
18 pericardial fluid, pericardial tamponade, is pushing on these
19 chambers, that's exerting a pressure that counteracts the
20 pressure of the blood coming back through the veins and can
21 prevent the heart from filling. So the heart can be
22 squeezing, but if it's not filling and it's empty, there's no
23 forward flow of blood through the system, there's no blood
24 pressure systemically.

1 And when this occurs, we really have one goal. We
2 have to get rid of this blood. We can do some things to buy
3 us a couple of minutes of time. We can open up all the
4 intravenous lines wide open so that we increase the fluid
5 pressure. Maybe that will fight back against the pressure
6 from the fluid in the sack around the heart.

7 But medicines that generally increase the
8 contractility of the heart tend not to be helpful, because
9 weak contractility isn't the problem. It's filling.
10 Medicines to clamp down the blood vessels to increase blood
11 pressure, probably not going to be helpful.

12 The problem isn't that the blood vessels are too
13 dilated. They might be in an infection called sepsis. The
14 blood vessel tone is okay, the problem is these chambers are
15 empty. So we have to allow them to fill.

16 There's two things that really help with that.
17 It's not going to be CPR. It's not going to be medicines to
18 clamp the blood vessels down. It's not going to be medicines
19 to increase the contractility of the heart. The things that
20 are going to help is draining this fluid, and perhaps simply
21 as a temporizing measure to buy us a short amount of time
22 while we're doing this, opening up the fluids to increase the
23 filling pressure of the heart to combat the pressure
24 squeezing the heart.

1 Q. In this case, there was a code blue that was
2 sounded, is that correct?

3 A. Correct.

4 Q. What time was that?

5 A. It depends on which records we're looking at.
6 There are different people taking notes on different pieces
7 of paper at the time and the notes are not consistent with
8 respect to timing.

9 So if we look at the sheets that are labeled as
10 the event sheets or code sheets, this is labeled SB01246, it
11 says CPR started at 12:42. Now, is there a way to project
12 this for the jury?

13 Q. Yes. Can we have this projected? It's the code
14 sheet. I believe it's up there, doctor.

15 A. Before I do that, I want to explain a little bit
16 about how this procedure is done, because we talked briefly
17 about getting to the left upper chamber to perform these
18 pulmonary vein isolation burns to treat the afib.

19 But we often have x-ray equipment in the room.
20 Unfortunately --

21 MS. POLLARA: Excuse me, your Honor. There's no
22 question pending at this point for the witness.

23 THE COURT: Go ahead, Mr. Kozak.

24 BY MR. KOZAK:

1 Q. Would you explain what the x-ray function is to
2 the jury?

3 A. So there's a couple of ways to get into the left
4 upper chamber. One way is to look at x-rays. Unfortunately,
5 x-rays just show us the shadow of the heart. The heart
6 muscle isn't very radio opaque. It doesn't show up on x-ray
7 like metal or bone would.

8 And so we can see our needle pointing towards the
9 left side, and if we look from the right side of the body,
10 that's what it might look like. If we look from the left
11 side of the body, we might get a hint that the lower chamber
12 was here and we might see our needle going there.

13 But we can't really see where the dividing wall
14 is. So something what we often do is put a catheter into the
15 upper chamber, which has an acronym, because the terminology
16 always is difficult here, it's called an ICE catheter.
17 That's an acronym for intracardiac echo. It's an ultrasound
18 catheter, it's an ultrasound tool that actually fits on a
19 catheter, perhaps the size of a pencil in thickness, and
20 gives us ultrasound images from within the heart. And it can
21 beam ultrasound and give us an image of things that are soft
22 tissue that don't show up on x-ray so well.

23 And what we might see is the dividing wall between
24 the right and left upper chamber and we can use this to guide

1 our needle so we can visualize what's going on there. We can
2 also visualize if there's pericardial tamponade, we can see
3 or try to see that our needle is not hitting the outside wall
4 of the heart while we're doing the procedure, and if the
5 blood pressure drops, we might see that there's fluid between
6 the sack and the heart collecting.

7 And so we can do this with our intracardiac echo
8 ultrasound, or we can have a technician come to the room with
9 an ultrasound probe they put on the chest, just like pregnant
10 women have when they get ultrasounds of their pregnancies of
11 their fetuses, and they can beam images from an ultrasound
12 probe to give us a picture from the outside of the heart.

13 Q. Doctor, in looking at the --

14 A. So going back --

15 Q. Is that the code note?

16 A. That is the code note. So going back to the
17 original question before we explained how we do these
18 procedures. So on the left upper part of the code note is
19 denoted time and it says 12:42. The next column is blood
20 pressure, and the notation there, it's written kind of
21 vertically, it says, I believe per anesthesia.

22 THE COURT: Doctor, we have a pointer. It's a
23 Nevada pointer.

24 THE WITNESS: I'm a former Nevada resident. So it

1 says per anesthesia. So I take it that the person who is
2 filling out this note was simply deferring to the anesthesia
3 doctor to be documenting what the pressures were and we'll
4 see the anesthesia sheet in a moment.

5 Now, here is a column for respirations. These
6 procedures are often done with the patient under general
7 anesthesia and breathing through a respirator machine. I do
8 them with conscious sedation and the patients breathing on
9 their own, typically, but that may be a little less common.
10 So the respirations aren't charted specifically, because it's
11 noted that the patient is intubated and the machine is
12 breathing for them at a constant rate, presumably.

13 There's a column for the oxygen saturation, and,
14 again, the horizontal times are different times and there is
15 no oxygen saturation noted.

16 Now, the next column, it's very hard to see, it
17 says, rate, and then underneath the diagonal line, it says,
18 cardiac rhythm. And the only notation in this column is
19 tamponade, which is this condition of fluid building up
20 around the heart, exerting pressure on the heart, which often
21 will prevent it filling if it's a substantial amount of fluid
22 and will cause the blood pressure to drop very low.

23 Now, the next column is indicated to be for
24 defibrillation or synchronize. Sometimes we shock the heart,

1 timing the shock to a native heartbeat. Sometimes we do it
2 without timing it to a heartbeat, which we call asynchronous.
3 And the next word here is joules. This is the amount of
4 energy we might dial up the defibrillator to, to shock the
5 heart.

6 There are no energies or joules or defibrillator
7 notations. This seems to be filled out with another notation
8 of time. In the row that starts with 12:42, we seem to jump
9 back to 12:41, and then we have drug doses, epinephrine,
10 presumably one milligram, and then atropine, one milligram.
11 Again, epinephrine is a drug that can increase the heart
12 rate, that can increase the contractility of the heart, and
13 it can increase how tightly the blood vessels are squeezing
14 down, but it will not increase ventricular filling. Atropine
15 is a drug that speeds the heart up, but, again, it won't do
16 anything for ventricle filling, which is our real problem
17 with tamponade.

18 There are some columns for some other drugs, which
19 do not appear to be given, amiodarone, vasopressin, Narcan,
20 which is a medicine to reverse narcotics.

21 There is a column for IV site, presumably to chart
22 what fluids are going in. There are no fluids going in, at
23 least none that are charted here as being given.

24 And this is hard for me to read, the column

1 printed says, IV solution, but something is written over that
2 that is hard for me to decipher.

3 Then there's a column for dopamine, which is a
4 blank. That's another presser medicine. It squeezes down
5 the blood vessels, increases the heart contracting, perhaps
6 the rate. Amiodarone, none given.

7 So if we go along to 12:41, it says, CPR, and then
8 this notation of time, 12:42, another ampule of epinephrine,
9 another ampule of atropine, no pulse. I'm sorry. I'm
10 getting off the times. 12:41 is no pulse. So again, at
11 12:42, we get another ampule of epinephrine, another ampule
12 of atropine; 12:43, another one of each; 12:45, another one
13 of each. I'm sorry. This appears to say bicarb, which is
14 bicarbonate.

15 When people have a cardiac arrest or a low blood
16 pressure for a long time, a condition called acidosis can
17 occur. We can build up acid in the bloodstream. Much as an
18 athlete might complain of lactic acidosis after a lot of
19 exercise where their muscles aren't getting enough oxygen.
20 This can be dangerous and it's not uncommon in a
21 resuscitation, if we think the blood is becoming too acid, to
22 give some bicarbonate. I believe it says bicarb. It's a
23 little bit difficult to discern.

24 It looks like at 12:45, they gave some bicarb.

1 Then there's a couple of more entries of epinephrine,
2 atropine and bicarb again and then bicarb again with no times
3 noted at.

4 Then at 12:54, so we're, it looks like 13 minutes
5 from here, pulse detected, blood pressure detected, see
6 cardiac flow sheet. So we have CPR started at a time that's
7 not noted. And then at 12:41, there's a notation of
8 tamponade. Of course, the other column says 12:42.

9 We have blood pressures that are going to be
10 referred to on the anesthesia flow sheet. We don't see that
11 any fluid was given. We don't see that a pericardial drain
12 was inserted at a specific time, though a pulse was detected,
13 so I assume at or just immediately prior to this time, the
14 drain was in fact inserted.

15 BY MR. KOZAK:

16 Q. Would that be the pericardiocentesis drain?

17 A. Correct. So if we superimpose on this picture of
18 the heart being squashed by pericardial fluid, blood, that's
19 squeezing the heart and preventing it from filling, we have
20 the breast bone here and we have ribs.

21 Now, outside the heart is lung. We don't want to
22 stick a needle in the lung, because air could fill up the
23 cavity in the lung and squash the lung. The lung lives in
24 cavity that also has a few drops of lubricant fluid, and if

1 air leaks out of the lung and fills that cavity, the lung
2 becomes squashed and we can't get oxygen into the system.

3 So we start out right near the breast bone, just
4 under the lowest rib in what we call the xyphoid area. The
5 very bottom of the sternum bone is called the xyphoid. And
6 we direct the needle upward at probably a 30-degree or
7 45-degree angle, if the patient is lying flat on the table
8 down. If I'm up right, it would be superiorly, aiming
9 towards the left shoulder, because we don't want to go to the
10 right lung, we want to go into this sack before we hit lung
11 or anything else.

12 And once we get blood return, we want to verify
13 that we're in the right place. We can do this with
14 ultrasound. We don't want to have a needle that's inserted
15 into an actual cardiac chamber, because if you start draining
16 blood out of the system, you're losing fluid, losing
17 pressure, losing filling pressures in the heart that is going
18 to drive filling.

19 So the general paradigm for this is our needle is
20 advanced until we get a little blood return. We're sucking
21 on our syringe as we advance the needle. We do not want to
22 be doing CPR during this. CPR causes a lot of motion. CPR
23 also doesn't help fill in the lung. CPR squeezes, but it
24 doesn't generally help the heart fill. We need pressure in

1 the veins and we need a lack of pressure in the pericardial
2 space.

3 But if we're advancing towards the heart with a
4 needle and the heart is moving a lot, as that needle
5 encroaches on the heart, it can start slicing things. It's a
6 sharp needle. The heart has arteries on the outside of it
7 that feed blood to the heart muscle. If our needle slices
8 one of those, that could cause more blood to collect.

9 So as soon as we get into the sack where we think
10 we're in the right place, we're sucking blood, we get some
11 blood in our syringe, we say, uh-huh, we're in the
12 pericardial space, we think.

13 So if we have ultrasound immediately available or
14 if we have x-ray immediately available, both of which I
15 believe to have been the case, we insert a soft, floppy wire
16 into this sack. And we can visualize that with ultrasound
17 and see that it's outside the heart, or we can visualize it
18 with x-ray.

19 With x-ray, we want to make sure that it's not
20 curled up in a distribution that it's in one cardiac chamber.
21 We want to see this going all around the heart. There's no
22 cardiac chamber that does this. So if it's going all around
23 the heart, it has to be in the pericardial sack, the right
24 place.

1 Either using ultrasound or x-rays, once we verify
2 that our soft, floppy, nontraumatic wire is in the right
3 place, we pull the needle out, and over the wire we advance a
4 soft, flexible, nondamaging plastic tube that we can leave in
5 there and it's through that tube that we start to drain.

6 The smaller the effusion is, actually, the more
7 dangerous it is to do the procedure. If you have a big
8 effusion with a lot of room, you'll hit the fluid way before
9 you hit the heart. You don't ever want to be aspirating all
10 of the fluid out of there with a needle, because at some
11 point, there will be no fluid left to give you a margin of
12 error. And if the heart is beating, you're more likely to
13 cut or lacerate the heart or its arteries. And you certainly
14 don't want to be doing CPR while you're inserting the needle,
15 because, again, you're increasing the heart motion.

16 Q. Do the records indicate that CPR continued
17 throughout, from 12:39 to 12:54?

18 A. It does. Can I see the EP logs, because there's a
19 notation of CPR and then there's a notation of CPR start, I
20 believe, without any notation of when CPR stopped. I'm not
21 sure. We can see the logs from the procedure?

22 This will be in the procedure note. We can go to
23 the anesthesia sheet. Can we switch to the anesthesia flow
24 sheet? This would be Renown Cath Lab 003.

1 Okay. So this is the anesthesia flow sheet that
2 was referred to for blood pressures in the code note. Again,
3 the code note started, depending on which column you look at,
4 12:41 or 12:42.

5 If we can zoom into this top section right here,
6 please? Actually, not quite that wide. We can just go to
7 here, right down to the bottom here. Thank you. So here we
8 see times. This is 12:00, dot dot, 12:30, each of these
9 small boxes is 5 minutes, 12:05, 12:10, 12:15, 20, 25, 30,
10 here's 1:00.

11 So this column right here is blood pressures. So
12 here we're hovering around 100 over 40, a pretty healthy
13 blood pressure. Here we're perhaps 105, 110 over 60. And
14 then we stay around 100 over 60 until about this time. This
15 time is roughly 12:50. It's ten minutes earlier than the
16 13:00 or 1:00 p.m. time.

17 Now, there's some vertical lines here with a
18 horizontal slash that says arrest. This would time out to
19 12:55, but there's no blood pressure in this one space. So I
20 infer that there was no blood pressure to document right
21 here.

22 And this goes on for some 20 minutes or so until
23 13:15 or 1:15 p.m.. The first documented blood pressure
24 appears to be about ten minutes after that, and this is at

1 13:25, this being 13:30 or 1:25 p.m.. So we have no blood
2 pressure until about 1:25 p.m. here. And the last one here
3 is at about 12:45 or so, leaving us 10, 20, 30, 35 to
4 40 minutes of no blood pressure documented with a notation
5 that says arrest lasting perhaps 20 minutes.

6 Q. Okay.

7 A. Now, these are the blood pressures that are
8 related on the anesthesia record. Again, the code note
9 simply refers back to these pressures.

10 Can I see lower down on this sheet, please? And
11 what I really want to see this square right here. So here we
12 have, before this happens, there's defibrillation. The
13 anesthesia note says V tack. We now have information that
14 suggests that the anesthesiologist, who is not an arrhythmia
15 expert, may have been incorrect in judging that V tack. But
16 as an anesthesiologist, we don't necessarily expect them to
17 be as well-versed as the arrhythmia doctors in diagnosing the
18 arrhythmias.

19 The arrhythmia doctor also has the advantage of
20 having wires in different chambers of the heart, so they can
21 tell where fast rhythms are originating. The
22 anesthesiologist often only has the EKG from outside of the
23 body.

24 At 12:50, the anesthesiologist notes cardiac

1. arrest, advanced cardiac life support initiated. Now, 12:50
2 is different than the last sheet we looked at. The last
3 sheet said 12:41 or 12:42. But there are different people
4 writing things down on different pieces of paper. There may
5 be multiple clocks in the room. A doctor or nurse may be
6 looking at their watch or cell phone for times. The mapping
7 system may have a clock on the screen that we're looking at.
8 These times may not all be synchronized.

9 So to me in looking at this after the fact, I can
10 allow for the times not being lined up, but I would expect
11 the sequence of events to be pretty consistent from one to
12 the other, even if the actual time is off by a few minutes.

13 12:50, we're starting CPR, chest compressions,
14 epinephrine five amps, which is a very high dose. From the
15 code sheet, it looks like this was given at perhaps
16 one-minute intervals. Atropine, five amps, also a very high
17 dose. And this actually says vasopressin, all given.

18 Ten minutes later, at 13:00, it says the
19 transthoracic echo was being done. That's an ultrasound from
20 outside the heart, outside the chest. And my understanding
21 from the records is the echo technician was called to the
22 room from outside the room. So they had to be paged or
23 summoned somehow.

24 When the echo was done, there was a large

1 pericardial effusion. So a lot of fluid there. Which leads
2 me to believe to a reasonable degree of certainty that at the
3 time the echo arrived, plugged in their machine, started
4 obtaining images, the drain had not yet been placed and the
5 fluid not yet drained. Because if it had, they should see
6 little or no pericardial effusion. Here it says several
7 hundred ccs or milliliters are aspirated. The other notes
8 say 300 ccs. That's a little more than a cup.

9 This is a not a huge pericardial effusion. A
10 pericardial effusion of under 100 ccs might be termed small
11 in terms of volume. 100 to 500 might be termed moderate.
12 And 500 might be termed large. But the amount of fluid isn't
13 the issue, as much as the pressure it's exerting on the
14 outside of the heart preventing expansion of the heart and
15 filling. A moderate effusion can still cause a loss of
16 filling and a severe collapse of blood pressure.

17 Typically, when we put these drains in, before we
18 we're even close to completely draining the blood, we can see
19 the blood pressure come up. And I've done this procedure on
20 patients who have blood pressure lines in the artery. We can
21 see the heartbeat and blood pressure beat-to-beat, and as you
22 take the first couple of syringes off, you can see the blood
23 pressure start to come up quite dramatically. It usually
24 doesn't take very long.

1 Then it says pericardial drain placed. At 13:15,
2 they have an arterial line for pressure measurements placed.
3 And at 13:20, they're reversing the heparin over ten minutes,
4 according to the anesthesia notes.

5 At 13:43, they've given what looks to be Anseth,
6 which is an antibiotic, and they're sending some blood tests
7 to be done. At 13:51, there's a note that says, little
8 residual effusion. So it looks like there's not continuous
9 bleeding.

10 There's a couple of issues as we do this
11 procedure. We want it to happen instantly. Nothing happens
12 instantly. There's always a little bit of time to do things.

13 So if we have a drop in blood pressure, our
14 current guidelines, and these were the guidelines in effect
15 at the time, really suggest that during this procedure when
16 we've entered the left atrium, we've anticoagulated the
17 patient aggressively, because we're worried that clots could
18 cause a stroke, any small puncture is going to bleed a lot
19 and it's going to happen quickly, because the patient's
20 clotting is impaired by the heparin until we give this
21 protamine, which reverses the heparin. So this can happen
22 quite quickly in these cases.

23 Q. Now, doctor, have you had this pericardial
24 effusion happen to you during your practice?

1 A. Several times.

2 Q. What do you do when that happens?

3 A. Well, if I am fortunate enough, as is my general
4 practice in every case probably over the last 10 or 12 years
5 when it became widely available, I look at my intracardiac
6 echo catheter and I can move by rotating the shaft, I can
7 sweep in front of and behind the heart to get a
8 two-dimensional image of what the heart structures look like
9 and whether there's any fluid around the outside of the
10 heart. I can also deflect the catheter to get views down in
11 this direction.

12 So I can quickly run to the table, manipulate the
13 catheter by rotating it and flexing the tip and confirm the
14 diagnosis. Then fluid wide open, reverse the heparin with
15 the protamine. I still have catheters in the left upper
16 chamber. Once I get protamine, those have to come out,
17 because I don't want clots that are going to cause a stroke,
18 then I start working on the drain.

19 While I'm doing this, the skin has not been
20 prepped for a pericardial drain. So it may take 30 or
21 60 seconds for the nurses to pull the drapes back, get some
22 iodine or hexedine cleaning fluid to clean the area I'm going
23 into and pull some towels over it with a small hole so that
24 my needle access site is germ-free, but the area around that

1 is covered so I can't contaminate my hands or my instruments
2 with bacteria on the skin.

3 And then we put the needle into the pericardial
4 space. As soon as I get blood return, the wire goes around
5 the heart. I step on the x-ray peddle, which is very quick,
6 document that it's in the right place, it's not trapped in a
7 little, tiny nugget of heart that says, maybe this is in a
8 chamber. Maybe I don't want to be taking all the blood out
9 of this. I want it in the sack and not in the chamber. If
10 it's in a chamber, I'll get blood until there's no more blood
11 left. That's not what we want to do.

12 Once I get that wire there, I pull the needle out,
13 because we don't want the needle to cut the heart or the
14 arteries outside the heart. We advance a thin, flexible
15 plastic drainage tube, typically called a pigtail, because at
16 the end of the tube, it curls around. And it has a bunch of
17 holes along it's distal end, so that if the very tip happened
18 to be butted up against something, I don't want all of my
19 ability to drain the fluid blocked. It has these side holes,
20 so no matter what the orientation of this is, I should be
21 able to get drainage and we drain the fluid.

22 Typically, the fluid does not recur once we've
23 reversed the heparin with the protamine as we've done here.
24 Rarely, drainage of blood will continue. And if we've gotten

1 a liter of blood, 1,000 mls or 1,500 mls, and it's not
2 stopping, that may be when we call the surgeon and say, you
3 know, there's a hole in there that someone needs to sew,
4 reversing the heparin, the anticoagulant, with the protamine,
5 and draining the blood that's there and waiting a few minutes
6 to see if it's going to be enough.

7 Q. Doctor, is that the standard of care when you have
8 a cardiac arrest while you're doing a catheter ablation?

9 A. If it's a drop in blood pressure. There's
10 different kinds of cardiac arrests. There are slow rhythm
11 cardiac arrests. There are dangerous fast rhythm cardiac
12 arrests. And there's what we call pulseless electrical
13 activity cardiac arrests where we might see an EKG signal,
14 but there's no blood pressure.

15 This tends to be in that latter group where the
16 heart's electrical system is firing, but there's no pumping
17 action with pressure. So, yes, if the blood pressure drops
18 during an atrial fibrillation ablation, given we're using
19 intravenous heparin anticoagulant, and given that we've stuck
20 a needle through the body from the leg and punctured the
21 dividing wall in the middle of the heart, which we know can
22 cause perforation on the outside of the heart, it is
23 incumbent on us to assume that this is pericardial tamponade,
24 fluid around the heart, squashing the heart, until proven

1 otherwise.

2 Q. Was that this case in Neil Dechambeau's case?

3 A. It doesn't appear to me that that's the case,
4 because what appears to have happened, according to the
5 records is CPR was done for ten minutes, a stat echo was
6 called for, and then there was some time elapsed for the echo
7 tech to arrive. And then he or she imaged the heart from the
8 outside of the chest wall and found that a large pericardial
9 effusion was there, which tells me that at that time, it had
10 not yet been drained.

11 Q. What is the reasonable length of time between the
12 time this cardiac tamponade is diagnosed and the pressure is
13 relieved from the heart?

14 A. Well, we would hope it would be as short as
15 possible. But I would allow that there are some things that
16 have to occur. So the patient's existing drape being moved
17 and the area scrubbed with some prep solution may take 20,
18 30 seconds, perhaps. Getting the pericardial drain tray off
19 the shelf and opening may take 30 seconds, maybe 60 seconds.
20 Getting the needle positioned and getting blood return may
21 take 30 or 60 seconds. If the anatomy is difficult for some
22 reasons, maybe two minutes.

23 Draining it should be quite quick with some
24 provisos. If you're in the wrong place, if you entered the

1 lung cavity, you're not going to get blood back. If the
2 sheathe is kinked like a straw would be if you bent it, you
3 might not be able to get the blood back there. If the blood
4 had clotted, because it's been a while and the patient wasn't
5 aggressively anticoagulated, you can't suck clots through
6 these thin catheters.

7 So there are a couple of things that might hamper
8 these efforts. But in general, I would think two to
9 five minutes would probably be the time that I would expect
10 this to have all been accomplished.

11 And if the blood pressure is low enough, it
12 doesn't take very much time of the brain not getting blood
13 flow for a severe injury to occur. In the sudden cardiac
14 death world, when people have life-threatening arrhythmias
15 that cause the heart to not squeeze, our general rule of
16 thumb is the thing that determines whether people live or die
17 is how quickly they get a shot that restores the heart
18 beating. In that instance, the death rate goes up about ten
19 percent every minute.

20 So if somebody drops dead and they shock the heart
21 back to normal 8 to 10 minutes later, the chances are pretty
22 slim. Whereas, if they got shocked quickly, for example, if
23 they're in a casino in Las Vegas where they put external
24 defibrillators in all the casinos in order to get back to the

1 tables, the survival rate can be quite good.

2 Q. In this case, do you have an opinion as to how
3 long it took from the time the cardiac arrest and cardiac
4 tamponade was diagnosed until the time that there was a pulse
5 restored?

6 A. I think to a reasonable degree of medical
7 certainty, it was greater than ten minutes. And if we look
8 at this record, which is really the only one that gives us
9 blood pressure data as well as the anesthesia record, it
10 looks like we have cardiac arrest at 12:50 and the effusion
11 is still there at 13:00. So ten minutes in, it doesn't look
12 like we've done anything to remedy the problem.

13 Q. Did you review the expert witness report of Dr.
14 Morady?

15 A. I did.

16 Q. Do you know Dr. Morady?

17 A. I do.

18 Q. How do you know him?

19 A. Dr. Morady was the director of the arrhythmia
20 program at the University of Michigan when I was an intern
21 and resident there in internal medicine and was among the
22 reasons that I became interested in electrophysiology.

23 Q. Were you aware that Dr. Morady was an expert
24 witness on behalf of the plaintiff in the original underlying

1 case?

2 A. I am aware of that.

3 Q. Are you aware that Dr. Morady then became an
4 expert witness on behalf of the defendant in this case?

5 A. I am aware of that.

6 MS. POLLARA: Excuse me, your Honor. That's not
7 in evidence and I have an objection to it being shown to the
8 jury at this point.

9 THE COURT: What's not in evidence?

10 MS. POLLARA: He's going to put up the declaration
11 of Dr. Morady and it's not in evidence.

12 MR. KOZAK: Yes, I am. I thought at the pretrial
13 conference, you ruled that was in evidence along with the
14 deposition.

15 MS. POLLARA: Can we approach, your Honor, please?

16 THE COURT: Ladies and gentlemen, stand up.

17 (Discussion at the bench.)

18 THE COURT: Thank you, ladies and gentlemen.

19 Please be seated.

20 BY MR. KOZAK:

21 Q. To the best of your recollection, doctor, what did
22 Dr. Morady opine in his expert witness report?

23 MS. POLLARA: Your Honor, objection.

24 THE COURT: Same objection, same ruling. Just ask

1 him what did he rely upon in his reaching his opinion.

2 BY MR. KOZAK:

3 Q. Did you rely on Dr. Morady's report?

4 A. I did not.

5 Q. All right. Thank you. Now, Dr. Smith is taking
6 the position that immediately after the code was sounded, he
7 performed a pericardiocentesis. Are you aware of that?

8 A. I am aware of that.

9 Q. Do you find that explanation to be credible?

10 A. I do not.

11 Q. Can you state the reasons?

12 A. Yes. If we can go back to the last item we were
13 looking at on the screen? So when the blood pressure drops,
14 our primary concern doing this particular procedure has to be
15 that we punctured the heart and that there's a layer of blood
16 around the heart compressing the heart. Acting, if you will,
17 if you're trying to inflate a balloon, it's pretty easy to
18 blow up a balloon if you have a good set of lungs. If you're
19 holding the balloon in your fist and squeezing it, not so
20 easy. That's kind of what pericardial tamponade is.

21 So we already have an echo catheter here. One way
22 to define whether or not there is fluid would be to
23 manipulate this for a couple of seconds and that's really
24 what it takes, this is seconds, not minutes, and show the

1 fluid.

2 Another thing we can do is say, the pressure is
3 low, maybe I don't have an echo catheter, maybe it's broken,
4 maybe we've taken it out at that phase of the procedure and
5 it's not sterile and we don't have another one. I have to
6 assume that there's fluid there and stick a needle in there
7 and drain it.

8 What appears to have happened in this case is
9 neither of those two things from what I can tell from the
10 record, because there's a notation that an echo was called.
11 Then some ten minutes go by and the echo arrives and their
12 first image shows there's lots of fluid there still.

13 So that echo person had to be called. They had to
14 bring a cumbersome machine that weighs a couple of hundred
15 pounds on wheels down one or more hallways, perhaps up or
16 down an elevator. They had to get into the room, plug it in,
17 wait for it to power up, which takes a minute or two, like
18 booting up a computer from scratch, and start imaging. And
19 even after that, there was fluid there.

20 Now, there are a number of reasons, again, why it
21 can be difficult to drain fluid. We have to go in at a
22 specific angle with this needle. If I draw the body and the
23 chest and the heart is sitting here and there's fluid around
24 the heart, I want to be at a 30- to 40-degree angle to get

1 into this sack.

2 But this is America, not everyone looks like this.
3 Some people look like that. And it may be very difficult to
4 get an angle if you have a very obese patient. The diaphragm
5 muscle is here. The heart sits on the diaphragm. You may
6 not be able to get from here into there, because this is in
7 the way. So that's a reason why we might have a slow
8 drainage.

9 Again, the tube instead of being nice and
10 straight, might kink like a straw. That might be a reason to
11 have problems getting fluid out. If the patient has had an
12 inflammatory disease of the heart or they've had open chest
13 surgery, this sack might not sit around the heart like a nice
14 organ with a big sack and the fluid evenly distributed. It
15 sack may be scarred down in size so that you can get into
16 this spot and drain this blood but can't get that blood or
17 this blood.

18 THE COURT: Just a minute, doctor. Ms. Pollara,
19 do you want to come around?

20 MS. POLLARA: Thank you, your Honor. I didn't
21 want to interrupt.

22 THE WITNESS: So there's a number of reasons why
23 this might not go well, but I would expect that in an
24 instance where there was a difficult path because of the

1 patient's body shame, because the effusion was what's called
2 loculated. Instead of being one continuous compartment,
3 there was a little bit here and then some scarring, a little
4 bit here and then some scarring, and a little bit here, you
5 can't drain it all.

6 Maybe the tube got drained. Maybe the needle
7 didn't go into the sack around the heart. Maybe we missed
8 and got our tube into the area below the diaphragm, which
9 sometimes we put the wire and we say, oh, the wire is not
10 going all around the heart. The wire is under the diaphragm.
11 I'm in the wrong place. I need to pull the wire out and try
12 again.

13 We would typically document in our notes this was
14 difficult because the effusion was loculated. The patient is
15 obese and I couldn't get the right angle on the needle. I
16 inadvertently entered the abdominal cavity and I had to try a
17 second time. But as far as I understand there was no
18 notation that this was anything but a routine
19 pericardiocentesis. The blood should come out within a
20 minute or two.

21 BY MR. KOZAK:

22 Q. Did you review Dr. Smith's procedure report?

23 A. I did.

24 Q. Do we have that procedure report? I think it's

1 Exhibit 11. Doctor, did you draw any conclusions from the
2 procedure report?

3 A. Yes. So it describes the preoperative diagnosis,
4 atrial fibrillation despite medication. So this tells me the
5 patient was having atrial fibrillation and they were already
6 on a rhythm medicine. And we know from the clinic notes,
7 this was having the patient experiencing symptoms.

8 So one of the things I look for is, was the
9 procedure reasonable and appropriate? And the answer seems
10 to be, yes. I would have probably done exactly the same
11 variety of procedure.

12 And then they attempted to isolate the veins in
13 the standard way for intermittent atrial fibrillation, making
14 circles of burns around each vein to try to electrically
15 disconnect them. So that the areas firing outside those
16 pulmonary veins can't get to the rest of the heart to pace it
17 into fibrillation.

18 Then it says, the procedure was complicated by
19 pericardial tamponade requiring CPR and pericardiocentesis or
20 drainage of about 300 mls or ccs of blood with resolution of
21 tamponade. So that says, we drained the blood, and the
22 tamponade, which is the whole constellation of fluid, low
23 blood pressure, cardiac arrest, that resolved. When did it
24 resolve? It resolved at the time of or immediately following

1 when the blood was removed, most likely, because that's
2 typically how these things go.

3 Now, farther down here, looking for the next
4 paragraph. So they decided during the procedure to do an
5 atrial fibrillation ablation. I'm just going to draw the
6 upper chambers for now. And, of course, the ablations are
7 going to be around these four pulmonary veins on the left
8 side of the heart, but our access through the vein is on the
9 right side of the heart and the inferior vena cava that
10 drains blood from the belly and the legs into the chest.

11 We have to get from here to there. We do that
12 with a needle puncture. Historically, we've done this with
13 x-ray guidance, but x-ray doesn't really show us exactly
14 where this dividing wall is.

15 An ultrasound image does a very good job, because
16 unlike x-rays which largely see things that are dense to
17 radiation, like bone or calcium or metal, the ultrasound sees
18 soft tissue like muscle. And so an intracardiac echo
19 catheter was advanced to show us where the septum was and
20 where the needle was going to be.

21 So we know we're not going to puncture too high or
22 we're not going to puncture too far forward outside the heart
23 or too far back outside the heart. That is known by Accuson,
24 which is a brand name. ICE, which is the acronym for

1 intracardiac echo. This is an ultrasound catheter and that
2 was advanced into the right atrium for visualization of the
3 septum, that's the dividing wall between the right and left
4 upper chamber.

5 But the tool isn't only used for that. It can be
6 used to guide that. It can be used to see that our catheter
7 is making good contact with the muscle as we're making our
8 burns. And if the blood pressure drops precipitously, it can
9 be used to immediately determine by bending the catheter, it
10 has a flexible handle, and rotating it, that there's blood
11 around the heart.

12 So at this point, we know the intracardiac echo
13 was there, and then they used the transseptal needle to cross
14 that septum. It's a long needle that comes up from the leg
15 and directed across the septum.

16 Let's go to the next page, please. So this really
17 talks about -- let's not get into that. Farther down, next
18 section, and let's start right here, one line up.

19 So they're doing the procedure, the ablation, and
20 they make another burn on the right side for a different
21 rhythm that they identify. They have come back from the
22 left. Now, they're making the burn down here for a rhythm
23 they identified called atrial flutter, which if we see it
24 during the ablation is a reasonable target. I would, if I

1 saw atrial flutter during atrial fibrillation similarly
2 target that ablation as well.

3 So as they're abating the isthmus, the area we
4 burned for the atrial flutter, the flutter terminated. So
5 that's always a nice sign. And then it says at the end of
6 the ablation, they had evidence of hemodynamic compromise.
7 That's medical speak for a drop in the blood pressure,
8 hypotension, and some slow heart rates. A stat echo was
9 performed, which showed a fairly large pericardial effusion.

10 Now, no notation is made that intracardiac echo
11 imaging showed a large effusion. There's no documentation
12 that anyone looked at an intracardiac echo during this phase
13 of the procedure.

14 There is documentation that an echo technician was
15 paged and arrived, and perhaps ten minutes into this, give or
16 take, their images are showing a large effusion. Now, what
17 that tells me is at this point, it had not yet been drained.

18 Then CPR was performed for approximately ten
19 minutes. I don't think this is necessarily sequential. I
20 believe, as Dr. Smith represents, that the CPR was going on
21 at the same time, but nevertheless when the echo was done the
22 fluid is there. That took time. CPR also not very effective
23 if the heart can't fill. Squeezing something out of an empty
24 cardiac chamber doesn't help.

1 They removed 300 ccs of frank blood and we
2 continue to monitor the patient and show evidence of minimal
3 pericardial effusion. So the effusion does not seem to have
4 recurred.

5 The blood pressure improved. They put a hard line
6 in, an intravenous line like tube into the artery to measure
7 blood pressure beat-to-beat. The blood pressures at this
8 point were greater than 100. They say five to 10 minutes of
9 CPR was done. Not very effective, typically. They got a lot
10 of medicine, epinephrine, atropine, bicarbonate. Again, not
11 very effective. Protamine to reverse the heparin, very
12 important if we're bleeding.

13 We have to remove the catheters in the left side
14 so clots don't cause strokes. Reverse the heparin effect
15 that is causing the bleeding with the protamine and drain the
16 blood out.

17 But, again, if we go back to what we discussed
18 with the anesthesia record, that's charted after 13:00 hours
19 or 1:00 p.m.. So that's charted by the anesthesiologist as
20 much later, the only place that notation exists. CT surgery
21 was consulted.

22 Let's go down. Sometimes if there's continuous
23 bleeding, you get out 300 ccs, the blood pressure goes up.
24 Then the blood pressure drops again, you get out another 300

1 ccs, the blood pressure goes up. If the blood pressure drops
2 again, you get out more blood. If the bleeding isn't
3 stopping, we have to have a surgeon cut the chest open find
4 out where the hole is. And if it's not stopping by itself,
5 sew it closed.

6 But it says that the cardiothoracic surgeon was
7 consulted and felt the patient was having no further
8 bleeding, no significant effusion. So the patient should be
9 monitored, and if they had more bleeding, then they would
10 consider an open operation to explore things and look for a
11 site of bleeding. But it looked like at this time the
12 bleeding was stopped. And then they reverse the anesthesia
13 and the patient can wake up.

14 Q. So, doctor, taking the record as a whole, can you
15 tell us whether or not you have formed an opinion to a
16 reasonable medical probability certainty that Dr. Smith
17 conformed to the standard of care in treating a tamponade, a
18 cardiac tamponade?

19 A. I have formed an opinion and I believe the
20 standard of care was breached, not in that something was done
21 improperly, but that it was done too slowly more than
22 anything else.

23 Q. Have you reached an opinion as to how fast this
24 condition was remedied by Dr. Smith?

1 A. It looks like it was significantly greater than
2 ten minutes as best as I can piece together the times in the
3 different flow sheets.

4 Q. Is it your opinion that this delay caused Neil
5 Dechambeau's demise from anoxia?

6 A. Yes.

7 MR. KOZAK: I have no further questions.

8 THE COURT: All right. Thank you very much.
9 Doctor, you may resume the stand.

10 Ladies and gentlemen, let's take our morning break
11 here. During the break, please, don't discuss this amongst
12 yourselves or with anybody else. Just remember the rest of
13 the admonition. The jury may retire.

14 (The following proceedings were had outside the
15 presence of the jury.)

16 THE COURT: Ms. Pollara, do you need any exhibits
17 or anything?

18 MS. POLLARA: I don't, your Honor. Thank you.

19 THE COURT: All right. Thank you. Mr. Kozak, do
20 we need to address anything before we take our break?

21 MR. KOZAK: No, your Honor.

22 THE COURT: Ms. Pollara.

23 MS. POLLARA: No, your Honor. Thank you.

24 THE COURT: Thank you very much. Court's in

1 recess.

2 (A short break was taken.)

3 (The following proceedings were had in the
4 presence of the jury.)

5 THE COURT: Counsel stipulate to the presence of
6 the jury?

7 MR. KOZAK: We will.

8 MS. POLLARA: Yes, your Honor.

9 THE COURT: Doctor, you may resume the stand. You
10 remain under oath. Ms. Pollara, your witness.

11 MS. POLLARA: Thank you, your Honor.

12 CROSS EXAMINATION

13 BY MS. POLLARA:

14 Q. Dr. Seifert, good morning.

15 A. Good morning.

16 Q. You advertise your services as an expert witness,
17 do you not?

18 A. I do.

19 Q. And you also charge for your time, don't you?

20 A. I do.

21 Q. And your charges for reviewing records, I think,
22 back at the time your deposition was taken was about \$600 an
23 hour?

24 A. Correct.

1 Q. Sometimes you charge more than that, don't you?

2 A. I do not. I charge on the hour. I think there's
3 one instance in which I suggested a much higher charge. It
4 was a case in which a cardiologist had sexually assaulted
5 multiple patients and I was asked to be an expert about one
6 of his cases, which I didn't think had any malpractice issues
7 associated with it. But I very much did not want to
8 associate my name with that case. So I named an exorbitant
9 price with the hopes, which were realized, that I not be
10 retained for the case.

11 Q. Well, there's been other cases where you have
12 testified where you charge up to \$750 an hour, correct?

13 A. I don't recall. If there is, it may have been in
14 the remote past, but I don't recall charging that much.

15 Q. Back in 2013, the month before you gave your
16 deposition in this case, do you remember giving a deposition
17 to that effect?

18 A. I don't recall.

19 Q. And you charge a minimum of 12 hours of your time
20 to come and testify at trial, don't you?

21 A. If it's out-of-town.

22 Q. And you're out-of-town?

23 A. Correct.

24 Q. How much are you charging for your visit to Reno?

1 A. The minimum for today would be 12 hours. For
2 yesterday, I was able to work the whole day in my office. So
3 it's simply actual time door-to-door from the time I left
4 Phoenix until the time I hit my hotel after meeting with
5 counsel.

6 Q. My question is, how much are you charging for your
7 visit to Reno?

8 A. It would be seven hours from yesterday, times six,
9 would be \$4,200, plus 12 hours for today at \$600 an hour,
10 which would be \$6,000, \$7,200, so probably in the
11 neighborhood of \$12,000.

12 Q. In addition to that previously, at least up until
13 the point of your deposition, you had spent about five, five
14 and a half hours working on the case up until that point and
15 that's about \$4,200, correct?

16 A. I don't recall the specifics, but I have no basis
17 to dispute those numbers.

18 Q. Have you reviewed your deposition transcript
19 recently?

20 A. I have.

21 Q. And so can you tell us how much time you've spent
22 on this case between the time of your deposition and getting
23 ready to come and testify here today?

24 A. The deposition I reviewed yesterday with a meeting

1 I had with Mr. Kozak, so that was included in yesterday's
2 billing.

3 Q. I'm sorry. My question wasn't clear. How much
4 time have you spent on this matter between when you gave your
5 deposition in mid 2013 and when you started your trip to
6 Reno?

7 A. I don't know the specific number. I would imagine
8 a handful of hours, single digit.

9 Q. Maybe five?

10 A. Perhaps that much.

11 Q. Okay. Thank you. And in addition to advertising
12 your services, and the reason you do advertise your services
13 is so you can make money as an expert witness in cases like
14 this, correct?

15 A. And I find the work interesting.

16 Q. But you're paid for it as well?

17 A. I am.

18 Q. And in addition to that, there's also a company
19 that you work with called -- it's called Consolidated
20 Consultants where they actually send you cases or hook you up
21 with attorneys, correct?

22 A. They have, yes.

23 Q. All right. Now, you would agree, Dr. Seifert,
24 that there are at least four other board certified

1 cardiologists, electrophysiologists who disagree with your
2 opinion in this case, correct?

3 A. I believe that to be correct.

4 Q. All right. Do you consider that you are here as
5 an advocate in this case?

6 A. No.

7 Q. You do agree that it would be inappropriate for
8 you to act as an advocate or as a partisan in this case?

9 A. Correct.

10 Q. And you understand that the decision as to whether
11 a witness is credible or not, that's a decision that's up for
12 the judges of the facts in this case, the jury, correct?

13 A. Correct.

14 Q. And so when you implied that you didn't find
15 Dr. Smith's testimony credible, that's really up for the jury
16 to decide, isn't it?

17 A. I think at the end of the day, that's correct.

18 Q. All right. Now, let's see if there are some
19 things that we can agree upon in the case. Dr. Seifert, you
20 would agree that Dr. David Smith is a well-educated and a
21 well-trained cardiologist, correct?

22 A. I have no reason to dispute that.

23 Q. You understand that he attended NYU Medical
24 School, correct?

1 A. Yes.

2 Q. You understand that he completed an internal
3 medicine internship and residency and that was done at UC
4 San Diego, correct?

5 A. Yes.

6 Q. You understand that he completed a fellowship in
7 cardiology at Harbor UCLA, correct?

8 A. Yes.

9 Q. It's a good program?

10 A. I have no reason to dispute that.

11 Q. He also completed an additional fellowship in
12 electrophysiology at Stanford, correct?

13 A. Yes.

14 Q. And so you would agree that as far as education
15 and training is concerned that Dr. Smith has a very similar,
16 if not identical, background by way of education and training
17 as you do?

18 A. I'm not sure what you mean by similar or same
19 level, but he is a well-educated, according to his CV, went
20 to respected programs and completed them, I believe
21 successfully, and I have no reason to dispute his training
22 and education.

23 Q. Right. But my question was a little bit
24 different. I mean, you attended a cardiology fellowship like

1 he did, correct?

2 A. Yes.

3 Q. And you attended a fellowship in electrophysiology
4 like he did, correct?

5 A. Yes.

6 Q. So really you both have very similar backgrounds
7 by way of your education and your training, true?

8 A. Well, unless we're getting into the nuances of
9 which program is ranked higher than which other program,
10 which I don't really have a basis to do, sure, I have no
11 reason to dispute that. I would not impeach his education
12 and training and claim it's inferior to mine.

13 Q. Thank you for that. You would agree that
14 Mr. Dechambeau had a longstanding history of atrial
15 fibrillation, correct?

16 A. Yes.

17 Q. And according to some of the records, he had it
18 for something like 35 years? Did you see those records?

19 A. Yes. It seemed to be longstanding.

20 Q. And would you agree that Mr. Dechambeau was an
21 appropriate candidate for this procedure that was performed?

22 A. I believe I already testified to that, yes.

23 Q. You agree that Dr. Smith, that he provided
24 Mr. Dechambeau with appropriate informed consent, correct?

1 A. I believe so.

2 Q. And, in fact, you would agree that Dr. Smith
3 talked with Mr. Dechambeau about some of the risks of this
4 procedure, as well as benefits and alternatives, correct?

5 A. I believe so.

6 Q. Okay. And, in fact, you would agree that
7 Dr. Smith informed Mr. Dechambeau that some of the risks
8 included bleeding, correct?

9 A. Yes.

10 Q. And included death, correct?

11 A. Yes.

12 Q. And you would agree that death as a complication,
13 although it's rare, it is a recognized risk of this
14 procedure?

15 A. Yes.

16 Q. You agree that Dr. Smith performed the atrial
17 ablation procedure appropriately?

18 A. The records seem to reflect that, yes.

19 Q. You don't have any reason to disagree with that,
20 do you?

21 A. Correct.

22 Q. You also agree that you can perform this procedure
23 appropriately and still have a complication occur?

24 A. Correct.

1 Q. It happens to the best of electrophysiologist who
2 are performing this procedure, doesn't it?

3 A. Correct.

4 Q. And that includes cardiac tamponade, correct?

5 A. Correct.

6 Q. And you would agree that cardiac tamponade is a
7 recognized complication of this procedure?

8 A. Yes.

9 Q. All right. Dr. Seifert, I believe that this may
10 be clear, but stating the obvious, you weren't in the
11 electrophysiology lab back on September 7th of 2006 when this
12 procedure was performed, correct?

13 A. Correct.

14 Q. You agree the records indicate that a diagnosis of
15 cardiac tamponade was made at 12:41, true?

16 A. They seem to reflect that, yes.

17 Q. And you would agree that that is reflected on the
18 code blue record that was shown to the jury during your
19 direct examination?

20 A. It is reflected on that record.

21 Q. And by the way, you agree that pericardiocentesis
22 tray was available in the electrophysiology lab, you have no
23 reason to disagree with that?

24 A. Correct.

1 Q. And you would agree that the fact that cardiac
2 tamponade is noted on the code sheet as being recognized at
3 12:41, that that information at least is some evidence that
4 Dr. Smith recognized that this patient had cardiac tamponade
5 or that he strongly suspected it by that time?

6 A. If we assume that notation was made at the time
7 that's listed, which is, I guess, depending on what column
8 you're looking at is either 12:41 or 12:42, yes.

9 Q. Actually, when you look at that specific part of
10 the code sheet, doctor, it specifically shows cardiac
11 tamponade at 12:41, correct?

12 A. Can you refresh my recollection as to which
13 exhibit that is?

14 MS. POLLARA: That's Exhibit 6 and maybe you can
15 bring it up.

16 MR. LUSIANI: I do have the witness copies of
17 these documents.

18 THE WITNESS: I've got it.

19 THE COURT: Thank you, counsel.

20 BY MS. POLLARA:

21 Q. Hold on just a second. There's no question
22 pending. Let's get this up. So could you please blowup,
23 let's see, this part right here?

24 Do you see those, and you can look at yours, Dr.

1 Seifert, just so it might be a little bit easier for you.

2 This is a copy of the original, correct?

3 A. I believe so.

4 Q. All right. And you would agree that it says
5 tamponade time, 12:41, doesn't it?

6 A. Well, if you look at the column to the right of
7 where it says right of tamponade, yes. If you look 2, 3
8 columns to the left where it says tamponade, no.

9 Q. Can we at least agree that it was recognized
10 sometime between 12:41 and 12:42? How about that?

11 A. That appears to be consistent with the record.

12 Q. All right. You would agree that Dr. Smith has
13 testified under oath that he did not wait to perform the
14 pericardiocentesis, true?

15 A. I'll agree with that, yes.

16 Q. You agree that he testified that he undertook to
17 perform the pericardiocentesis without waiting for the echo
18 machine to arrive, correct?

19 A. Correct.

20 Q. You agree that if in fact Dr. Smith did that, that
21 if he took steps to immediately perform the
22 pericardiocentesis, that he complied with the standard of
23 care in this case, true?

24 A. If he did them in a timely fashion, yes.

1 Q. All right. And so we're clear, your position in
2 this case is that essentially Dr. Smith is being untruthful
3 when he says that, true?

4 A. At a minimum, he's being inconsistent with the
5 transthoracic echo notation on the anesthesiologist record.

6 Q. Well, you would agree -- let's talk about that.
7 You would agree that the anesthesiologist record -- and can
8 we now pull it up, please? It's Exhibit 5. Let's just leave
9 that up right now. You're not an anesthesiologist?

10 A. Correct.

11 Q. You don't fill out these reports, do you?

12 A. Correct.

13 Q. And, in fact, let's just talk about this situation
14 a little bit. In a code situation when there is an
15 emergency, what occurs, doctor, is that the surgeon who is in
16 charge hopefully barks out a lot of orders for people to
17 start doing things to help the patient, right?

18 A. That's what I would expect.

19 Q. And, in fact, that would include things like
20 getting the pericardiocentesis tray, getting medications,
21 starting CPR, opening fluids, getting an echo machine,
22 whatever that surgeon thinks is necessary at the time,
23 correct?

24 A. Correct.

1 Q. And you would agree that at that point that
2 there's one person who is actually charged with keeping track
3 of things realtime during the code, correct?

4 A. That should be correct.

5 Q. All right. Well, you're familiar with a code
6 scribe, aren't you?

7 A. Yes.

8 Q. And, by the way, there are in most hospitals,
9 there are code drills, aren't there? So that they practice
10 running codes so that everybody knows what their job is and
11 one person's job is to write things down.

12 A. I don't know that every hospital does drills in
13 that fashion, but I would expect people who are in procedure
14 rooms where these things are expected to occur from time to
15 time will be getting recertified at a minimum of every two
16 years.

17 Q. Right. But the point I'm trying to make is that
18 there is a person who is designated as the scribe who is
19 writing things down realtime?

20 A. There should be, yes.

21 Q. All right. You have no reason to think that
22 didn't happen here, do you?

23 A. I think there was someone who appears to have been
24 filling out the code sheet. I think there were some

1 omissions in that record.

2 Q. Well, and you would agree with me, doctor, that
3 you've never seen a perfect chart, have you?

4 A. I've not looked at charts for ascertaining
5 perfection or the lack of it. But I don't know what the
6 definition of a perfect chart would be.

7 Q. All right. You would agree with me that the
8 anesthesia record is not filled out by the anesthesiologist,
9 Dr. Kang, in this case, in the middle of the code, correct?

10 A. I assume it is. I think that the blood pressures
11 are being charted contemporaneously, because the code sheet
12 defers to the anesthesia records for the blood pressure and
13 the respirations.

14 Q. You would agree with me that in the code -- by the
15 way, you weren't there, correct?

16 A. Correct.

17 Q. In a code situation, the anesthesiologist is
18 pushing the medications, correct?

19 A. They or other members of the staff.

20 Q. In this instance, you agree that the
21 anesthesiologist was pushing the medications, true?

22 A. It's not entirely clear to me that's true.

23 Q. All right. Let me ask you this --

24 A. There's a section of the second page of the

1 anesthesia records where the top six lines of the chart,
2 which I believe are the page after this in the records you're
3 displaying, have a space for agents given, and I don't see
4 agents charted as being given during the code on the
5 anesthesia record.

6 Q. Let's be clear about this, Dr. Seifert. You're
7 not holding yourself out in this case as an expert on
8 anesthesiology, are you?

9 A. Correct. I'm not.

10 Q. You've never filled out one of these records,
11 correct?

12 A. Correct.

13 Q. In fact, you don't have any information one way or
14 the other as to whether or not this record was filled out in
15 the middle of the code or not, true?

16 A. Correct.

17 Q. And, in fact, let's just be really clear about
18 this, when you're -- you would agree with me that it would be
19 inappropriate for a physician to stop providing hands-on care
20 to a patient in an emergency to write something down,
21 correct?

22 A. If their hands are actually required, which I
23 don't necessarily believe to have been the case throughout
24 this event for the anesthesiologist.

1 Q. But you don't know that, do you?

2 A. Well, we know the patient was ventilated and we
3 know the patient was intubated. So we know the
4 anesthesiologist was not in a code tasked with getting an
5 airway established as might happen in an unexpected code in
6 an emergency room or on the floor.

7 We know the patient was on a mechanical
8 ventilator, so the machine was getting the air in and out of
9 the lungs. So the anesthesiologist or other personnel would
10 not be tasked with squeezing the ambu bag to fill the lungs
11 and allow them to empty.

12 So the only tasks remaining for the
13 anesthesiologist are to give medicines, which takes a few
14 seconds for each medicine and chart. They're not doing CPR,
15 they're not intubating, they're not ventilating.

16 Q. Let's see if we agree on this. Doctor, you would
17 agree that it would be inappropriate for a physician to stop
18 providing care to a patient in an emergency to chart,
19 correct?

20 A. If they were needed to do specific tasks, yes, I
21 would agree that not performing tasks that are required in an
22 emergency to do recordkeeping would be inappropriate.

23 Q. Thank you. In other words, you agree that patient
24 care takes precedence over charting, simply, correct?

1 A. Yes.

2 Q. All right. And that would also be true for an
3 electrophysiologist, a cardiologist, they're not going to
4 stop taking care of the patient in this situation to chart,
5 correct?

6 A. In general, they're not doing charting during
7 these procedures at all.

8 Q. Right. Now, you told us during direct that you
9 know Dr. Fred Morady, correct?

10 A. I do.

11 Q. You would agree he's one of the premier cardiology
12 electrophysiologist in the country?

13 A. He's very well-respected, yes.

14 Q. He's a pioneer in the field, isn't he?

15 A. One of them, yes.

16 Q. In fact, you've recognized him as a pioneer in the
17 field yourself?

18 A. Yes, I believe that's correct.

19 Q. In fact, he was one of the main reasons that you
20 went into the field of electrophysiology was because of your
21 interactions with him, true?

22 A. With him and with others.

23 Q. And you personally hold him in high regard?

24 A. I do.

1 Q. You know his reputation is one of being an honest
2 physician?

3 A. Yes.

4 Q. And you also know that his reputation is as a
5 reputable physician?

6 A. I'm sorry. Is that a question?

7 Q. Yes.

8 A. Yes.

9 Q. And you would agree that he's a leader in the
10 field of electrophysiology?

11 A. Yes.

12 Q. And you in reviewing the materials that you've
13 been provided in this case, you were provided with not just
14 the medical records that you've looked at, but you were
15 provided with other things like declarations of different
16 people, depositions of different people, including Dr.
17 Morady, correct?

18 A. Yes.

19 Q. And including Dr. Smith, correct?

20 A. Yes.

21 Q. And you would you agree that Dr. Morady concluded
22 in this case that there was no breach in the standard of
23 care, true?

24 A. He did after he declared that there was. So there

1 was a change of opinion.

2 Q. Right. So you understand that he originally
3 looked at some information, but then later on as the case
4 developed, he changed his opinion and he came to the opinion,
5 which he testified to under oath, that Dr. Smith complied
6 with the standard of care in all respects, correct?

7 A. Yes. I'm aware of that.

8 Q. In other words, ultimately it was his opinion that
9 Dr. Smith had not committed any malpractice at all in this
10 very tragic situation, true?

11 A. Apparently correct.

12 Q. And you would agree as -- you would agree yourself
13 that as an expert witness in this case, as an expert witness
14 generally, that there's a code of ethics that you're required
15 to comply with, correct?

16 A. Yes.

17 Q. And, in fact, that's very plainly stated by the
18 American College of Cardiology, true?

19 A. I believe so. I haven't gone on their website in
20 a while.

21 Q. Among other things, it is required of you as an
22 expert witness to be fair, correct?

23 A. Yes.

24 Q. And to be objective, correct?

1 A. Yes.

2 Q. And to be truthful?

3 A. Yes.

4 Q. And you would agree that as an expert if you came
5 upon additional information that caused you to conclude that
6 your opinion should be different than it was originally, you
7 have an obligation to make that clear, correct?

8 A. Yes.

9 Q. And you wouldn't fault anyone for doing that,
10 would you?

11 A. I would not.

12 Q. All right. Now, you also mentioned Dr. Calkins in
13 your direct testimony. You know Dr. Calkins?

14 A. I do.

15 Q. And you first met him when you were a medical
16 student at Johns Hopkins?

17 A. I believe so.

18 Q. He was doing his cardiology fellowship when you
19 were a medical student there, true?

20 A. Correct.

21 Q. And then when you were doing your internal
22 medicine residency at the University of Michigan, which is
23 where you met Dr. Morady, Dr. Calkins was actually one of
24 your attending physicians there?

1 A. Correct.

2 Q. And you are familiar with the fact that Dr.
3 Calkins is also one of the premier cardiology
4 electrophysiologist in this country, true?

5 A. Correct.

6 Q. You respect him?

7 A. I do.

8 Q. He is a lead author and a cochair of the Heart
9 Rhythms Society Task Force Consensus On Atrial Ablation
10 Surgery, correct?

11 A. Atrial fibrillation ablation, yes.

12 Q. And he's authored a number of articles pertaining
13 to that, correct?

14 A. Yes.

15 Q. You actually had one at your deposition?

16 A. I don't recall.

17 Q. All right. And you understand that it's his
18 opinion that Dr. Smith complied with the standard of care in
19 all respects in this case, true?

20 A. True.

21 Q. And it's his specific opinion that there was no
22 delay in performing the pericardiocentesis, true?

23 A. True.

24 MR. KOZAK: Your Honor, I'm going to object to

1 this unless we actually have the expert witness report of Dr.
2 Calkins, because he didn't say that.

3 THE COURT: Well, you can bring that up in cross
4 examination. Go ahead.

5 MS. POLLARA: Thank you, your Honor.

6 BY MS. POLLARA:

7 Q. Now, let me just ask you a couple more questions.
8 You also as a part of the information that you were provided,
9 you also saw a declaration from Dr. Bandari, correct?

10 A. Yes.

11 Q. He's another board certified, well-qualified
12 cardiology electrophysiologist, correct?

13 A. Yes.

14 Q. And he differs with your opinion in this case?

15 A. Yes.

16 Q. And then, lastly, Dr. Seifert, you were first
17 contacted in this case in September of 2012, is that right?

18 A. That sounds right. I don't recall specifically.

19 Q. Do you want to refresh your recollection with your
20 deposition?

21 A. I'd be happy to.

22 Q. Page seven, line 22, just take a quick look at
23 that.

24 A. I'm sorry. Which exhibit is that?

1 Q. It's not an exhibit. It's your deposition
2 transcript, which I thought you had in hand.

3 A. I'm not sure I have it in front of me.

4 MS. POLLARA: May I approach the witness, your
5 Honor?

6 THE COURT: Certainly.

7 MS. POLLARA: Thank you.

8 BY MS. POLLARA:

9 Q. You don't have to read it out loud. If you could
10 look at page seven, line 22, and refresh your recollection on
11 that point?

12 A. Yes. That would appear to be correct on or about
13 September 30th, 2012.

14 Q. All right.

15 MS. POLLARA: Thank you, your Honor. That's all
16 the questions I have.

17 THE COURT: Thank you, Ms. Pollara. Mr. Kozak.

18 REDIRECT EXAMINATION

19 BY MR. KOZAK:

20 Q. Doctor, have you seen the declaration of Hugh
21 Calkins, MD, in this case?

22 A. I don't recall specifically what I've seen from
23 Hugh. I think I've seen something. I don't remember if it
24 was an affidavit or a declaration. Do you have an exhibit

1 that goes with that?

2 Q. Yes, we do. Can we have Dr. Calkins' report.
3 It's Exhibit 16.

4 MS. POLLARA: Your Honor, again, may we approach
5 for a moment?

6 THE COURT: Yes. Ladies and gentlemen, stand up.
7 (Discussion at the bench.)

8 THE COURT: Thank you, ladies and gentlemen.
9 Please be seated.

10 BY MR. KOZAK:

11 Q. Now, you've been referred to Dr. Morady's expert
12 witness report, correct?

13 A. Correct.

14 Q. Did Dr. Morady ever say why he was changing his
15 opinion?

16 A. It wasn't clear to me. There was the emergence of
17 information that was initially described as ventricular
18 tachycardia and was shocked, according to the
19 anesthesiologist notes, was in fact atrial flutter. So there
20 was a criticism of Dr. Morady that initially the procedure
21 should have stopped as soon as there was ventricular
22 tachycardia until the cause was identified. So I can suppose
23 that if that information changed, that aspect of his opinion
24 could be expected to change.

1 However, he had a number of other criticisms about
2 CPR not being effective during tamponade and the primary
3 issue being draining the effusion. And I don't know what the
4 basis of changing those opinions might be or how the
5 information on flutter versus ventricular tachycardia rhythms
6 being present might affect those opinions.

7 Q. Did Dr. Morady make this statement, a
8 transthoracic echocardiogram was not ordered until
9 approximately 12:44 p.m. on September 2nd, 2006, and did not
10 arrive until approximately 12:49 p.m.. The transthoracic
11 echocardiogram was performed too late to benefit Neil
12 Dechambeau. Did he make that statement?

13 A. I believe he did. And I think an interesting
14 factor that was omitted in that statement is there was echo
15 imaging available the whole time right in the heart already
16 in the form of the intracardiac echo catheter.

17 Q. And did Dr. Morady state that David Smith, MD,
18 failed to timely perform a pericardiocentesis procedure on
19 Neil Dechambeau?

20 A. That was one of his criticisms, yes.

21 MR. KOZAK: No further questions.

22 THE COURT: Ms. Pollara.

23 MS. POLLARA: Thank you, your Honor.

24 RE CROSS EXAMINATION

1 BY MS. POLLARA:

2 Q. Actually, what happened, Dr. Seifert, is he later
3 changed that opinion, correct?

4 A. I understand that is correct.

5 Q. And, in fact, you read his deposition when you
6 were reviewing all of the materials, correct?

7 A. I believe so, yes.

8 Q. And, interestingly, when you say you don't know
9 the details of why he changed his opinion, you understood
10 from looking at that deposition transcript that counsel for
11 the plaintiffs, the Dechambeaus, elected to take his
12 deposition by written questions. Were you aware of that?

13 A. Yes.

14 Q. In other words, Mr. Kozak didn't go and sit down
15 with Dr. Morady and question him in person about why he
16 changed his opinion, what was important to him in changing
17 his opinion. He basically submitted questions, correct?

18 A. That's my understanding.

19 Q. Now, you've been an expert witness many times,
20 have you not?

21 A. I would say several.

22 Q. You've done at least a dozen times, haven't you?

23 A. Yeah.

24 Q. And in all of the cases that you've given

1 depositions, have you ever done it by written questions?

2 A. I have not.

3 Q. A little bit unusual?

4 A. In my perhaps dozen or, you know, 10 to 15, I've
5 not run across that.

6 Q. But you would agree, nonetheless, that Dr. Morady
7 as an ethical, honest physician and expert had the right to
8 change his opinion if he had more information, true?

9 A. Yes.

10 Q. All right. And you find that he's a very
11 thoughtful, very experienced physician based upon your
12 experience with him?

13 A. I believe that to be correct, yes.

14 MS. POLLARA: Thank you, your Honor.

15 THE COURT: Yes, Mr. Kozak.

16 REDIRECT EXAMINATION

17 BY MR. KOZAK:

18 Q. Yes. Doctor, are you aware of any new information
19 that Dr. Morady was provided between the time he rendered the
20 opinions that I just read and the time that he changed his
21 mind?

22 A. The only thing that I'm aware of was that he
23 obtained a copy of the disks that were recordings of the
24 electrical tracings during the procedure. And he was able to

1 ascertain that the rhythm for which the patient was shocked,
2 which was described in the anesthesia notes as VT,
3 ventricular tachycardia, a lower chamber life-threatening
4 rhythm, and which he criticized the operator, Dr. Smith, for
5 not stopping the procedure until the cause of this
6 ventricular tachycardia could be identified before
7 proceeding.

8 He later looked at the recordings and with more
9 information, which is different catheters recording
10 electrical signals from different chambers in the heart
11 simultaneously was able to show that this rhythm was not
12 ventricular tachycardia originating from the bottom chamber
13 of the heart, but was in fact atrial flutter, a
14 nonlife-threatening rhythm originating from the upper chamber
15 of the heart.

16 So I can certainly appreciate how the criticism
17 of, if there's ventricular tachycardia you should stop the
18 procedure if you don't have a good reason for that to be
19 happening until you can determine what's going on, it makes
20 perfectly good sense to me why that opinion would change. I
21 don't know of any other information that would change any of
22 the other opinions.

23 Q. Did Dr. Morady explain what additional facts he
24 had acquired in his deposition that --

1 A. Not in my mind about the other criticisms.

2 Q. Does ventricular tachycardia have anything to do
3 with the failure to do a pericardiocentesis timely?

4 A. It does not.

5 MR. KOZAK: No further questions.

6 MS. POLLARA: Just two questions, your Honor.

7 THE COURT: Two.

8 RE CROSS EXAMINATION

9 BY MS. POLLARA:

10 Q. Number one, Dr. Seifert, Dr. Morady was never
11 asked in his deposition what other information he looked at
12 in order to form the opinions that he expressed at his
13 deposition, true?

14 A. I didn't see that question.

15 MS. POLLARA: I'll do it in one question, your
16 Honor. Thank you.

17 THE COURT: All right. Thank you. Doctor, you
18 may step down. Thank you, doctor.

19 THE WITNESS: Thank you, sir.

20 THE COURT: Ladies and gentlemen, we'll take our
21 lunch break here. I can tell you I spoke with the attorneys
22 over last night and we're on track. So, please, I know
23 you're working hard, so are the lawyers as well. It's
24 important to everybody here to just remember the admonition.

1 Don't talk about this case. Don't conduct any independent
2 investigation. Don't do any independent research. Don't
3 allow anybody to talk to you about the case. Keep an open
4 mind. We've got a lot more work ahead of us. Jury may
5 retire. I'll see you here at 1:30. Jury may retire.

6 (The following proceedings were had outside the
7 presence of the jury.)

8 THE COURT: Mr. Kozak, do we need to address
9 anything before we take our lunch break?

10 MS. KOZAK: No, your Honor.

11 THE COURT: Ms. Pollara.

12 MS. POLLARA: Your Honor, there's just a couple of
13 exhibits, I think, if Mrs. Dechambeau is going to be put on
14 after lunch. We can address it at that point or now.

15 THE COURT: Let's talk about it now.

16 MS. POLLARA: They were stipulated to.

17 THE CLERK: Your Honor, I have a general question,
18 you want to admit all the exhibits counsel stipulated to?
19 There are several.

20 THE COURT: That we have not admitted. We'll go
21 ahead, Ms. Clerk, and admit Exhibits 23, 24, 25, 26, 27, 28,
22 29, 30 through 32, 40 through 45.

23 THE CLERK: I believe that's it, your Honor.

24 THE COURT: Ms. Pollara, do you have any other

1 exhibits?

2 MS. POLLARA: Nothing further, your Honor.

3 THE COURT: Mr. Lusiani.

4 MR. LUSIANI: Your Honor, we have received an
5 updated exhibit from Mr. Teichner, who is anticipated to be
6 testifying this afternoon. There was one item on it,
7 however, that was added from the original exhibit. And in
8 speaking with Ms. Pollara, she's willing to stipulate to the
9 changed exhibit absent this one particular entry, which we're
10 trying to get taken off of there, and then a new calculation
11 in terms of just an overall amount.

12 THE COURT: When you clean up the exhibit, let's
13 just deal with it after lunch.

14 MR. LUSIANI: Okay.

15 THE COURT: We'll admit it at that time.

16 MR. LUSIANI: Thank you, your Honor.

17 THE CLERK: Counsel, are you talking about
18 Exhibit 22?

19 MR. LUSIANI: 25, I believe.

20 THE CLERK: We have a 25 and a 25A.

21 MR. LUSIANI: This is 25.

22 THE CLERK: We're going to be dealing with that in
23 relation to 25? Will that take the place of 25?

24 MR. LUSIANI: Yes.

1 THE COURT: So that will be 25B.

2 THE CLERK: I would suggest that, your Honor. So
3 is 25 not going to be admitted?

4 MR. LUSIANI: No.

5 THE CLERK: Your Honor, you want to rescind your
6 admission of 25 and we remark that as 25B and that will be
7 admitted?

8 THE COURT: Yes.

9 MR. LUSIANI: That's fine. Thank you, your Honor.

10 THE COURT: Thank you very much, counsel. This
11 Court's in recess.

12 (A lunch break was taken.)

13 (The following proceedings were had in the
14 presence of the jury.)

15 THE COURT: Counsel stipulate to the presence of
16 the jury?

17 MR. KOZAK: We do.

18 MS. POLLARA: Yes, your Honor.

19 THE COURT: Mr. Kozak, your next witness.

20 MR. LUSIANI: Your Honor, we would call Jean Paul
21 Dechambeau.

22 (One witness sworn at this time.)

23 THE COURT: Counsel, do you need that on the
24 witness stand?

1 MR. LUSIANI: No, we don't, your Honor. May I
2 approach?

3 THE COURT: Yes. If they're exhibits, bring them
4 back to the clerk. Counsel, your witness.

5 MR. LUSIANI: Thank you, your Honor.

6 JEAN PAUL DECHAMBEAU
7 called as a witness and being duly sworn did testify as
8 follows:

9 DIRECT EXAMINATION

10 BY MR. LUSIANI:

11 Q. Mr. Dechambeau, good afternoon. You are the son
12 of Neil Dechambeau?

13 A. Yes.

14 Q. And you are aware of the proceedings that have
15 been prosecuted here so far as being present here in the
16 courtroom throughout its duration, correct?

17 A. Yes.

18 Q. Can you tell me if you -- what your business,
19 profession or occupation is, please?

20 A. I am a production lead consultant with Fed Ex
21 Office.

22 Q. How long have you been in that position?

23 A. One year and five months.

24 Q. Okay. As the son of Neil Dechambeau, were you

1 living with your parents from the time of birth until when?

2 A. Until 2006.

3 Q. And what happened in 2006?

4 A. My father passed away.

5 Q. What was your age at the date, at the time of your
6 father's passing?

7 A. 18..

8 Q. And you had been in the house ever since your
9 birth during that time frame, correct?

10 A. Correct.

11 Q. Was your mother and father in the house with you
12 during that time frame?

13 A. Yes.

14 Q. In other words, there had been no separation
15 between the two of them?

16 A. Correct. No separation.

17 Q. Can you just characterize what the result or the
18 impact of your father's passing was on you?

19 A. Devastating. It felt like I got hit by a Mack
20 truck.

21 Q. How would you characterize your relationship with
22 your father up to the point in time of his death?

23 A. He was my best friend. When he was -- when he was
24 home from work, I would spend lots of time with him. He

1 would show me music, he showed me games, he taught me how to
2 play chess, he taught me how to play cribbage, rummy, all
3 sorts of different card games.

4 Q. Were those activity you participated in with him
5 during his lifetime?

6 A. Yes, many times.

7 Q. Would that have been up to the point in time of
8 his death?

9 A. Yes.

10 Q. When did you first hear of his death?

11 A. His death specifically was when I was at the
12 hospital at the time that it occurred.

13 Q. Was there any information provided to you prior to
14 that, that gave you the information that he was seriously
15 ill?

16 A. Yes. My mother contacted me when I was at the
17 university.

18 Q. And when would that have been?

19 A. That would have been the day before his death, I
20 believe September 6th. My mother called me while I was on a
21 break between classes.

22 Q. So you were a student at UNR?

23 A. Yes. I was a student at the university.

24 Q. While a student at the University of Nevada, Reno,

1 were you employed?

2 A. Yes.

3 Q. And what was your occupation at that point?

4 A. I was a cashier at Best Buy.

5 Q. What were you studying for in terms of your
6 studies at UNR?

7 A. Political science.

8 Q. Do you recall the specific time frame when you
9 actually became aware of your father's passing?

10 A. We were in the hospital room when I was called to
11 a meeting and it was a meeting between my family, friends,
12 doctors, et cetera. And they told me that they had to pull
13 the plug, because he was not going to wake up.

14 Q. So that was a meeting in the hospital?

15 A. Yes. There was a conference room in the hospital.

16 Q. And at that point in time, do you recall whether
17 Dr. Smith was there?

18 A. I do not believe he was in that meeting.

19 Q. Was your mother in that meeting?

20 A. Yes.

21 Q. When had you originally arrived at the hospital on
22 or about September 7th or 8th, 2006?

23 A. I arrived at the hospital probably a half hour
24 after I received the first call from my mother that something

1 was wrong. I don't remember a specific time of day. It was
2 just afternoon.

3 Q. And what information was provided to you that
4 brought you to the hospital at that time?

5 A. My mother called and said that something terrible
6 had happened.

7 Q. Now, were you aware of him having an operative
8 procedure on that date, the date that you got the phone call
9 from your mother?

10 A. Yes.

11 Q. Do you recall what type of procedure was being
12 done?

13 A. It was a cardiac ablation.

14 Q. Were you familiar with the process?

15 A. At the time, no.

16 Q. Had your parents discussed the operative procedure
17 that was to be done?

18 A. Yes.

19 Q. And what was your understanding of the reason for
20 or need for that particular procedure?

21 A. The procedure was to help fix a rhythm problem
22 with my father's heart. My father would have episodes where
23 he would have to bear down, he wouldn't be able to move, it
24 would make him tired. And it would be temporary. It

1 wouldn't last for a very long time, but he wouldn't be very
2 mobile or very active. And I was told this kind of surgery
3 was required to fix the problem.

4 Q. What was your attitude towards the operative
5 procedure?

6 A. I was informed the risk was low. There was risk,
7 but low. And that I was to expect him that evening as it was
8 an outpatient procedure.

9 Q. Now, when you first arrived at the hospital, were
10 you able to see your father at that time?

11 A. Yes. He was in his room.

12 Q. And at that point, was he hooked up to anything or
13 not?

14 A. I believe he was on a ventilator.

15 Q. Through the evening hours -- strike that. Was
16 this sometime in the evening hours that you went into his
17 hospital room initially?

18 A. I believe it was in the afternoon. I don't
19 remember not being able to see him when I arrived.

20 Q. And what happened during that afternoon? Were you
21 contacted by anyone relative to your father's condition?

22 A. Not directly. All the information more or less
23 went through my mother to me.

24 Q. Okay. How long were you at the hospital that

1 afternoon and/or evening?

2 A. Until after the sun went down, I know that. We
3 went home for a short time afterwards and then came back and
4 stayed the night at the hospital.

5 Q. Okay. We'll get to that in a second, but in terms
6 of the period of time late afternoon into the evening hours,
7 did your father have any response to anything externally at
8 all that you were aware of?

9 A. No.

10 Q. In looking at your father, what was your
11 impression of him?

12 A. Nonresponsive.

13 Q. He was nonresponsive?

14 A. Yeah. His eyes were open.

15 Q. His eyes were open. Was he able to focus on
16 anything? Did you see his eyes move at all?

17 A. No. There was no movement. Nothing but the
18 breathing.

19 Q. What, if anything, did you do with or for him
20 during that short interval?

21 A. I tried talking to him. I remember putting
22 headphones on, because somewhere along the line I had been
23 told or I knew that sometimes people who were in a state like
24 that, they could understand, hear music. So I put his

1 headphones on.

2 Q. Did he enjoy music?

3 A. Yes.

4 Q. Was there any response from having put the music
5 on him through the headsets?

6 A. No.

7 Q. At some point in the evening, you and your mom
8 went home, is that correct?

9 A. Yes.

10 Q. At that point, what was your -- what was the
11 condition of your father? Had it changed at all?

12 A. Not at all.

13 Q. Had anything been explained to you in terms of
14 what his state was at that time?

15 A. I was under the impression that he had been
16 without oxygen for an extended period of time, at least
17 15 minutes. I didn't know the exact time frames that are
18 required, but I do know that was a very long time to be
19 without oxygen and he had most likely suffered brain damage.

20 Q. Had you received any information from any of the
21 medical personnel as to what the possibility of his survival
22 might be?

23 A. Not that evening. The next morning, yes, but not
24 that evening.

1 Q. You and your mom went home that evening?

2 A. Correct.

3 Q. Was there anyone at the hospital that requested
4 that you stay?

5 A. Not directly to me. They requested that of my
6 mother, but not to me.

7 Q. When you went home that evening, what did you do?

8 A. I went to bed. I don't remember if I slept, but I
9 went to bed.

10 Q. Were you then -- did your mother then contact you
11 that night indicating you had to go back to the hospital?

12 A. Within an hour or two, yes.

13 Q. You then went back to the hospital?

14 A. Correct.

15 Q. And what happened then?

16 A. We went into a waiting room and we were told that
17 he's resting and that we were intending to stay the night in
18 the waiting room. I was given a pillow and a blanket.

19 Q. Did you in fact spend the night in the waiting
20 room?

21 A. Yes.

22 Q. Was there any contact with any medical personnel
23 as it relates to your father during that evening and during
24 the nighttime, which was intended, I suppose, to sleep?

1 A. Not that I remember.

2 Q. Were you able to sleep?

3 A. I honestly don't remember.

4 Q. Do you recall what the first contact was from
5 anyone the next morning? Would it have been from your
6 mother? Would it have been from hospital personnel?

7 A. It would have been my mother. She was there with
8 me.

9 Q. Do you recall the first contact with hospital
10 personnel that morning?

11 A. No.

12 Q. Do you recall approximately what time it was that
13 you went to this meeting that you already described?

14 A. Sometime in the late morning.

15 Q. Okay. And in -- strike that. As a result of this
16 meeting, your understanding was that -- well, strike that.
17 What was your understanding of your father's condition at
18 that time?

19 A. My understanding at that time was that there was a
20 very small chance of him even batting an eyelid.

21 Q. Was there a reference to being brain dead?

22 A. Yes.

23 Q. Was there any indication in your mind that he was
24 currently at that point in time on a ventilator of some sort?

1 A. Yes. He was still on a ventilator.

2 Q. Did the people in the committee indicate to you
3 that he was going to have to be taken off of the ventilator?

4 A. Yes.

5 Q. Were you able to see your father at any point in
6 time after hearing or being part of this meeting and
7 ultimately his demise?

8 A. Yes. I was there the entire time.

9 Q. And did you go back into his room at that time?

10 A. Yes.

11 Q. Was his condition changed as far as you could see?

12 A. No.

13 Q. Did you have an opportunity to say good-bye?

14 A. Yeah.

15 Q. Were you there when he was taken off the
16 ventilator?

17 A. Yes.

18 Q. Were you there at the point in time when he
19 stopped breathing?

20 A. Yes.

21 Q. What were your emotions or feelings at that point?

22 A. Difficult to describe. Pain, sadness,
23 overwhelming.

24 Q. Since then, what thoughts or feelings have you had

1 about your father?

2 A. Generally the same, a longing, a missing, a
3 missing piece. There were times that I could have used his
4 guidance. I didn't have it. It would come and go. The
5 longer it's been, the less likely that I would break down,
6 but it's still poignant.

7 Q. Have you been able to put your father's death
8 behind you and move forward with your life at this point?

9 A. Yes, but not easily.

10 MR. LUSIANI: I have no further questions. Thank
11 you, your Honor.

12 THE COURT: Thank you, Mr. Lusiani. Ms. Pollara.

13 MS. POLLARA: I have no questions, your Honor.
14 Thank you.

15 THE COURT: Thank you, Mr. Dechambeau. Watch your
16 step. Thank you.

17 Mr. Lusiani, next witness.

18 MR. LUSIANI: Thank you, your Honor. We would
19 call Angela Dechambeau.

20 (One witness sworn at this time.)

21 THE COURT: Counsel, your witness.

22 MR. LUSIANI: Thank you, your Honor.

23 ANGELA DECHAMBEAU

24 called as a witness and being duly sworn did testify as

1 follows:

2 DIRECT EXAMINATION

3 BY MR. LUSIANI:

4 Q. Mrs. Dechambeau, you're the plaintiff in the
5 current action, correct?

6 A. Yes.

7 Q. What was your relationship to Neil Dechambeau?

8 A. I was his wife.

9 Q. How long were you married to him before his death?

10 A. 25 years we were married and dated before that.

11 Q. You must have been pretty young when you got
12 married?

13 A. I was 27 when I got married.

14 Q. Okay. How long had you and Mr. Dechambeau gone
15 together prior to getting married?

16 A. A couple of years.

17 Q. Where did you meet?

18 A. In Chattanooga, Tennessee.

19 Q. When did you first come to Reno?

20 A. To live in I believe it's 2000.

21 Q. Okay. We have met Jean Paul. He is your son?

22 A. Yes.

23 Q. Do you have any other children?

24 A. No.

1 Q. Did you and Mr. Dechambeau talk about having other
2 children?

3 A. No.

4 Q. Happy with what you had?

5 A. Yes.

6 Q. What was your anniversary date?

7 A. August -- you'd have to ask me. August 15th,
8 1981.

9 Q. What was your most favorite thing about your
10 husband?

11 A. He had a corny sense of humor. He could make the
12 room light up in his jokes and things. Any question you had,
13 you asked him, he seemed to know all about it. And if he
14 didn't have the answer, he would find the answer. He loved
15 music. He was a man that just loved life.

16 Q. When you first met him, did he have any medical
17 problems that you were aware of?

18 A. When I first met him, he had just had -- he had
19 fallen off a tanker truck and had surgery on his arm.

20 Q. Approximately when did you first become aware of
21 the fact that he did have a heart condition of some sort, the
22 atrial fibrillation?

23 A. After we got married. It wasn't pronounced when
24 we first got married, but after I got married to him, as the

1 years progressed, it was going worse and worse. He would
2 always reach for his neck to kind of get it in -- something
3 you do with your neck to get out of that mode. But it worked
4 for a long time and then it just started to get where it
5 wasn't working anymore.

6 Q. At some point in time, you came to meet with
7 Dr. Smith with regard to the procedure ultimately done on
8 Neil?

9 A. Yes.

10 Q. And how did you come to find Dr. Smith initially?

11 A. Well, initially, Neil went to Reno Heart
12 Physicians through our primary care and then just stayed with
13 that group because of our insurance.

14 Q. And was Dr. Smith a part of that group at that
15 time?

16 A. Yes.

17 Q. Do you recall meeting with your husband and
18 Dr. Smith with regard to his heart condition?

19 A. Yes.

20 Q. Did you have one or more than one meeting with
21 Dr. Smith prior to the actual operative procedure?

22 A. More than one.

23 Q. Were you in each one of those?

24 A. I was at all of them except one.

1 Q. Which one might that have been if you can
2 differentiate?

3 A. It was kind of at the end, because I had a back
4 problem at that time and I had to have an MRI done and that
5 had to be the same day.

6 Q. Okay. Had you and your husband had discussions
7 about his heart problem prior to meeting with Dr. Smith?

8 A. What do you need to know?

9 Q. I'm just asking if you and your husband had talked
10 about his heart condition prior to actually coming in contact
11 with Dr. Smith?

12 A. Yes.

13 Q. And what was the -- in going to Dr. Smith and so
14 forth, what were your hopes as it relates to the medical care
15 he might be able to provide?

16 A. Well, we went to Dr. Smith or the group, because
17 Neil's quality of life had diminished, where this was
18 interfering with his life enough that drugs weren't working
19 as well for him. And so he wanted to see what the doctor
20 could do to take care of that and what came up with was the
21 ablation.

22 Q. Do you recall having discussions with Dr. Smith as
23 it relates to what the anticipated result of the procedure
24 might be?

1 A. Yes.

2 Q. What was that?

3 A. Dr. Smith had said that no ablation is
4 100 percent, but in Neil's case it was a good chance that he
5 would come out of it much better than he was.

6 Q. Okay. Now, on the date of the procedure that was
7 to be done, the ablation to be done, did you go with your
8 husband to the hospital?

9 A. Yes.

10 Q. And what happened initially after you got checked
11 into the hospital itself?

12 A. Well, once we arrived, we were in the room where
13 they prep you for the procedure and they did a -- the nurses
14 came and did a few things like checking his blood pressure
15 and all that. And then they put him in a gown. And that was
16 kind of a funny thing. He kind of played around with that.
17 But they gave him -- he was a big guy and they gave him a
18 little gown, so everybody got a good laugh out of that one.

19 But then one of the nurses came out and said that
20 Dr. Smith wanted to have an x-ray done before the procedure,
21 another one, because he had one the day before at one of the
22 hospitals that was required and then another procedure as
23 well. And that day, they wanted to have another x-ray,
24 because Dr. Smith called for it.

1 Q. Now, at some point in time, he was taken back for
2 the procedure to be initiated, correct?

3 A. Yes.

4 Q. Did you have the opportunity to talk with him as
5 he was going back for the procedure? What was the
6 communication between the two of you?

7 A. Well, he was in the room, because once they took
8 him through the little side door, I couldn't go with him. So
9 the room where he was being prepped and everything was the
10 same room. And they said we're taking him back there now.
11 And at that point, I talked to my husband, and I said, I love
12 you, I'll be here when you get back. And I prayed with him
13 and then assured him, again, that everything should be fine.
14 And he -- they took him back there.

15 Q. Were you given an estimate of how long the
16 procedure would take?

17 A. Yes. They told me originally about six hours.

18 Q. Now, he goes back for the procedure to begin and
19 did you stay in the same room?

20 A. I had a nurse friend -- not the prep room. The
21 nurse friend said, well, he's going to be back there having
22 the procedure, they were getting him ready and so forth, and
23 I can't go back there.

24 So at that point, she said, let's go down to the

1 cafeteria at Washoe, Renown, and let's get something to eat.
2 And so that's what we did and then we came back up.

3 Q. When you came back up, where did you go to, a
4 waiting room?

5 A. A waiting room, the big waiting room.

6 Q. Six hours goes by and is the procedure completed?

7 A. No. Six hours came and went and I'm still sitting
8 there and I'm going, okay, there must have been a delay.
9 Nobody had come out to talk to me. Seven hours came and
10 went, still nobody came out to talk to me. And I'm just
11 sitting there and --

12 Q. Pardon me for interrupting. At that point in
13 time, are you having any concerns or what's your thought
14 process at that point?

15 A. Yeah. Neil and I were very close and I felt in my
16 gut at six hours something was wrong. Seven hours, I really
17 felt there's got to be something wrong. And at that point,
18 then, around seven hours or so, I made a call to my nurse
19 friend, because she was working on the floor that day, and I
20 said --

21 MS. POLLARA: Your Honor, excuse me, it's hearsay.

22 THE COURT: Sustained. It hasn't gotten to that
23 point yet. Go ahead.

24 BY MR. LUSIANI:

1 Q. Thank you, your Honor. You contacted your friend
2 who was a nurse working at the hospital as well, correct?

3 A. She's the one that I saw originally, yes.

4 Q. And at that point, did you have concern about the
5 procedure itself?

6 A. About the procedure, no, but just in the fact that
7 there was a long delay.

8 Q. And what was your concern in that regard?

9 A. Well, he was supposed to be out in six and I felt
10 somebody should have come out and talked to me after that to
11 say something was going on or what was happening and
12 everything was quiet.

13 Q. Did you get to eight hours?

14 A. Did get to eight hours. And at eight hours, I'm
15 really getting -- inside, I was getting very much upset,
16 because nobody was telling me anything. At eight hours,
17 Dr. Smith came out, sheet white, he's a white man anyway, but
18 he was -- had no color. He came out and I immediately said,
19 what happened? That was my first words to him is, what
20 happened?

21 Q. And what did you come to understand happened at
22 that point in time?

23 A. His comment to me was that the first -- at the
24 eight-hour period was that my husband had been without oxygen

1 for between 5 and 7 minutes. And at that point, I said, his
2 brain is fried. And he kind of shook his head in the yes
3 position. And I started asking him some questions about my
4 husband as to what happened. And he said some things that
5 had happened in the surgery that had gone awry. And he said,
6 for all intents and purposes, my husband wasn't there. Then
7 he said he wanted to go back in for another hour and he would
8 be back out.

9 Q. Did you have an emotional reaction to this news?

10 A. Yes. From what he told me, I knew something had
11 terribly gone wrong and I knew my husband was probably not
12 going to come out of this as he went in.

13 Q. Now, did Dr. Smith go back, then, wherever he was
14 going to where he had planned on going as far as you know?

15 A. As far as I know, he went back into the room where
16 high husband's body was.

17 Q. Did he come out to see you again?

18 A. At about the ninth hour, yes. He was more
19 colorless than he was before. And he said, I'm so sorry.
20 Now, whether he meant to say it or not, he said to me, I'm so
21 sorry, and he said, I killed your husband.

22 MS. POLLARA: Your Honor --

23 THE COURT: Sustained. Ladies and gentlemen, that
24 last statement is stricken. You're not to consider that. Go

1 ahead, counsel.

2 MR. LUSIANI: Thank you, your Honor.

3 BY MR. LUSIANI:

4 Q. Did he tell you anything else as it relates to the
5 procedure itself?

6 A. He said the procedure, it was not 5 to 7 minutes
7 where he didn't have oxygen, it was 15 to a little more than
8 15.

9 Q. Did you have an emotional reaction to that?

10 A. Yeah. I was not too happy with the information I
11 was getting from him. And he was just saying he didn't
12 understand why. And then he had to go in and see what --
13 take care of some things in the room that had to do with my
14 husband.

15 Q. So after he indicated that perhaps it was
16 15 minutes or more without oxygen for your husband, did he
17 then go back, leave the room that you were in?

18 A. He left the waiting room and he went back, I
19 assume, back into that room.

20 Q. Well --

21 A. I can't say where he went.

22 Q. Let's focus on what you observed and so forth. At
23 that point in time, then, did you remain in the waiting room?

24 A. I waited in the waiting room until this -- they

1 brought his body out on a gurney in the waiting room and he
2 had a sheet from -- covering all the way up to his neck, his
3 head. And there was one nurse with him. And I walked over
4 there and I touched his hand and his hand was like ice. And
5 I said, oh, he's cold. I looked at his eyes and they were
6 fixed and dilated -- they're just fixed. There was no
7 movement, nothing. And at that point, I said to the nurse --

8 MS. POLLARA: Excuse me, your Honor. It's
9 hearsay.

10 THE COURT: Not what she said to the nurse.

11 MR. LUSIANI: I'll ask another question.

12 THE COURT: All right.

13 BY MR. LUSIANI:

14 Q. Ms. Dechambeau, at the point in time that your
15 husband was brought out on the gurney, was that literally
16 into the waiting room?

17 A. Into the waiting room.

18 Q. Was there anyone else?

19 A. The lady that sits behind a little desk that
20 usually tells people what's going on in the back with all the
21 people. You know, she comes out and tells what's going on in
22 the back with the patients.

23 Q. Okay.

24 A. And there was some other people there, too.

1 Q. There was other relations or friends and families
2 and so forth of other patients?

3 A. Yes.

4 Q. At that point, was doctor -- there was just one
5 nurse was with your husband?

6 A. Just one nurse.

7 Q. Was he hooked up to any machines or anything that
8 you could tell?

9 A. No.

10 Q. What, if anything, did she tell you about your
11 husband at that time?

12 MS. POLLARA: Your Honor, it's hearsay.

13 THE COURT: Sustained.

14 MR. LUSIANI: I'll rephrase, your Honor. Thank
15 you.

16 BY MR. LUSIANI:

17 Q. What happened in terms of your husband on the
18 gurney being wheeled out from the waiting room? Was that
19 just within a few minutes of him coming out initially or was
20 that -- was he left there for some time?

21 A. When they brought him -- when she brought him out
22 on the gurney, she was passing through to go take him out the
23 door. And that's when I had gotten up to -- I said, okay,
24 and I went over and I touched him. And --

1 Q. Did you follow him out the door, then?

2 A. No. At that point, I said, where are you going
3 with him? And she said, I have to take him upstairs.

4 Q. Okay. What was your understanding of what
5 upstairs was?

6 A. Well, I asked her, I said, where upstairs? She
7 said, ICU.

8 Q. Did you then follow them up to ICU?

9 A. She said I couldn't follow her upstairs in the
10 elevator, that elevator, because they went up to a different
11 elevator, and I had to go up on a different elevator and she
12 would meet me upstairs.

13 Q. Okay. Now, had Jean Paul come to the hospital by
14 then?

15 A. No.

16 Q. So did you then follow-up in the different
17 elevator to ICU?

18 A. Yes.

19 Q. Once you got up to the ICU, was your husband
20 there?

21 A. They had put him in a room, yes.

22 Q. Was he hooked up to any machines at that point in
23 time that you could tell?

24 A. At that time when they put him in the room, he was

1 on a -- they had some things hooked up to him. I can't say
2 exactly what all they were.

3 Q. All right. Did anyone else come up to you to
4 discuss with you what your husband's condition was at that
5 time?

6 A. When I first went up there?

7 Q. Yes.

8 A. Not when I first went up there, no.

9 Q. At what point in time did Jean Paul actually
10 arrive at the hospital, if you recall?

11 A. It was after my husband was already in the room
12 and it would have been in the afternoon sometime.

13 Q. Okay. Did he come up to the ICU room?

14 A. Yes.

15 Q. Did you and he have a discussion as it relates to
16 your husband and what his condition was?

17 A. I'm sure.

18 Q. Did he appear upset?

19 A. Yes.

20 Q. Did he express any anger, frustration, emotion at
21 that time?

22 A. He was disgusted, and at that particular time, you
23 could just tell he was mad.

24 Q. Okay. Approximately what part of the evening was

1 this once Jean Paul got there and your husband was up in ICU
2 and so forth? Was this into the evening hours?

3 A. Yeah, mid afternoon. I had one of my pastors --
4 he had a daughter about the same age as my son and he came
5 and took JP out, or Jean Paul out, and to keep him busy.

6 Q. Okay. Did anything else go on in the ICU room
7 that you observed from that point in time until evening
8 hours, say, 8, 9, 10:00 at night?

9 A. They were fidgeting around with him, my husband,
10 checking on him all the time and putting drops in his eyes
11 and there was a lot of -- they were messing around with him.

12 Q. What was your state of mind at this point in time
13 when you're in the ICU with your husband? Did you -- strike
14 that. Did you check your husband's condition in terms of his
15 eyes or any other aspect of what his condition was during
16 that time frame?

17 A. Yes.

18 Q. And did he have any change whatsoever?

19 A. No.

20 Q. Did you have any type of an impression or an
21 emotional reaction to that?

22 A. All I knew is the man I knew for many years was
23 not there and he didn't appear to be alive.

24 Q. Was there a point in time that evening where you

1 left the hospital and left the ICU room with your husband in
2 it?

3 A. Yes. Late in the evening, because I have a
4 medical condition that I had been there all day and I had --
5 I was tired. And reviewing the situation that was going on
6 and so forth, and knowing what I knew at that point, I asked
7 Dr. Smith, I said, I need to go home and get some sleep. I
8 don't think I'm going to be needed here right now. I need to
9 go home and get some sleep. He did not have a problem with
10 that.

11 Q. So did you go ahead, then, and leave?

12 A. After one of the nurses had confronted me at that
13 point and said, well, I need --

14 MS. POLLARA: Excuse me, your Honor. Hearsay.

15 THE COURT: Sustained. That is hearsay. Next
16 question.

17 MR. LUSIANI: Thank you, your Honor.

18 BY MR. LUSIANI:

19 Q. You ultimately left the hospital that evening,
20 correct?

21 A. Yes.

22 Q. Was JP with you?

23 A. I went to the church and picked him up.

24 Q. Okay. So then you went home?

1 A. Yes.

2 Q. And what did you do when you got home?

3 A. At that point, I said that he, you know, he needed
4 to go get some sleep. We're going to have a big day the next
5 day. Basically, I was trying to relax and get some sleep
6 myself.

7 Q. And did you in fact go to bed?

8 A. I did get into bed, but I did get a phone call
9 from the hospital.

10 Q. What did you do as a result of the phone call?

11 A. Well, the first phone call was right after I had
12 gotten to bed and said I needed to come back to the hospital.

13 Q. And, ultimately, did you then get back up and go
14 back to the hospital?

15 A. No, I did not. I said to them, what's going on?
16 And why do you think I need to come back to the hospital
17 right now? I'm 30 minutes out from the hospital. And I
18 said, we need to get some rest. And I said, call me if
19 there's any change in the machines or anything, because I
20 didn't think there was going to be any change.

21 Q. So, then, ultimately, you did go back to the
22 hospital, however?

23 A. Not that time. I got another phone call later
24 than that and it was another nurse that said --

1 MS. POLLARA: Excuse me, it's hearsay.

2 BY MR. LUSIANI:

3 Q. Let's not get into what anybody said at this
4 point, Ms. Dechambeau. I understand you're trying to tell
5 the story. Let's just focus on what you did at this point,
6 okay?

7 A. Well --

8 Q. In terms you got the subsequent phone call and you
9 then returned to the hospital?

10 A. The second phone call, yes.

11 Q. And did Jean Paul go with you?

12 A. That was the purpose or reason I went back there.

13 Q. What was that?

14 A. Because it was said to me that my son needed to
15 come back and see his father.

16 Q. Okay. So you go back to the hospital with Jean
17 Paul?

18 A. Yes.

19 Q. When you got there, were you allowed to see
20 Mr. Dechambeau?

21 A. When we got to the hospital in the middle of the
22 night, morning, we were handed -- both of us were handed a
23 pillow and a blanket and ushered to the waiting room.

24 Q. Did you get the chance to go into his room?

1 A. No.

2 Q. When was the next time you had the opportunity to
3 go into Mr. Dechambeau's room?

4 A. They told me that I could -- they would come out
5 after the doctor saw him to determine if he was brain dead or
6 so forth. That after, when that doctor came in that morning,
7 then they would come out and get us, and they did.

8 Q. Okay. Was that first thing, then, the next
9 morning?

10 A. It wasn't bright and early. It was sometime mid
11 morning.

12 Q. And did you and Jean Paul go into Mr. Dechambeau's
13 room?

14 A. After they came back out and said the procedure
15 was done, the checking to see if he was brain dead.

16 Q. Okay. And when you went back into the room, had
17 there been any change in his condition?

18 A. No.

19 Q. Was he still on those machines that you had seen
20 the day before?

21 A. He was on some machines. I can't say which ones
22 at this time.

23 Q. Okay. Did you attend the -- well, strike that.
24 You were here when Jean Paul testified about some sort of a

1 committee meeting. Did you attend that meeting as well?

2 A. I'm the one that called it.

3 Q. Okay. What was the purpose of that meeting?

4 A. Basically, it was a meeting of my church people
5 that were there at the hospital. My pastors wanted JP there,
6 Jean Paul. And I wanted to go over what I knew with all of
7 my friends there and my pastoral staff to make sure that --
8 because my son did not realize his father was -- was not
9 there.

10 And so we wanted to, this was on the second day,
11 we wanted to make sure that he understood that his -- after
12 the doctor said that he was brain dead, that we could take
13 him off the machines. But I knew that JP would have to -- I
14 wanted his approval as well before I did anything. So I did
15 talk to him.

16 Q. Was Mr. Dechambeau taken off of all support at
17 that point?

18 A. After our meeting, yes.

19 Q. Okay. Did you have an opportunity to say good-bye
20 to him at that point?

21 A. I went in the room, yes.

22 Q. And were you there when they disconnected the
23 support mechanisms?

24 A. Yes. Before that, we had a little -- well, at

1 that time, we had a little church service in the room where
2 one of our pastors read a scripture that my husband likes and
3 we had people standing around the bed and we sang Amazing
4 Grace and had a mini memorial service before they pulled him
5 off, once they pulled him off, because his numbers went, as
6 soon as they disconnected him, it was like 13, 12, you know,
7 it just kept going down, down, down.

8 Q. Did you have any specific feelings as that was
9 happening?

10 A. I had feelings of sadness for the loss of my life.
11 My husband was my life. He was my best friend. And then the
12 fact -- I mean, my whole life changed in a heartbeat.

13 Q. Did you seek any medical care, be it through
14 medical people or did you seek any support from your church
15 subsequent to Mr. Dechambeau's death?

16 A. My church, I talked to them for a while, and then
17 I eventually went to a therapist, psychiatrist, the one that
18 handles medicines. But I didn't take any medicines for that.
19 But he was into that field where he saw me a couple of times
20 a week.

21 Q. For how long did he did you see him?

22 A. I'd say probably for a year.

23 Q. Okay. Did your feelings or emotions change at all
24 after the treatment or after seeing this particular

1 physician?

2 A. It helped me get through some rough points in the
3 road, because you don't ever get -- you don't ever get over
4 grief. But he helped me to -- it gave me a place to go to
5 talk without being judged or people just saying words and
6 realizing, you know, not realizing there's words that can
7 affect your moods and so forth. So I just needed somebody
8 who could talk to me and listen to me and give me some
9 guidance.

10 Q. Has your emotions changed significantly since
11 stopping your treatment with this physician?

12 A. I felt he gave me -- he helped me to get stronger
13 and realize that I could stand on my own two feet and carry
14 on.

15 Q. When you think about Neil now, Mrs. Dechambeau,
16 what are your feelings?

17 A. I miss him. He can't be replaced. He was
18 one-of-a-kind. He was my sweetheart. Like I said, he was my
19 best friend. I will miss him every day of my life. And the
20 conversations we had, we could talk about virtually anything,
21 and we could do -- we loved doing things together. That's
22 all changed. So, yes, it has affected me quite a bit.

23 MR. LUSIANI: No further questions, your Honor.

24 THE COURT: Thank you, Mr. Lusiani. Ms. Pollara.

1 MS. POLLARA: Thank you, your Honor.

2 CROSS EXAMINATION

3 BY MS. POLLARA:

4 Q. Good afternoon, Mrs. Dechambeau. I just have a
5 few questions for you. You understood that your husband had
6 suffered from an arrhythmia for quite a long time back to
7 when you first got married, correct?

8 A. After we got married.

9 Q. And since that time, I know that you moved to the
10 Modesto area after you married and you lived there for a
11 period of time, is that true?

12 A. Modesto, Ceres, yes.

13 Q. And your husband actually saw a cardiologist for
14 his arrhythmia in that area back during that time frame?

15 A. Briefly.

16 Q. And then your husband continued to have these
17 arrhythmias as the years went on and after you moved to Reno
18 as well, is that true?

19 A. It got more pronounced as we -- as the years went
20 on, yes, and we moved to Reno.

21 Q. And then your husband's primary care physician was
22 a woman by the name of Patricia Levan?

23 A. Levan.

24 Q. Levan. Okay. And actually you went to the visits

1 that your husband had with her as well, correct?

2 A. Yes.

3 Q. And on a number of those visits, your husband
4 brought up his arrhythmia with Dr. Levan, true?

5 A. Yes. She was his primary, too.

6 Q. And then eventually she actually is the one that
7 referred your husband over to Reno Heart and that was in
8 December of 2005, is that true?

9 A. I don't remember the actual date right now, but --
10 I just can't remember the actual date.

11 Q. I'll represent to you that the records show that
12 in the latter part of December 2005, that your husband had
13 the first visit with Dr. Berndt, Dr. Ted Berndt over at Reno
14 Heart? Does that sound about right?

15 A. I remember him, yes.

16 Q. And your husband was about six-foot tall?

17 A. About that.

18 Q. The records from Washoe Medical Center from the
19 day he was admitted indicate that he told the staff that he
20 weighed about 272 pounds. Do you have any reason to disagree
21 with that being his general weight back at that time?

22 A. That sounds about right.

23 Q. Your husband started going to Reno Heart and he
24 first saw Dr. Berndt for a number of visits, correct?

1 A. Yes.

2 Q. During those visits, there was discussion about
3 his arrhythmia which you understood was atrial fibrillation at
4 that point?

5 A. Yes.

6 Q. And then your husband also saw Dr. John Grinsell
7 at some point for a stress echocardiogram?

8 A. Yes.

9 Q. Then he was sent back to Dr. Berndt for additional
10 care, correct?

11 A. Yes.

12 Q. At some point, Dr. Berndt put your husband on
13 Coumadin, do you remember that?

14 A. Yes.

15 Q. And that was something that was an effort to help
16 with his arrhythmia, true?

17 A. It was one of the treatments they recommended him
18 try, yes.

19 Q. Right. You understood that was to thin out his
20 blood to keep it from clotting, is that what you understood
21 from that?

22 A. I knew it was a blood thinner, right.

23 Q. You weren't happy with that prescription, were
24 you?

1 A. I was not and neither was he.

2 Q. Right. I mean, you had some prior understanding
3 of some of the risks of Coumadin, and you and your husband
4 were not happy about the fact that he was being placed on
5 that medication because of what you knew?

6 A. Of what we knew, yes.

7 Q. All right. But he agreed to try it, correct?

8 A. Right.

9 Q. And then at some point, he was -- your husband was
10 getting more and more frequent arrhythmias, they were
11 continuing to worsen, weren't they?

12 A. Yes.

13 Q. So at that point, Dr. Berndt referred your husband
14 over to Dr. Smith?

15 A. At some point, yes.

16 Q. The records indicate that was around May of 2006.
17 Does that general time frame seem about right to you?

18 A. I know it wasn't too long before the procedure.

19 Q. All right. The records indicate that it was in
20 May of 2006. Do you have any reason to disagree with that,
21 if that's what the records show?

22 A. It seems right.

23 Q. Okay. And you understood that the reason for the
24 referral to Dr. Smith was that he was actually a rhythm

1 specialist, someone who specialized in treating rhythm
2 disorders?

3 A. That's what I was aware of.

4 Q. Okay. And as I understand it, by the time your
5 husband saw Dr. Smith, at that point, he was having
6 arrhythmia episodes at least every three days and sometimes
7 they were lasting up to 30 hours is what you told us
8 previously, is that true?

9 A. Correct.

10 Q. And it was something that was making him
11 uncomfortable and anxious, at least those feelings he was
12 experiencing from what he told you, correct?

13 A. Well, the medicine that he was put on seemed to be
14 making it worse, yes.

15 Q. All right. And, actually, Dr. Smith in the first
16 visit with him, we'll forget about the date right now, but in
17 the first visit with him, he recommended that your husband
18 try medication first as an option to see if there was another
19 medication that might help him, correct?

20 A. And he did, yes.

21 Q. And that was a prescription called Tambocor?

22 A. Right.

23 Q. And so your husband went on that medication and he
24 had some really serious or significant side effects for him,

1 correct?

2 A. Yes.

3 Q. Made him very tired. He thought he'd gained
4 weight. It was not something that was working for him at
5 all, right?

6 A. It was not working for him, no.

7 Q. All right. And then in the initial meeting, there
8 was the plan to put your husband on the Tambocor, but during
9 that first appointment, there was discussion about different
10 options, what might have been available for your husband,
11 either doing nothing, trying medication, and if those things
12 didn't work, considering an ablation surgery, correct?

13 A. I know that was talked about in several visits, so
14 I can't really say it happened at that one visit. That
15 conversation was at several visits.

16 Q. And you understood the plan was, let's try the
17 medication and let's see how you do, and then we can talk
18 about it further down the road as far as having surgery if
19 nothing else works?

20 A. Yes.

21 Q. And so then your husband went back to see
22 Dr. Smith, I believe, in mid July of 2006, and that is the
23 visit you did not attend?

24 A. Right.

1 Q. But after the visit, your husband came home and
2 you understood at that point that he was probably going to
3 have the surgery?

4 A. Yes, I did.

5 Q. All right. And then there was a number of things
6 that were done to prepare for that surgery. I know he went
7 to Saint Mary's and he had some other testing, correct?

8 A. Yes.

9 Q. He also signed a last will and testament on
10 September 6th, the day before the surgery, correct?

11 A. Yes. He updated his will and everything, yes.

12 Q. Okay. And then when he was at the -- at the
13 surgery or at the hospital the next day on the 7th, he did
14 sign some consent forms for the surgery, you're aware of
15 that?

16 A. Yes.

17 Q. And you've looked at those before and you verified
18 that they have his signature on them, correct?

19 A. Yes.

20 MS. POLLARA: That's all I have, your Honor.

21 Thank you.

22 THE COURT: Thank you, Ms. Pollara.

23 MR. LUSIANI: Nothing further, your Honor.

24 THE COURT: Ma'am, you can step down. Watch your

1 step going down.

2 THE WITNESS: Thank you.

3 THE COURT: Mr. Lusiani.

4 MR. LUSIANI: Your Honor, would now be a
5 reasonable time to break for a few minutes?

6 THE COURT: Sure. We can take a few minutes.
7 Ladies and gentlemen, I'm going to talk to the lawyers and
8 see in terms of schedule and I'll have more to report to you
9 when we get back. We'll take our afternoon break here. Just
10 remember the admonition. The jury may retire.

11 (The following proceedings were had outside the
12 presence of the jury.)

13 THE COURT: Who is next?

14 MR. LUSIANI: We have Mr. Teichner ready to go at
15 this point and I think that's it for the plaintiff for today.

16 THE COURT: Are you going to rest?

17 MR. KOZAK: I think we are.

18 THE COURT: Okay. Do you have anybody in the
19 wings to fill out the rest of the day?

20 MS. POLLARA: Your Honor, I don't. I have two
21 witnesses. I have Dr. Smith who is going to be here at 9:00
22 tomorrow morning and then Dr. Calkins on Friday morning.

23 THE COURT: Okay.

24 MS. POLLARA: And so those are the only two

1 witnesses. I think we are on track. I know you like to keep
2 everyone, like, moving forward so I apologize those are my
3 only two people.

4 THE COURT: Don't apologize. When you're dealing
5 with busy professionals who are at the mercy of their
6 schedule as well. Did my law clerk provide with the packet
7 of jury instructions?

8 MR. LUSIANI: Yes.

9 THE COURT: We can go through those tomorrow
10 afternoon.

11 MR. LUSIANI: That's great.

12 THE COURT: Let's take 15 minutes here.

13 (A short break was taken.)

14 (The following proceedings were had in the
15 presence of the jury.)

16 THE COURT: Will counsel stipulate to the presence
17 of the jury?

18 MR. KOZAK: We do.

19 MS. POLLARA: Yes, your Honor.

20 THE COURT: Mr. Kozak, Mr. Lusiani.

21 MR. LUSIANI: We would call Mr. Teichner, CPA, to
22 the stand.

23 (One witness sworn at this time.)

24 MR. LUSIANI: Your Honor, Mr. Teichner is being

1 called as an expert witness in accountancy. I believe by
2 stipulation of the parties he can testify as such. There
3 will be no challenge to his qualifications.

4 THE COURT: All right. He may testify pursuant to
5 50.275. Go ahead, Mr. Lusiani.

6 MR. LUSIANI: Thank you, your Honor.

7 RICHARD MICHAEL TEICHNER

8 called as a witness and being duly sworn did testify as
9 follows:

10 DIRECT EXAMINATION

11 BY MR. LUSIANI:

12 Q. Would you give us your full name, please?

13 A. Richard Michael Teichner.

14 Q. What is your business, profession or occupation?

15 A. I'm sorry?

16 Q. Your business, profession or occupation?

17 A. I'm a certified public accountant.

18 Q. In this case, were you asked to provide analysis
19 and opinion of an expert nature with regard to economic
20 losses sustained as a result of the allegations of the
21 litigation itself?

22 A. Yes, I was.

23 Q. And, specifically, what were you asked to address?

24 A. To determine what the damages were as a result of

1 loss of income of Mr. Dechambeau.

2 Q. And can you tell me what documents you had to
3 review in order to come to your analysis?

4 A. Well, I had the complaint, I had interrogatories,
5 I had depositions of Mrs. Dechambeau and Jean Paul
6 Dechambeau.

7 Q. Did you have tax returns?

8 A. I had tax returns from 2000 to 2006. This is
9 individual tax returns of the Dechambeaus, Mr. and
10 Mrs. Dechambeau.

11 Q. Did you also have the death certificate and the
12 last will and testament of Mr. Neil Dechambeau?

13 A. Yes, I did.

14 Q. Were there other documents that you might have
15 liked to review in order to come up to your ultimate
16 opinions?

17 A. That's hard to say. There's always -- if you
18 don't know what you don't know, then there may be some other
19 documents. I, for example, I didn't see the medical records,
20 but I'm not a doctor, so I don't think I'm qualified to
21 assess those.

22 Q. Okay. And in coming to your opinions, did you put
23 together a calculation of economic loss due to lost earnings
24 in the matter?

1 A. Yes.

2 MR. LUSIANI: Your Honor, I'd like to have
3 Exhibit 25 up on the screen, please.

4 THE COURT: All right.

5 BY MR. LUSIANI:

6 Q. It's kind of hard to tell from here, Mr. Teichner,
7 does that look like the document you produced?

8 A. Yes. That's the original document that I
9 prepared.

10 Q. And in doing this type of an analysis, what are
11 you looking for? What are you using as a basis of your
12 analysis?

13 A. Well, I'm looking at what the historical earnings
14 were of the decedent in this case, Mr. Dechambeau, and using
15 it as a basis to determine what the loss of earnings are
16 through his estimated work life expectancy.

17 So at the time I did this particular schedule, it
18 was before the ending of Mr. Dechambeau's work life
19 expectancy. So I computed the earnings up until the date of
20 the -- the date that I was deposed, more or less, because I
21 was deposed in this matter.

22 And then I also projected out the income up
23 through the date of his work life, the end of his work life
24 expectancy, using the same basis that I did for the

1 historical information.

2 Q. What is a work life expectancy?

3 A. We all have a work life expectancy based on our
4 age, based on our health, based on our education. And so
5 there are tables that determine the work life expectancy.
6 And so I used the tables that I thought were appropriate to
7 determine what the work life expectancy is.

8 In other words, what is the normal date of
9 retirement is the work life expectancy. In other words, what
10 would you expect based on the population and based on the
11 various criteria that I just mentioned what the work life
12 expectancy is of a person who is, in this case, 57 years old
13 at the date of his death. Mr. Dechambeau was 57 at the date
14 of his death.

15 Q. What would the tables that you reviewed and so
16 forth and in your expert opinion, what would his remaining
17 work life have been?

18 A. The table that I used, it was 9.8 years.

19 Q. Beyond the date of his death?

20 A. Yes.

21 Q. Now, you've reviewed Exhibit 25, the document
22 that's on the screen in recent weeks at my request, correct?

23 A. When you say Document 25?

24 Q. Exhibit 25.

1 A. Exhibit 25.

2 Q. That's the document that you're looking at right
3 now.

4 A. Yes.

5 Q. And have you found there to be any inconsistencies
6 or typographical errors in the document itself?

7 A. Yes. There was one typographical error that I
8 found. And since date of birth 9/4/59, by the way, this is
9 kind of read, too, it's blurred. September 4th, 1959, and it
10 actually should be '49, but that doesn't change any of the
11 other information. It was just a typo. It should have been
12 1949, because that was the year that he was born.

13 Q. Okay. Now, your Honor, may I ask that the exhibit
14 be enlarged in certain areas? Let's open up this section
15 here, first, please. What does this part of the document
16 represent, Mr. Teichner?

17 A. Well, the figures I'm showing just mean --

18 Q. What's the concept of it?

19 A. Oh, okay. First of all, I tried to determine what
20 his earnings were historically and that was based on the most
21 recent year, because his earnings were increasing every year.
22 So it was based on 2005, but I took 2006 and annualized it,
23 because he died in 2006. So what I did is I took the
24 earnings from his tax preparation business and from his

1 trucking wages, the trucking services that he provided, and I
2 took those and from that I determined what the growth rate
3 was, which I can explain in a minute, but that's not part of
4 this.

5 And then what I did is on each year in which I
6 took the earnings that he should have earned or he would have
7 earned had he lived, I computed the interest on that to the
8 date of his -- of his work life expectancy.

9 In other words, if in 2007 he was to earn -- let's
10 pick a figure, \$50,000, since I took those amounts out to the
11 date of his end of his work life expectancy, there's an
12 interest factor on it. There's a value to that money. And I
13 used a U.S. Treasury Bill obligation rate, which is the most
14 conservative risk-free rate you can use. Trying to be very
15 conservative in using those rates.

16 So what this shows is the interest rate or what it
17 explains there is the interest rate, the average interest
18 rate for each period that is shown up there. And it's from
19 September 22nd, 2007 to 2008, 2008 to 2009, and so on. What
20 that is is just a delineation of the different years that I
21 used, because the interest changes. The average interest
22 changes for each period that I used. So I took the interest
23 for each particular period, took an average during that
24 one-year period.

1 Q. Can we expand this, please, to include the upper
2 part? All the way up to the top there and expand it over to
3 here, please. Thank you.

4 Are these the earnings that you used from the
5 trucking activity of Mr. Dechambeau?

6 A. Yes. You really have to go out a little further
7 to the right, because it explains what that figure represents
8 at 47,151. And what I did is I took the earnings that he
9 earned, the amounts that he earned up through September 8th,
10 which is the date -- the date of his death, and what I did is
11 I annualized it, because that was 36 weeks. So I took that
12 36-week figure and expanded to a 52-week figure and saying
13 that's what he would have earned had he lived for the whole
14 year. And that figure is \$47,151.

15 And, by the way, that was less than what he earned
16 in 2005. But, again, I was trying to be conservative. You
17 never know. It's kind of sporadic. So the income could have
18 been more, it could have been less, actually, but that was
19 the best information I had at the time. So that's all I
20 could use.

21 Q. And your opinions were based on the documents
22 we've already discussed, correct, the tax returns,
23 essentially?

24 A. Yes.

1 Q. And then deposition testimony and some of the
2 discovery devices, interrogatories and so forth, in the
3 litigation?

4 A. Yes. I considered all of those, yes.

5 Q. You indicated that you were taking conservative
6 views in certain areas. Can you tell me what those areas
7 might be?

8 A. Well, like I said, I think that the earnings from
9 the trucking is conservative. But, again, that's the best
10 information I had. The earnings from the tax preparation
11 business, I took an average of 2004 and 2005. 2005 was much
12 higher than 2004. His income kept going up every year, but I
13 still took an average just based on not having any additional
14 information, and instead of just using the 2005 earnings,
15 which would have been a lot higher.

16 Also, I didn't add back, which I guess I could
17 have, salary that was paid to his son, Jean Paul,
18 Mr. Dechambeau's son, because that was taken as a deduction.
19 And my understanding is that he would -- that Jean Paul was
20 paid as a result of needing the money for a car and for a
21 college education.

22 But I didn't add back that to the income. I
23 included that as a deduction, just as it was on the tax
24 return, on the basis that the tax return is what was filed

1 with the government and that's what I'm going to use.

2 Q. So you took Mr. Dechambeau's earnings as a truck
3 driver, correct?

4 A. Yes.

5 Q. You took his earnings as a tax preparer, correct?

6 A. Yes.

7 Q. You took those incomes and you projected them out
8 over the period of time of his work life, which was
9 9.8 years?

10 A. Yes.

11 Q. And did you do anything else with regard to those
12 figures in coming to an ultimate opinion as to what the
13 economic loss was as a result of this case?

14 A. Well, first of all, when you say projected out, I
15 used the same basic figures that I started off with. In
16 other words, the total of the earnings from the trucking and
17 the tax preparation, which is 15,351, and I increased it
18 three percent per year as a growth rate, which was a lot less
19 than his historical growth rate of his earnings. His
20 earnings historically was a lot more than three percent, but
21 I used three percent, again, being conservative.

22 And I don't know if I answered your question, but
23 then, again, like I indicated before, for each year that
24 there was a loss of earnings, I computed interest from the

1 date -- the average interest rate from the ending date. I
2 didn't even use a middle date. I used the ending date for
3 the earnings each year and computed the interest to the date
4 of that the report, which was -- I don't have it. You have
5 to scroll down.

6 Q. Sometime in 2013?

7 A. Yeah. Correct.

8 Q. Could you drop the enhancement of the exhibits
9 down to the bottom? Yeah. This whole section. What does
10 this represent, Mr. Teichner?

11 A. Again, I don't know if the jury can read this, but
12 the first column, the figures in it, it says, lost earnings
13 with growth. And, again, I've taken each year -- when I say
14 year, I'm talking about a year from the date of his death to
15 one year later, and that is the earnings I just described.
16 That's the amount, that 58,000 that was up at the top, with
17 the three percent a year growth on it. Okay.

18 And so that is just -- that column just shows the
19 growth at three percent rate. The next column is the income
20 taxes that would be attributed to those earnings and I deduct
21 those. And that was based on his tax rate, his tax rate that
22 he was paying after the deductions and so on.

23 Now, I did that, again, being conservative. I've
24 been in other matters where taxes are not deducted and do not

1 reduce the lost earnings, but, again, I was being
2 conservative and I deducted the taxes that would be
3 attributable to that those earnings.

4 So now I come up with the third column figures,
5 net lost earnings. That's the earnings in the first column
6 less the income taxes on those earnings to come up with the
7 net earnings. Okay. Then from that in the next column is
8 personal consumption and I deduct that.

9 Now, what the personal consumption is is when
10 somebody passes away, a spouse, for example, the expenses,
11 the household expenses are less. They go down. So as a
12 result of those going down, those decrease in expenses should
13 not be part of the earnings that were made.

14 In other words, somebody earns money, but they
15 also -- they lose -- the spouse loses the benefit of those
16 earnings that the other spouse made. In this case,
17 Mrs. Dechambeau lost the benefit of the earnings of
18 Mr. Dechambeau. But she'll won't lose all of that, because
19 there's no expenses for him to be incurred in the household.
20 So the personal consumption is a reduction of the loss.

21 So I reduced the earnings, the net earnings by a
22 personal consumption factor, which I talked -- I had a
23 conversation with Mrs. Dechambeau and what kind of expenses
24 were incurred by Mr. Dechambeau during his lifetime. And

1 there are tables on this, too, but it's more accurate when
2 you can actually get the expenses, the actual expenses as
3 opposed to just going by some tables.

4 So after deducting the personal consumption, I
5 come up with the net loss, and that is the next column. The
6 first figure of that column is \$39,900 and, of course, that
7 grows, again, by the three percent per year.

8 Then I added to the losses in that net column the
9 interest that I was talking about before, the interest from
10 the date of, for example, the first column, the first row is
11 September 8th, 2006 to September 7th, 2007.

12 So from September of 2007 to the date that I
13 prepared this schedule, I computed the interest based on the
14 treasury bill rates and that interest amount is shown in the
15 next column.

16 And then I add the interest to the net loss and I
17 come up with a total, historical total at the date I did the
18 calculation. So that's the first set of rows.

19 Q. You did that for each subsequent year, correct?

20 A. What?

21 Q. You did that for each subsequent year?

22 A. Subsequent year to which year, when you say
23 subsequent year.

24 Q. You ran those calculations for age at the end of

1 58 at the year?

2 A. For each consecutive year, right.

3 Q. Right. Did you come up with a total of what you
4 feel the economic loss was?

5 A. Up through age 64?

6 Q. Yes.

7 A. Yeah. That was \$341,109 and that's just the total
8 of that far right column.

9 Q. And then the next horizontal segment looks to be
10 three more -- well, 65, 66, and 66.8. What do those
11 represent? Is that into the future?

12 A. Okay. Again, I did this as of July 30th, 2013.
13 That's a couple of months after I got -- around the time I
14 think I got involved in this matter. And so at that time, I
15 didn't -- you know, I had the past information, but now I
16 have to say, okay, from that date, the date that I was asked
17 to do this report or this schedule, from that date to the
18 date of the work life expectancy, the end of the work life
19 expectancy, which is 66.8 years, I have to project out what
20 the lost earnings were.

21 And I did the same thing that I just explained,
22 except there's no interest on that net amount, because
23 interest is past, based on past monies that were not
24 received.

1 In fact, what you do is in the far right column,
2 it says, present value of future lost earnings, you actually
3 have to reduce that loss, because in the -- the money in the
4 future is not worth the same as it is today. So it was a
5 reduction. In other words, if you -- if you say, okay, give
6 me a dollar in five years from now, well, if somebody is
7 going to give me a dollar in five years from now, you're not
8 going to give them a dollar now. You're going to give them
9 something less than that, because you want interest on that
10 money.

11 So a dollar in five years from now is worth less
12 today and that's the concept between the present value of
13 lost earnings. And so I actually reduce the amount by what
14 we call discounted interest rate. They use the same interest
15 rate that is up above, but it's like a reverse interest rate,
16 if you will, and that is what is in the far right column.
17 Those three amounts total up to \$91,617.

18 And when you add that to the past lost earnings,
19 one is future and one is past, the total loss is, that I
20 computed, is \$432,727 rounded.

21 Q. So it's your expert opinion that as a result of
22 Mr. Dechambeau's death in September of 2006, the family
23 sustained economic damage and loss in what amount as a result
24 of his death?

1 questions on personal consumption. You told us, sir, that
2 there are actually tables that forensic economists like
3 yourself refer to from time to time in a case like this when
4 they're looking at personal consumption rates, correct?

5 A. Well, not exactly. If they have no other actual
6 information, then they can refer to those tables. The
7 problem is with the tables, as far as I can tell, the last
8 table that I think has some validity was published in 2007.
9 So it was kind of obsolete. I could not find anything more
10 current.

11 But, again, I did look at the table just to see if
12 I was anywhere near in the ballpark based on the actual
13 figures.

14 Q. So answering my specific question, my specific
15 question was, there are tables that are available to forensic
16 economists who are looking at the issue of personal
17 consumption, agreed?

18 A. Certainly they're available.

19 Q. Thank you. All right. Now, let's make sure we
20 understand what personal consumption is. Personal
21 consumption, you would agree, is that amount of money that is
22 brought into the household by the person who has passed away
23 that they would have consumed themselves on expenses that
24 they would have incurred had they lived? True?

1 A. Right.

2 Q. In other words, it's money that would have gone to
3 them as opposed to other people in the household?

4 A. It would have gone for their expenses, yes.

5 Q. Right. And that can conclude things like
6 groceries, clothing, car maintenance for them if they have a
7 separate car, it can be for if they have other hobbies or
8 activities or things that they do, all of those things would
9 go into the personal consumption of that person?

10 A. Correct.

11 Q. And if there are more than two people in the
12 household, the personal consumption rate is different than if
13 there are two people in the household, correct?

14 A. Generally, yes.

15 Q. All right. Now, in this case, you say that you
16 did not use the tables, because you had another source of
17 information, correct?

18 A. Right.

19 Q. And what the source of information that you had
20 was that you interviewed Mrs. Dechambeau, correct?

21 A. Right.

22 Q. Now, you did not do any further investigation to
23 verify the information that you got from her. You didn't do
24 things like look at checking book statements or bank

1 statements or credit card statements or anything like that to
2 verify what was being spent in the household for groceries
3 and things like that, correct?

4 A. Correct.

5 Q. You basically interviewed her and took her word
6 for it?

7 A. Yes. They were very conservative figures and I
8 had no reason to disbelieve them.

9 Q. But you would agree that when you look at the
10 number, for example, in this first line that's up there, the
11 \$53,599.31, that would be for the year 2006, 2007, correct?

12 A. Yes.

13 Q. All right. And for that year, the personal
14 consumption that you came up with is about 22.8 percent,
15 true?

16 A. I guess so.

17 Q. That's what you told us at your deposition, right?

18 A. Okay. Yes.

19 Q. And you would agree that that would be a year
20 when -- did you assume there were two people in the household
21 or three people in the household?

22 A. Well, again, you look at the tables, to answer
23 your questions, when you look at the tables, the tables are
24 based on whether you have somebody under 18, a child under

1 18. If they're over 18, then they're discounted. So I took
2 the same -- I did the same thing in this case is where I only
3 -- the personal consumption had to do only with those
4 expenses that were attributed to Mr. Dechambeau. It had
5 nothing to do with anybody else in the household.

6 Q. I understand. But you would agree, sir, that
7 there are tables that are in existence where you have
8 personal consumption being -- personal consumption rate for a
9 two-person household where the rate has been at least
10 25 percent, correct?

11 A. It could be, yeah.

12 Q. And you've seen tables with a two-person household
13 where it's been a greater than 25 percent --

14 A. No.

15 Q. -- interest rate?

16 A. No. No.

17 Q. That's what you said --

18 A. Actually, most of the ones I've seen are less than
19 that, less -- even less than 22 percent. I have -- I did
20 independent research on that for this particular case where I
21 saw where there were -- they weren't tables, but they were --
22 yes, there was one that did have tables and there was another
23 one that just discussed in a narrative form and gave
24 percentages. And they were all less than even the 22 percent

1 that I used.

2 Q. Sir, you gave a deposition in this case back in
3 2013, didn't you?

4 A. Yes.

5 Q. And you testified under oath at that time?

6 A. Yes.

7 Q. And you were prepared at that time?

8 A. Yes.

9 Q. And you knew that you were being -- you were
10 giving your deposition in this case for the purposes of this
11 lawsuit?

12 A. Right.

13 Q. Isn't it true at the time of your deposition that
14 you testified that you had seen tables in a book where you'd
15 seen 25 percent used, correct?

16 A. Correct.

17 Q. And you also said that you probably seen rates
18 higher than 25 percent used. That was your testimony at that
19 time, right?

20 A. Yeah. But I don't know if that's all of my
21 testimony, because I thought I also said that there were
22 other -- in other words, that there were other tables or
23 other -- there was other resources that had something less
24 than that or that it could be as high as that much. I don't

1 remember my exact wording, but --

2 Q. I can read the question and answer for you, if
3 you'd like?

4 A. Okay.

5 Q. Question, have you seen rates higher than
6 25 percent used? Answer, well, probably.

7 A. Yes. That's correct. That's correct. I have
8 seen them higher than 25 percent.

9 MS. POLLARA: Thank you. That's all I have.
10 Thank you, your Honor.

11 THE COURT: Thank you, Ms. Pollara.

12 MR. LUSIANI: Nothing further, your Honor.

13 THE COURT: Mr. Teichner, you're done. Watch your
14 step going down.

15 MR. KOZAK: We're going to rest, your Honor.

16 THE COURT: Thank you very much. Ladies and
17 gentlemen, the plaintiffs have rested their case. I've
18 spoken with counsel here. We have two more witnesses for the
19 defense, their experts. So their schedules are a little
20 different than ours. You'll hear them tomorrow morning.
21 So you'll have tomorrow afternoon off. We'll be working on
22 the jury instructions tomorrow afternoon. But it's likely
23 that you'll be able to get this case by Friday, just as we
24 planned.

1 So, please, overnight, remember the admonition.
2 Don't talk about this case amongst yourselves or with anybody
3 else. Don't allow anybody else to talk to you about the
4 case. Don't form any conclusions until the case has been
5 submitted to you. Don't conduct any independent
6 investigations, any independent experiments, engage in any
7 social media, do any Internet research. Don't read any
8 newspaper account, listen to any radio or television account.
9 We're getting close. So, please, just remember the
10 admonition. Have a good evening. I'll see you tomorrow at
11 9:00. Jury may retire.

12 (The following proceedings were had outside the
13 presence of the jury.)

14 THE COURT: Refresh my recollection, who is up
15 next?

16 MS. POLLARA: Dr. Smith is on tomorrow morning,
17 who will be bright and early, 9:00 to start. And I expect
18 that his testimony will probably take at least on direct a
19 couple of hours.

20 THE COURT: Probably all morning. Okay. And then
21 we have Friday morning?

22 MS. POLLARA: Correct.

23 THE COURT: Which will be?

24 MS. POLLARA: Dr. Calkins.

1 THE COURT: That's right. Thank you. We've got
2 the packet of material. Let's just plan on getting together
3 1:30 or so after lunch and we'll go through the jury
4 instructions. All right. Anything further, counsel, before
5 we break for the evening?

6 MR. KOZAK: Nothing further.

7 MS. POLLARA: No, your Honor.

8 THE COURT: Court's in recess.

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1 STATE OF NEVADA)
2 County of Washoe) ss.

3 I, STEPHANIE KOETTING, a Certified Court Reporter of the
4 Second Judicial District Court of the State of Nevada, in and
5 for the County of Washoe, do hereby certify;

6 That I was present in Department No. 7 of the
7 above-entitled Court on January 18, 2017, at the hour of 9:00
8 a.m., and took verbatim stenotype notes of the proceedings
9 had upon the trial in the matter of ANGELA DECHAMBEAU, et
10 al., Plaintiff, vs. STEPHEN C. BALKENBUSH, et al., Defendant,
11 Case No. CV12-00571, and thereafter, by means of
12 computer-aided transcription, transcribed them into
13 typewriting as herein appears;

14 That the foregoing transcript, consisting of pages 1
15 through 194, both inclusive, contains a full, true and
16 complete transcript of my said stenotype notes, and is a
17 full, true and correct record of the proceedings had at said
18 time and place.

19
20 DATED: At Reno, Nevada, this 1st day of June 2017.

21
22
23
24

S/s Stephanie Koetting
STEPHANIE KOETTING, CCR #207

EXHIBIT 4

EXHIBIT 4

1 4185
2 STEPHANIE KOETTING
3 CCR #207
4 75 COURT STREET
5 RENO, NEVADA
6

7 IN THE SECOND JUDICIAL DISTRICT COURT
8 IN AND FOR THE COUNTY OF WASHOE
9 THE HONORABLE PATRICK FLANAGAN, DISTRICT JUDGE

10 --oOo--

11 ANGELA DECHAMBEAU, et)
12 al.,)
13 Plaintiffs,)
14 vs.) Case No. CV12-00571
15 STEPHEN BALKENBUSH, et) Department 7
16 al.,)
17 Defendants.)

18 TRANSCRIPT OF PROCEEDINGS

19 TRIAL

20 VOLUME III

21 January 19, 2017

22 9:00 a.m.

23 Reno, Nevada

24 Reported by: STEPHANIE KOETTING, CCR #207, RPR
Computer-Aided Transcription

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APPEARANCES:

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1 RENO, NEVADA, January 19, 2017, 9:00 a.m.

2
3 --oOo--

4 THE COURT: Good morning, ladies and gentlemen.
5 Will counsel stipulate to the presence of the jury.

6 MR. KOZAK: We do, your Honor.

7 MR. POLLARA: Yes, your Honor.

8 THE COURT: Ms. Pollara.

9 MR. POLLARA: Thank you, your Honor. At this
10 time, we'll call David Smith to the stand.

11 THE COURT: Dr. Smith.

12 (One witness sworn at this time.)

13 THE COURT: Doctor, if you pull the mic so it's
14 pointing towards you. That's it.

15 DAVID SMITH

16 called as a witness and being duly sworn did testify as

17 follows:

18 DIRECT EXAMINATION

19 BY MS. POLLARA:

20 Q. Good morning, Dr. Smith.

21 A. Good morning.

22 Q. You were the doctor who performed the procedure on
23 Mr. Dechambeau on September 7th of 2006?

24 A. I am.

1 Q. Had you been his treating physician his
2 cardiologist for a period of time before that?

3 A. For a few months.

4 Q. I know it's been a long time since 2006, but as
5 you are sitting here today, do you remember Mr. Dechambeau?

6 A. I do.

7 Q. And do you remember Mrs. Dechambeau?

8 A. I do.

9 Q. Do you remember the procedure that you performed
10 on September 7th or at least parts of it?

11 A. I remember parts of it and I remember most of it.

12 Q. All right. And focusing specifically on the end
13 of the procedure, at the point that Mr. Dechambeau suffered
14 the arrest, do you remember details of what occurred at that
15 point and moving forward?

16 A. I do.

17 Q. All right. Dr. Smith, was there any warning
18 before the arrest occurred?

19 A. There was not.

20 Q. After the arrest occurred, did you suspect that he
21 was suffering from a cardiac tamponade?

22 A. I did.

23 Q. And at that point, did you take steps to perform a
24 pericardiocentesis?

1 A. I did.

2 Q. Was there any delay?

3 A. No.

4 Q. Did you wait for the echo machine to arrive before
5 you started performing the pericardiocentesis?

6 A. I did not.

7 Q. We're going to go into that in more detail, but I
8 want to ask you some questions now about your background and
9 education and experience, if I could. Where were you born
10 and raised?

11 A. I was born in La Habra, California.

12 Q. And can you tell us where and when did you go to
13 college?

14 A. I went to UCLA between 1980 and 1984.

15 Q. What was your degree in?

16 A. Biochemistry.

17 Q. After you completed your college education, did
18 you then go to medical school?

19 A. I did.

20 Q. Can you tell us where and when you went to medical
21 school?

22 A. I went to New York University between 1984 and
23 1988.

24 Q. All right. And then after you graduated from

1 medical school, did you then complete an internship and
2 residency in internal medicine?

3 A. I did.

4 Q. Now, we've heard the term residency. Can you
5 briefly explain to us what is a residency?

6 A. A residency is a physician training and it
7 involves -- internal medicine involves three years of
8 training in basically all aspects of internal medicine, which
9 involve cardiology, oncology. It's a very large specialty.

10 Q. It was a three-year process?

11 A. Correct.

12 Q. You completed that successfully, I take it?

13 A. I did.

14 Q. After you completed your internship residency in
15 internal medicine, did you then go through a fellowship?

16 A. I did.

17 Q. Now, you actually did two fellowships, didn't you?

18 A. Correct.

19 Q. What was the first fellowship you completed?

20 A. The first one was in general cardiology.

21 Q. And so can you explain to us just briefly what is
22 a fellowship and how is it different than a residency?

23 A. It's specializing in just the basics and the
24 aspects of cardiology, which involves arrhythmias, vascular

1 disease, myocardial infarctions, congestive heart failure,
2 multiple aspects of cardiology that's just dealing with the
3 heart.

4 Q. Okay. And how long was your residency in
5 cardiology -- how long was your fellowship, excuse me, in
6 cardiology?

7 A. Three years also.

8 Q. And where did you do your fellowship in
9 cardiology?

10 A. At UCLA.

11 Q. When did you complete that?

12 A. '95.

13 Q. Okay. And then after you completed your
14 fellowship in cardiology, did you do a fellowship in
15 electrophysiology?

16 A. I did.

17 Q. Can you explain to us what was involved in your
18 fellowship in electrophysiology?

19 A. It's a subspecialty of cardiology and just deals
20 with heart rhythm problems, involves with different kind of
21 arrhythmias, abnormal heart rhythms that affect patients and
22 also deals with slow heart rhythms and fast heart rhythms.
23 So we put in pacemakers, we do ablations to get rid of
24 abnormal arrhythmias. We use medications that are

1 specialized for arrhythmia management.

2 Q. Where did you do your fellowship in
3 electrophysiology?

4 A. At Stanford.

5 Q. And when did you complete that?

6 A. It was '96 or '97.

7 Q. All right. And was that a one-year fellowship?

8 A. It was. I spent another six months at Kaiser
9 doing further training. It was kind of off-the-record.

10 Q. Okay. All right. And then after you completed
11 your fellowship in electrophysiology, did you then go through
12 some board certification processes?

13 A. I did. So you have to take internal medicine
14 boards after internal medicine training, you have to take
15 cardiology boards after cardiology training, you have to
16 electrophysiology boards after electrophysiology training, so
17 I took all three.

18 Q. Did you successfully become board certified in all
19 of those specialties?

20 A. I did.

21 Q. To do that, do you have to first go to a training
22 program that is recognized by the organization that board
23 certifies you and then take an exam?

24 A. To sit for the boards, you have to be in an

1 accredited program, so, yes.

2 Q. And have you maintained your board certification
3 in all three specialties up to the present time?

4 A. I maintain my specialties, my board certifications
5 in cardiology and electrophysiology. Not internal medicine,
6 because I don't practice internal medicine.

7 Q. Now, did you become licensed to practice medicine
8 in the State of Nevada?

9 A. I did.

10 Q. When did you first do that, approximately?

11 A. Probably 1997.

12 Q. Whenever you came here?

13 A. Or '96, one of the two.

14 Q. All right. And after coming to Reno, did you gain
15 privileges to practice at any facilities or surgery centers
16 here in the area?

17 A. I did.

18 Q. And can you tell us generally what hospitals and
19 facilities you have privileges at?

20 A. Renown Medical Center was Washoe Medical Center
21 back then, Saint Mary's Medical Center. We also had
22 privileges at Northern Nevada Medical Center.

23 Q. This procedure occurred it was then known as
24 Washoe Medical Center?

1 A. Correct.

2 Q. Dr. Smith, during the course of your training, and
3 I don't know how far back this went, but during the course of
4 your education and training, did you learn about pericardial
5 effusion, cardiac tamponade, those topics?

6 A. Yes.

7 Q. And did you learn how to do pericardiocentesis?

8 A. Yes.

9 Q. And where were you in your training when you first
10 started learning how to do that procedure?

11 A. During general cardiology training. You also get
12 more during electrophysiology training.

13 Q. Was that a procedure that you were familiar with
14 and you knew how to do as of September of 2006 when this
15 event occurred?

16 A. Yes.

17 Q. After you came to Reno, did you join a practice
18 here?

19 A. I did.

20 Q. What practice did you join?

21 A. It was Reno Heart Physicians.

22 Q. Are you still with that group?

23 A. We were bought out by Renown Medical Center, but
24 most of the physicians I joined are still within that same

1 group of practicing doctors.

2 Q. At the time that you saw Mr. Dechambeau, it was
3 still Reno Heart Physicians at that point?

4 A. Correct.

5 Q. Okay. Now, when you joined Reno Heart Physicians,
6 were there any other electrophysiologists in that practice?

7 A. There was not.

8 Q. What was your general role in the practice? Did
9 you do general cardiology or was it a more specialized focus?

10 A. It was all electro cardiology, dealing with
11 arrhythmia management. I did manage some general cardiology,
12 but very little. So I took general cardiology call, which
13 everybody had to, which was nighttime, but my daytime job was
14 electrophysiology.

15 Q. That was your focus?

16 A. Correct.

17 Q. Can you explain to us what different types of
18 procedures you have done between the time you came to Reno
19 and up to September of 2006? Can you give us an idea of what
20 your practice entailed as far as procedures were concerned?

21 A. Well, the basic procedures in electrophysiology
22 are procedures to treat slow heart rhythms, which generally
23 is pacemakers, and procedures to fast rhythms
24 life-threatening arrhythmia's, which are defibrillators, which

1 are small surgical procedures. And then the other procedures
2 are ablations. Ablations are basically taking catheters up
3 through the groin, no different than an IV, and finding
4 abnormal circuits and do ablation, which is basically burning
5 the tissue that causes the arrhythmia.

6 Q. Are those ablation procedures generally -- we've
7 all heard of open heart surgery. Are these open procedures?

8 A. They are not. They are interventional, but
9 they're done through catheters and IVs.

10 Q. All right. We'll talk about a little more. Could
11 I please have Exhibit 41? Doctor, be careful, I put a cup of
12 water there.

13 A. Thank you.

14 Q. But there's a green binder there, and if you could
15 please turn -- first of all, before we get into this, once
16 you get your glasses on, first, can you turn to Exhibit 46
17 for just a moment. We're not going to put it up on the
18 screen. I'm just going to ask you to identify what that
19 document is.

20 A. It's a CV.

21 Q. Is that your CV?

22 A. It is.

23 Q. Is it a true and accurate copy of your CV?

24 A. Yes.

1 Q. If you could please turn to Exhibit 41? And if
2 you can go to the first page of Exhibit 41?

3 A. Okay.

4 Q. All right. I'm not going to show a lot of this
5 blown up, but I just want to take you through a sequence of
6 events, Dr. Smith. So does this appear to be part of the
7 Reno Heart Physicians chart for Mr. Dechambeau?

8 A. It does.

9 Q. And did Mr. Dechambeau come to Reno Heart
10 Physicians on December 28th of 2005 to see Dr. Berndt?

11 A. He did.

12 Q. Who is Dr. Berndt?

13 A. He is one of my colleagues in the group of general
14 cardiologists.

15 Q. What was your -- strike that. What was the
16 purpose of that visit?

17 A. He was referred over by his primary physician for
18 recurrent palpitations or heart arrhythmias.

19 Q. All right. And did Dr. Berndt evaluate him and
20 make some suggestions about further workup?

21 A. He did.

22 Q. Could you please blowup, please the bottom, the
23 second page. If you could turn to page two of that document
24 and just where it says assessment down at the bottom. So

1 what was Dr. Berndt's plan at that point, assessment plan as
2 to Mr. Dechambeau?

3 A. Take him off of his cough medications, which I
4 assume might have been causing some of the problems. Get him
5 monitored, which is a 24-hour monitor, which is basically a
6 constant EKG to see what arrhythmias he had. To get a stress
7 echocardiogram to see if there's evidence of blockage in the
8 arteries. Also check thyroid functions, because sometimes
9 thyroid abnormalities cause arrhythmias.

10 Q. If you could turn to the third page of that? Did
11 Dr. Berndt, then, refer Mr. Dechambeau to Dr. Grinsell for
12 the stress echocardiogram?

13 A. He referred him over to the office for stress
14 echo. Dr. Grinsell was the covering physician on that day
15 and I think the tech came over and saw that he was in atrial
16 fibrillation. That's how John Grinsell got involved.

17 Q. And so can you just explain that a little bit,
18 Dr. Smith? So the tech puts an EKG leads on Mr. Dechambeau
19 and what was discovered according to the records when that
20 happened?

21 A. It was scheduled for a stress test, but he was in
22 atrial fibrillation that day and I think it was the first
23 documentation that he had been having symptoms of this. But
24 he was in the arrhythmia or atrial fibrillation that day. So

1 that's when John Grinsell saw him.

2 Q. And there's a notation that Mr. Dechambeau was in
3 atrial fibrillation with a rapid ventricular response. Do
4 you see that?

5 A. I do.

6 Q. Can you explain what that is?

7 A. Well, normally people are sinus rhythm. That's
8 the natural pacemaker of the heart and these heart rates are
9 going to be 60 to 80 beats per minute. When he went into
10 atrial fibrillation his heart rate was 160 beats. So
11 anything over 100 is considered rapid, but 160 is pretty
12 fast.

13 Q. Did Dr. Grinsell recommend that Mr. Dechambeau be
14 placed on Coumadin?

15 A. He did.

16 Q. Can you explain to us what is Coumadin?

17 A. Coumadin is a blood thinner, which helps prevent
18 stroke in patients with atrial fibrillation. Atrial
19 fibrillation increases the risk of stroke and by thinning
20 your blood, it prevents stasis within the atrium that could
21 cause a stroke.

22 Q. What is stasis?

23 A. Stasis is blood pooling, basically blood pooling
24 and forming a clot.

1 Q. All right. Can you just briefly explain to us,
2 Dr. Smith, what is it about atrial fibrillation that causes
3 or may cause blood to pool and cause clotting? How does that
4 work?

5 A. So atrial fibrillation means that the chambers are
6 going literally like 450 beats per minute. They're going
7 very fast. Your heart rate is what's get down to the bottom
8 chamber. His heart rate at the bottom chamber was basically
9 160. But when it beats that fast, it doesn't squeeze the
10 blood out, the blood sits there and potentially forms clots
11 and that's why you're put on blood thinners.

12 Q. If it forms clots, the clots can travel where?

13 A. It can go out the aorta and into the carotid
14 arteries and cause a stroke.

15 Q. Okay. Now, if you can turn to the next page,
16 Dr. Smith, at the bottom, it says SB01077. I think it's a
17 three-page document that is dated May 22nd.

18 A. Which exhibit is that?

19 Q. It's still in the same exhibit. It's in
20 Exhibit 41.

21 A. Okay. What was the date again?

22 Q. I believe it is May 22nd, it's your consultation
23 note?

24 A. May 15th.

1 Q. I'm sorry.

2 A. No problem.

3 Q. Now, is this three-page document, just looking at
4 the top of the first page here on the screen, but can you
5 explain what this three-page document is, Dr. Smith?

6 A. Yes. It's electrophysiology consult. So Dr.
7 Berndt sent Mr. Dechambeau over to me for further treatment
8 of his atrial fibrillation.

9 Q. And did you talk with Mr. Dechambeau at that time
10 about what problems he was experiencing?

11 A. I did.

12 Q. And can you tell us what he told you?

13 A. He had been having palpitations and feeling
14 somewhat poorly with it. Sometimes he could break them with
15 deep breathing. He had been put on beta blockers, which are
16 to kind of try to control arrhythmias. But, basically, he
17 was having difficult with symptomatic arrhythmias.

18 Q. And did he indicate to you that these problems had
19 been going on for sometime, but they seemed to be getting
20 worse?

21 A. Correct.

22 Q. And did he also describe to you that he thought he
23 was actually having two different types of arrhythmias?

24 A. He described possibly two different types of

1 arrhythmias.

2 Q. Did you do a physical examination?

3 A. I did.

4 Q. And was Mr. Dechambeau a bit on the larger side?

5 A. He was.

6 Q. All right. On your physical examination, were
7 there any particular findings that you were able to discern
8 when you physically examined him?

9 A. There wasn't much to it. He was larger. He was
10 not in an abnormal rhythm during the examination.

11 Q. All right. And so then did you look at the
12 laboratory data that was available to you at that time?

13 A. I did.

14 Q. So, Dr. Smith, can you explain to us what
15 laboratory data did you examine or look at in the context of
16 seeing Mr. Dechambeau. And what significance, if any, did it
17 have for you that day?

18 A. So the date I looked at was his electrocardiogram
19 from that day, which showed a finding of a larger left
20 atrium, which makes you more apt to have atrial fibrillation.
21 I also looked at a stress echocardiogram, which showed
22 enlarged atrium, but no evidence of ischemia, meaning there
23 wasn't any suggestion of coronary artery disease. Also
24 looked at EKG strips from the stress test and the previous

1 EKG that Dr. Grinsell had done. And also looked at his blood
2 work.

3 Q. Did you have a conversation with Mr. Dechambeau
4 that day, Dr. Smith, about what your diagnosis or assessment
5 was of him and what recommendations you had for him at that
6 point?

7 A. I did.

8 Q. And can you explain to us what you told him?

9 A. I told him that he had definite atrial
10 fibrillation. That's been documented. He may have had
11 another heart rhythm problem that caused a regular fast
12 rhythm, but I'm not 100 percent sure of that. Clinically, he
13 stated something that was more consistent with that. And
14 that the options are kind of live with it the way it is, but
15 he was pretty symptomatic, or try new medication, which would
16 be stronger and may get the arrhythmia under control.

17 Q. Looking at the bottom of the page, there's a
18 notation regarding starting him on Tambocor. Do you see
19 that?

20 A. I do.

21 Q. Is that the stronger medication that you were
22 referring to?

23 A. Yes. It's an antiarrhythmic medication.

24 Q. Antiarrhythmic meaning what?

1 A. It's really a medication just to treat arrhythmias
2 like atrial fibrillation. The beta blocker, the Timolol that
3 he was on, sort of treats arrhythmias. It makes it a little
4 bit better, but it doesn't usually control it.

5 Q. Are there potential side effects of that
6 medication?

7 A. There are.

8 Q. And what are some of the more common side effects?

9 A. People get a little GI side effects,
10 gastrointestinal side effects, sometimes some nausea,
11 vomiting. Common side effect would be double-vision.
12 Pro-arrhythmia, sometimes it turns atrial fibrillation into a
13 different arrhythmia, which can be troublesome. It's not
14 felt to be a great drug for people who have had coronary
15 artery disease. Those are some of the main ones.

16 Q. If you could turn to the second page? Did you
17 also have a conversation with Mr. Dechambeau that day about
18 ablation as a possible option for him?

19 A. I did.

20 Q. And why did you talk with him about ablation at
21 that point if you were going to put him on medication?

22 A. Because often the medications don't work. At that
23 time, we always try medications, antiarrhythmic medications
24 first. And you have about a 40 to 50 -- maybe 50 percent

1 chance of having good control with the medication. So half
2 the time people don't respond real well with it.

3 Q. All right. And you probably don't remember this
4 conversation with him, but did you have a custom and practice
5 back at that time, Dr. Smith, as to what you would tell
6 patients in this situation about atrial fibrillation ablation
7 and can you tell us what that was?

8 A. It's a long time ago, but I know what I do right
9 now. I talk about the risks of atrial fibrillation, the
10 stroke, and he was on Coumadin already to help protect him
11 against stroke. But also talk about the medications, the
12 side effects, the potential response to them. And I also
13 give them usually other options in case the medications don't
14 work. I also tell them if they have side effects on the
15 medications, to call us and we may adjust them one way up or
16 down. So the main gist of the conversation.

17 Q. All right. And then in the note, there's a
18 mention a king of hearts monitor, do you see that?

19 A. I do.

20 Q. Can you tell us what is a king of hearts monitor?

21 A. So it's like having an EKG machine, but you only
22 get one rhythm. An EKG gives you 12 leads and king of hearts
23 give you one lead. It gives you what your rhythm is. It's
24 something that you wear for anywhere from two to four weeks

1 and it really gives you an idea of how much burden atrial
2 fibrillation, or how much arrhythmia the patient has. It
3 kind of gives an idea where the symptoms are coming from and
4 whether the medications are working.

5 Q. If you could next turn to your -- you have a note
6 of May 22nd, 2006, which is also in Exhibit 41, is that true?

7 A. Yes.

8 Q. And can you just briefly describe what is that
9 note and what reference, just explain that to us?

10 A. The note from May 22nd?

11 Q. Correct.

12 A. When I saw the patient in the clinic, I looked at
13 the report of the echocardiogram. This is that I actually
14 set my eyes on it and looked at it and reviewed it myself. I
15 was just writing down what I saw.

16 Q. All right. And then did Mr. Dechambeau return on
17 May 31st of 2006?

18 A. Correct.

19 Q. What was the purpose of that visit?

20 A. It's follow-up to see how he's doing.

21 Q. Did he offer any complaints to you at that time?

22 A. He had more fatigue with the Tambocor.

23 Q. So was it your impression he was having some side
24 effects from that?

1 A. It sounded like it.

2 Q. And then did he next return on July 12th of 2006?

3 A. Yes.

4 Q. What was the purpose of that visit?

5 A. Also a follow-up to see how he's doing on the
6 medication.

7 Q. At the time of that visit, Dr. Smith, what was
8 your impression from what he was telling you as to how he was
9 doing on the medication?

10 A. He was not getting great control on the
11 medication.

12 Q. All right. And so at that point, was there a
13 discussion with him about the possibility of an atrial
14 fibrillation ablation to try to help him?

15 A. We did talk. I did talk to him about that.

16 Q. All right. And can you tell us at this point,
17 and, again, understanding this was a long time ago, at the
18 point that you're talking with a patient like this about the
19 actual procedure, what discussion do you have about the
20 procedure itself?

21 A. I usually describe what the procedure is, what its
22 purpose is to make them have less or no atrial fibrillation.
23 I discuss how it's done.

24 Q. Can you tell us what you would say to a patient in

1 that situation about how it's done?

2 A. Sure. So basically tell them it's done under
3 general anesthesia, because it's a somewhat long procedure,
4 anywhere from two to four hours. And, basically, we prep and
5 drape the groin and the neck and we put some IV catheters in
6 the groin and the neck, pass the catheters up to the heart
7 through basically the right chamber and do mapping in the
8 left chamber.

9 And the way we get over to the left chamber is we
10 do what's called a transseptal catheterization, which is a
11 needle that punctures the septum that goes over to the left
12 atrium. We puncture it twice in the standard procedure. One
13 catheter goes over there for mapping and the other catheter
14 goes over there for ablation, which is the cauterization of
15 the arrhythmias.

16 Told him it would be about two to four hours. We
17 give blood thinners during the procedure. After the
18 procedure, generally patients stay one day, and they go home.
19 And success rates for SVT, which was the other arrhythmia
20 that I thought he had, would be about 90 to 95 percent. The
21 reason it's higher for that arrhythmia is because there's
22 only one circuit you have to burn. The success rate for
23 atrial fibrillation ablation is going to be about 60 to
24 70 percent. Meaning that you can get rid of the arrhythmias

1 and patients don't need medication. And the complications
2 rates are going to be two to three percent.

3 Q. And did you at that point have a conversation with
4 him about what some of those potential complications would be
5 or could possibly be?

6 A. I wrote that I did. I generally do. I don't
7 recall the conversation, but it's in my note that I did.

8 Q. Would those things include things like stroke,
9 bleeding, hopefully not, but on occasion death and things of
10 that nature?

11 A. Yes.

12 Q. All right. Looking at the next page, did he make
13 up his mind at that visit that he was going to actually have
14 the procedure?

15 A. He did not.

16 Q. If you could look at the next page of Exhibit 41,
17 doctor, does it appear at some point Mrs. Dechambeau called
18 and said he made the decision to have the procedure?

19 A. It appears that he did and I think his wife called
20 to schedule.

21 Q. Now, doctor, we're done with the green binder.
22 What I'd like you to do is you can put that aside and the
23 white binder in front of you what I'd like you to do is turn
24 to Exhibit 2. Could you identify what this document is for

1 us?

2 A. It's the history and physical for the admission
3 for the procedure.

4 Q. And is this a document that you created?

5 A. I did.

6 Q. All right. I'd like to just turn to page two of
7 that procedure. And before we do that, are you required as a
8 physician who is admitting a patient for a procedure to
9 create this type of document?

10 A. I am.

11 Q. And, generally, what is the purpose of having a
12 document like this, generally speaking?

13 A. It basically tells the staff why the patient is
14 there. Helps them with the management so they can help me
15 with the management of the patient. Also to discuss the --
16 what the patient had, also to talk about the risks in the
17 procedure.

18 Q. What I'd like you to do is turn to the second page
19 of history and physical, Exhibit 2, and I want to focus on
20 assessment for a moment. And so, doctor, the assessment and
21 plan, this was your assessment and plan for Mr. Dechambeau
22 that day?

23 A. Correct.

24 Q. And you do indicate the success rate is

1 approximately 60 percent, correct?

2 A. Correct.

3 Q. You say prior to the procedure, the Coumadin has
4 been held.

5 A. Correct.

6 Q. Why do you do that?

7 A. At that time, we held the Coumadin. Coumadin is a
8 blood thinner and would increase the risk of bleeding during
9 the procedure.

10 Q. And it also says he will get a transesophageal
11 echocardiogram. Do you see that?

12 A. I do.

13 Q. Can you explain a transesophageal echocardiogram
14 and why do you do that at the beginning of the procedure?

15 A. The transesophageal cardiogram is another way of
16 looking at the heart, but it's basically a tube that goes
17 down the esophagus and gives you excellent views of the heart
18 so you can see whether there's any chamber enlargement, see
19 whether there's an anatomic abnormalities, and also to see if
20 there's any clots in the left atrium, which would put the
21 patient at risk for a stroke during the procedure.

22 Q. All right. And was in fact the echocardiogram
23 done at the beginning of the procedure? If you could turn to
24 Exhibit 9?

1 A. Exhibit 9?

2 Q. Yes.

3 A. Yes, it was.

4 Q. Was it sufficiently done showing no clots so that
5 he could have the procedure?

6 A. Yes.

7 Q. And who did that echo?

8 A. Dr. Coley.

9 Q. And did he remain in the electrophysiology lab for
10 the entire procedure, or did he come in to do this? What was
11 his involvement?

12 A. He just came in for the transesophageal
13 echocardiogram.

14 Q. If you could go to Exhibit 2 and go back to
15 assessment and plan once again. The last line says, also, we
16 will use an intracardiac echographic catheter. Do you see
17 that, the last line?

18 A. I do.

19 Q. All right. What is an intracardiac
20 echocardiographic catheter?

21 A. It's another way of looking at the structures in
22 the heart via a catheter that is placed within the right
23 atrium. It's ultrasound technology that allows you to get
24 kind of unencumbered or something that is not blocked of view

1 of the septum. We used it at that time for the transseptal
2 catheterization.

3 Q. We heard a little about this yesterday, Dr. Smith.
4 Is that basically a little camera that you thread up through
5 one of the veins or arteries up into the heart?

6 A. It's a catheter thing. A catheter that is
7 threaded up via the vein in the groin up into the right
8 atrium and it's an ultrasound. So it's not really a camera,
9 but it's an ultrasound probe.

10 Q. When you say the groin, there's a vein that you
11 access down in the leg area?

12 A. Correct. It's either the right or left femoral
13 vein, which goes directly up to the inferior vena cava, which
14 goes to the right atrium with this catheter.

15 Q. How long, approximately, is the catheter that
16 you're threading up into the heart from that location?

17 A. So it's a little bit longer from -- longer than
18 the area from your vein down in the groin, up to the heart.
19 So it's probably, I don't know, 60, 70 centimeters.

20 Q. All right. And so we'll talk a little bit more
21 about that in a moment, but let's now go to Exhibit 4 and
22 let's just look at the first page of that.

23 All right. Doctor, this is a 25-page document
24 that is a part of the hospital record, is that correct?

1 A. Correct.

2 Q. And generally speaking, can you just tell us what
3 this document is? And not particularly any one part of it,
4 but how would you describe this document?

5 A. This is the log that is printed out from the
6 Prucka system or the electrophysiology computer. So it's a
7 log. Some of the entries are placed manually and some are
8 automatic.

9 Q. And can you explain what is a Prucka, P-r-u-c-k-a?

10 A. Correct. It's just a recording system that we use
11 for the electrophysiology study. So it gives us all the
12 intracardiac electrograms, meaning that when we put catheters
13 into the heart, you can see exactly where the electrical
14 circuits are coming from and it's recorded on a computer and
15 on a video.

16 Q. Are there some entries, I think you mentioned
17 this, just to clarify, are there some entries that are placed
18 in the log automatically by the computer?

19 A. Correct.

20 Q. Can you explain what entries are placed
21 automatically by the computer?

22 A. Blood pressures usually are automatic, sometimes
23 pulses are automatic, and the ablations, the times of the
24 ablations are automatic. If you pace, that automatically

1 goes into the computer, too.

2 Q. What do you mean pace?

3 A. Basically, when you put a catheter into the heart,
4 you can put an electrical stimulus to the tip of the
5 catheter, which will pace the heart, make the heart go
6 faster.

7 Q. And why would you do that?

8 A. To look for different types of arrhythmias. So
9 when we do an electrophysiology study, we were concerned that
10 he had what we call supraventricular tachycardia, or SVT,
11 which is a single circuit. So we would basically go through
12 a whole protocol to see whether I can get him into that fast
13 rhythm and those things would be recorded. It's a standard
14 protocol that you're taught during cardiology and
15 electrophysiology.

16 Q. This Prucka tape, the equipment that it's run on,
17 is it a proprietary GE equipment?

18 A. The company was bought by GE. It's not a tape,
19 it's a disk.

20 Q. And is that something that is easy to reproduce
21 and bring into a courtroom to show people?

22 A. At this time, pretty hard. It's such old
23 technology.

24 Q. All right. Now, this is just part of the first

1 page and it indicates staff that are in the room and so
2 forth, correct?

3 A. Correct.

4 Q. Now, there's some entries that you told us are
5 automatically put in. Are there entries that are put in that
6 are manually put into this log?

7 A. Yes.

8 Q. And can you explain to us what entries are placed
9 manually into the log?

10 A. Notations of different heart rhythms that might be
11 put in by the tech, notations of different equipment that you
12 use during the procedure. Those are most of the manual
13 entries.

14 Q. Okay. On the same page, doctor, we see a number
15 of entries for procedures on page one of Exhibit 4. Do you
16 see that?

17 A. I do.

18 Q. And under the word procedure on the right-hand
19 side where it says venus access, et cetera, down to
20 pericardiocentesis, is it your understanding that those are
21 all manual entries?

22 A. They are.

23 Q. It says here that the pericardiocentesis time was
24 1:35 p.m., do you see that?

1 A. I do.

2 Q. Is that accurate?

3 A. No.

4 Q. So someone had to actually manually go in and type
5 that in?

6 A. Correct.

7 Q. What I'd like you to do is go in the same exhibit,
8 please, I want you to go to it's page 1261, which is about 13
9 pages down, and it's the beginning of the event log.

10 A. Okay.

11 Q. All right. So this is the event log that is in
12 the electrophysiology log for this patient?

13 A. Correct.

14 Q. And we see that there's comments on the right-hand
15 side?

16 A. Correct.

17 Q. Generally, is that what you're referring to when
18 you were talking about making manual entries into the log as
19 you go along?

20 A. Correct.

21 Q. Is that done by you during the procedure,
22 Dr. Smith?

23 A. No.

24 Q. Who does that generally speaking?

1 A. The cardiovascular tech who is on the computer
2 near the keyboard.

3 Q. Did this procedure start as far as getting the
4 patient into the room at about 8:00 in the morning?

5 A. Yes.

6 Q. All right. But then before the procedure could
7 actually start was there some preparation that had to happen
8 before you could actually start doing ablations?

9 A. Yes.

10 Q. Now, was Dr. Kang the anesthesiologist?

11 A. He was.

12 Q. Is he still living in Reno?

13 A. I think he's deceased.

14 Q. All right. Now, you mentioned a while ago
15 generally about putting sheathes in or catheters in.
16 Dr. Smith, can you explain to us generally the process by
17 which you're going to get these catheters up into the heart?
18 What's the process that you follow?

19 A. So the patient comes into the lab. Anesthesia is
20 given to the patient as per the anesthesiologist. So tubes
21 are put down into the trachea, so he's breathing on the
22 machine.

23 Then we prep and drape the groin and the neck. We
24 use a little bit of local lidocaine and we put IV catheters

1 within the groin. In this case, we put two IV catheters in
2 the right femoral vein and one IV catheter in the left
3 femoral vein and one in the right internal jugular vein.
4 They're no different than putting an IV catheter into your
5 arm. They're just bigger vessels that give you direct access
6 to the heart.

7 Q. And then after you do that, you're then able to
8 pass the equipment that you're using up into the heart?

9 A. Correct. They go up under bioscopies or x-rays,
10 you see them so you can safely pass them up there. And then
11 we can actually see these catheters with kind of a GPS 3-D
12 mapping system so you don't have to be on x-ray as long.

13 Q. And you talked about mapping a couple of times.
14 Can you explain to us, what does it mean when you're doing a
15 mapping?

16 A. So you get the patient into the abnormal heart
17 rhythm. You take these catheters, which have multiple
18 electrodes, which are sensing the electrical activity within
19 the heart. And you're basically seeing where the arrhythmia
20 starts so you can map it, such that you can actually ablate
21 the location that is causing the arrhythmia. Usually, if you
22 have an successful ablation, the arrhythmia will simply
23 disappear.

24 Q. If you could turn to, I think it's the next page,

1 1262. And, doctor, we were talking about this intracardiac
2 echo catheter. And I'm just going to point to this so we can
3 blow it up. At a certain point during this procedure, did
4 you put in the intracardiac echo catheter?

5 A. I did.

6 Q. All right. Let's see here. You can probably see
7 it easier than me, but can you tell me how many lines down it
8 is on this page?

9 A. It's on --

10 Q. Is it on the prior page?

11 A. It's the top one quarter. It's at 8:53:30.

12 Q. Just right here. Okay. So, doctor, did you put
13 in the ICE catheter or the intracardiac echo catheter?

14 A. I did.

15 Q. And can you explain why you did that?

16 A. We use it for safe transseptal catheterization.
17 So when we pass the mapping and the ablation catheter from
18 the right atrium to the left atrium, you have puncture the
19 septum between the right atrium, left atrium and you use a
20 needle. And with a needle, you can see it with a
21 intracardiac echo catheter very carefully so you can safely
22 puncture the septum.

23 Q. Did you say there were two punctures?

24 A. There's two.

1 Q. And why do you make two punctures?

2 A. One catheter goes over there, it's either a halo
3 or a spiral catheter, and that's the mapping catheter. You
4 put those in the pulmonary veins where most of the atrial
5 fibrillation occurs, so you can see the signals there. You
6 leave it in the pulmonary vein. And you take another
7 catheter and ablate around the outside of the pulmonary vein
8 in the atrium so you can see the signals disappear. That's
9 the way you treat atrial fibrillation.

10 Q. And so, generally speaking, as this procedure was
11 carried out by you, was it uneventful up until the arrest?

12 A. Yes.

13 Q. And can you just generally explain what did you do
14 for Mr. Dechambeau during the procedure before the arrest
15 occurred? Just give us a description of what the procedure
16 entailed.

17 A. So we got all the catheters in. We did the
18 transseptal catheterization under the ICE or the intracardiac
19 echocardiogram guidance and put the mapping catheter into the
20 left atrium. There's four veins that go into the left
21 atrium. There's the left veins and right veins. We take
22 another ablation catheter and we encircle them so that none
23 of the signals can come out. Then after that, we try to
24 induce arrhythmias.

1 Prior to that, we look for the single arrhythmia,
2 the supraventricular tachycardia, which he did not have. We
3 did not see that. So we did not go any further with that.
4 But basically the ablation around the pulmonary veins.

5 Q. All right. And then were there any complications
6 during that part of the procedure?

7 A. No.

8 Q. Now, Dr. Kang in his anesthesia note documents
9 that at 12:22 -- if you go to page two, please?

10 A. Which exhibit is this?

11 Q. This is Exhibit 5. And if you could go to page
12 two. Dr. Smith, Dr. Kang documents that at 12:22 p.m., that
13 there was a V tack and that as a result, the patient was
14 defibrillated for that rhythm. Is that accurate?

15 A. It is not.

16 Q. Can you explain what rhythm the patient had at
17 that time?

18 A. Atrial fibrillation slash atrial flutter, one of
19 the two.

20 Q. Was there anything unusual about the patient
21 having either atrial fibrillation or atrial flutter at that
22 point in the procedure?

23 A. No. I think I actually induced it, because we
24 were doing the testing. It's pretty common.

1 Q. Was there anything unusual going on at that point
2 in the procedure, as far as you could tell?

3 A. No.

4 Q. All right. Now, was there anything that caused
5 you to think there was anything wrong, anything bad was
6 happening to Mr. Dechambeau?

7 A. No.

8 Q. All right. Now, at some point in this procedure,
9 did you remove the intracardiac echo catheter?

10 A. I did.

11 Q. And how do you know that you took it out?

12 A. Because I had to put another mapping catheter in
13 the right atrial to ablate the atrial flutter that was
14 induced.

15 Q. If you can turn in Exhibit 4, and it is page 21.
16 And if you look down at the bottom, doctor, it's 1269.

17 A. Okay.

18 Q. What catheter did you put in in place of the ICE
19 or the intracardiac echo catheter?

20 A. The halo catheter.

21 Q. Is that noted at 12:32:39?

22 A. Yes.

23 Q. So can you explain that? In other words, why
24 would you take out the intracardiac echo and why would you

1 put this in again. Just explain that to us?

2 A. Because the arrhythmia that was induced was an
3 atrial flutter and that comes from the right atrium, not the
4 left atrium. This is a catheter that is specifically
5 designed to map in the right atrium and it's used as a
6 standard of care for right atrium mapping to get rid of
7 atrial flutter that was induced.

8 Q. And so why did you have to take the intracardiac
9 echo to put that in? Couldn't you just use something else to
10 get that in there?

11 A. It would entail, you would have to get access
12 again, and we had three catheters in the groin already, we
13 had one in the neck, and it was the general treatment at that
14 point is to take the ICE out, things are stable, and just
15 replace it with a halo catheter. Because you're really on
16 the right side, not on the left side, which is the lower risk
17 of bleeding.

18 Q. So at that point, there was no echo in either
19 atrium, correct?

20 A. Correct.

21 Q. And, in fact, you testified to that your
22 deposition, didn't you?

23 A. I don't remember. I'd have to see it.

24 Q. All right. And did you put the ICE back in at any

1 point after you took it out?

2 A. I did not.

3 Q. Were you essentially going to be done with the
4 procedure in a fairly short period of time after that, at
5 least that was the plan?

6 A. I was hoping.

7 Q. Now, let's move to what happened next, if we
8 could, Dr. Smith. What was your first indication that
9 Mr. Dechambeau was having a problem?

10 A. The blood pressure, which is monitored by the
11 anesthesiologist, he stated that it was quite low.

12 Q. And before that, did you have any warning at all
13 that there was a problem at all with this?

14 A. It happened suddenly.

15 Q. Now, at that point, did you form an impression as
16 to what you thought was going on?

17 A. I did.

18 Q. And what was your concern or thought at that time?

19 A. Cardiac tamponade.

20 Q. Why did you think that was possibly what was
21 happening?

22 A. It would be the most common complication at that
23 setting of the procedure.

24 Q. Now, in order to do the procedure, is the patient

1 on a blood thinner?

2 A. We take them off the Coumadin, but during the
3 procedure, we give a lot of heparin. That's to prevent any
4 kind of clot from forming during the ablation or the burning.
5 It's to prevent strokes. He received quite a bit of heparin.
6 The amount of heparin or blood thinners you give is based on
7 the weight of the patient, so he got quite a bit.

8 Q. So heparin is also a blood thinner, it's just a
9 different type?

10 A. Short-acting, IV.

11 Q. Now, was there a pericardiocentesis tray in the
12 room?

13 A. There is always.

14 Q. And can you just explain to the ladies and
15 gentlemen of the jury, when this happened, take us through
16 what occurred at that point, what did you do?

17 A. Called a code. So the anesthesiologist, he gives
18 lots of volume, he gives medications. CPR is started. We
19 asked for the pericardiocentesis tray. We asked for a stat
20 echo to come down and help with the pericardiocentesis in
21 case there's a problem with it. We also asked for the
22 surgeons. We also asked to reverse all the blood thinners.
23 It all happens almost simultaneously.

24 Q. So is it the case that you're barking out orders

1 and the team is jumping into gear?

2 A. Correct.

3 Q. Why order CPR if you thought the patient had
4 cardiac tamponade? Isn't it useless in that setting?

5 A. It's pretty standard to do CPR in that setting.
6 You're not 100 percent sure it's cardiac tamponade. You're
7 99.9 percent. So it certainly wouldn't hurt the patient. It
8 may not be effective. It may be effective once you get some
9 of the blood out. But it would be kind of standard.

10 Q. Was this the first time, Dr. Smith, that you had
11 ever been in a code situation?

12 A. No.

13 Q. Unfortunately?

14 A. Unfortunately.

15 Q. Now, prior to this particular event with
16 Mr. Dechambeau, had you ever had a patient arrest during an
17 atrial fibrillation ablation procedure?

18 A. I have not.

19 Q. Have you had patients arrest during other types of
20 procedures where you had to go in and do a
21 pericardiocentesis?

22 A. I have. The blood pressure didn't go. On these
23 patients, the blood pressure didn't go down as rapidly as
24 this.

1 Q. Can you explain that?

2 A. When you have a blood pressure that's literally a
3 110 or 120 over 70 and it goes down to 25, which is the upper
4 number, and -- so when people get cardiac tamponade, it can
5 be a slow drain or it can be fast. It's quite rapid. The
6 patient's blood pressure can go down quite quickly.

7 If it's slower, it can gradually go down. So you
8 can -- a lot of times you don't have to do CPR, because the
9 patient has a blood pressure and he's responding. Some
10 people are not on anesthesia at that time, so you can talk to
11 them and you can do the pericardiocentesis. You still have
12 to do the pericardiocentesis, but the patient is not in a
13 code situation.

14 Q. All right. Thank you. Now, I want to go to
15 Exhibit 5 again, if we could. You made a comment, Dr. Smith,
16 about Dr. Kang pushing fluids. What I'd like you to do is
17 blowup, please, right here.

18 Mr. Dechambeau had some intravenous lines in place
19 at the beginning of the procedure just to get intravenous
20 fluid and heparin and things like that, correct?

21 A. Correct.

22 Q. This is part of the anesthesia record that Dr.
23 Kang created?

24 A. Correct.

1 Q. I've blown up this entry under the graph, and
2 there's a box there that has kind of a tip to it. Can you
3 read what that says for us?

4 A. 6 to 8 liters of IV fluid total.

5 Q. Can you read what it says right before that?

6 A. Multiple lines started.

7 Q. So is it your understanding and recollection that
8 during this code Dr. Kang put in additional lines?

9 A. Yes.

10 Q. And what was your understanding as to why that was
11 being done?

12 A. To give IV fluid and also to use pressers.

13 Q. And so when you look at that and you look at 6-8,
14 what does the L stand for?

15 A. Liters.

16 Q. And what are IVF?

17 A. IV fluids.

18 Q. Is it your recollection that this patient was
19 getting IV fluids during this arrest?

20 A. I was concentrating on the pericardiocentesis, but
21 that would have been standard, and Dr. Kang was a very good
22 anesthesiologist. And I'm sure we talked about it, but I
23 don't have any recollection that he was actually giving IV
24 fluids. But that would be quite a bit of IV fluid, so he

1 must have gotten some.

2 Q. All right. So generally speaking, can you
3 describe for us, Dr. Smith, what the team was doing during
4 this approximate 13 to 15 minute period? We'll talk about
5 the time frames in a minute, but what were people doing in
6 the room?

7 A. So Dr. Kang was helping with the code. He was
8 giving IV fluids. He was giving pressers. He was giving
9 things to hopefully help the heart rate come up, because the
10 heart rate got somewhat slow. There was one person who was
11 doing CPR. There was another person helping me with the
12 pericardiocentesis. You have to quickly prep and drape the
13 area right below the sternum to do that. And I was doing the
14 pericardiocentesis.

15 There's other people documenting. There's one
16 person documenting the code, one of the nurses. Usually
17 there's a lot of people in the room. When a code is called,
18 it's not just the crew, other people come to help. It's --

19 Q. Was anyone just standing around?

20 A. No. No. Everybody is working hard. It's a
21 stressful situation, but everyone is working as hard as they
22 can.

23 Q. Doctor, I asked you this at the beginning of your
24 testimony, did you hesitate at all in getting ready to and

1 then performing the pericardiocentesis on Mr. Dechambeau?

2 A. I did not.

3 Q. He was a larger man, were you able to get the
4 needle in?

5 A. I was.

6 Q. And can you describe generally, Dr. Smith, what is
7 that process? Can you take us through that? How actually
8 are you doing the pericardiocentesis?

9 A. So you got to basically prep the area right below
10 the sternum. And you take a long needle, it looks like a
11 spinal needle, and it goes directly towards either the left
12 shoulder or a little bit more rightward. And you aspirate as
13 you come out until you get blood back. And once you get
14 blood back, you pass a wire through the needle and then put a
15 sheathe in there to drain the blood.

16 You also look under x-ray to see that the wire is
17 in the right location. And you also get an echocardiogram to
18 make sure that the needle is in the proper location, that you
19 didn't go into the chamber. Because if you put the needle
20 into the chamber, which is one of the risks, because the
21 pericardial space is on the outside, if you go a little bit
22 too far, it's blind, you go a little far, you could be in the
23 chamber. You would be draining blood from the chamber. That
24 would make things worse, not better. So that's the standard

1 treatment is to drain the blood or the fluid around the
2 pericardial sack.

3 Q. And let me ask you this, when you put the needle
4 in, did you get blood out?

5 A. This is 11 years ago, but, yes. I mean, I was
6 getting blood back. I was getting a lot of blood back.

7 Q. Let me stop you for a second. I'm trying to
8 visualize it and to get an understanding. Once you put the
9 catheter or the drain in to the pericardial space, does the
10 blood just gush out or do you have to do something to take it
11 out?

12 A. You have to draw it out. So you'll see blood --
13 as you put it into the space, you're pulling back on the
14 syringe. As you pull -- you come in, you're pulling back on
15 the syringe and nothing is coming out, it might be that
16 you're near some tissue or you're near air, it could be
17 anything. Once you get into the space, as you draw back, you
18 get blood.

19 It's much like if you put a needle into a vein.
20 So if you're -- as you put an IV in there, you don't get
21 blood back until you get into that space.

22 Q. So to picture this, you have a needle and you have
23 a syringe on the end of the needle?

24 A. Usually, like a 20 cc syringe is the standard one.

1 Q. Are you pulling back on the plunger to get blood
2 out?

3 A. To get negative pressure to pull back, yes.

4 Q. And so in this case, as you were getting blood
5 out, would you typically expect a response from
6 Mr. Dechambeau or a patient if you're getting blood out of
7 the pericardial space in this situation?

8 A. You're hoping for the blood pressure to come back
9 up, yes.

10 Q. And as you were taking blood out, was that
11 happening?

12 A. Initially, no. Once I got enough of the blood
13 out, yes.

14 Q. Okay. So, initially, was the patient responding
15 as you expected that he would as you were drawing blood out?

16 A. If it had been a small pericardial effusion, he
17 wouldn't have been responding as I expected. If it was a
18 large pericardial effusion, it would just take time to get
19 all the blood out. It may take a few minutes to get the 300
20 cc or 400 ccs of blood that has accumulated within the
21 pericardial space.

22 Q. And are you able to tell at that point whether the
23 patient is continuing to bleed into the pericardial space or
24 not?

1 A. There's no way of knowing.

2 Q. You just knew you were taking blood out and he
3 wasn't responding?

4 A. Correct.

5 Q. All right. And at some point, the echo tech did
6 arrive with the machine, correct?

7 A. Correct.

8 Q. Let's go to Exhibit 4, if we could. Let me have
9 just a moment, your Honor. If you could turn, Dr. Smith,
10 it's in Exhibit 4 in the white binder, if you look down at
11 the bottom, it says page one of 25.

12 A. Okay.

13 Q. And so this is part of the event log that is in
14 Exhibit 4 from the lab, correct?

15 A. Yes.

16 Q. And the notations that are on the right, again,
17 are those manually entered at some point by someone?

18 A. They are.

19 Q. And so does that indicate what time there was no
20 pulse detected and CPR was started?

21 A. It does.

22 Q. And what time is that?

23 A. 12:39:50.

24 Q. And did you thereafter shortly recognize the

1 tamponade and everybody jumped into action?

2 A. I did.

3 Q. And then it says stat echo paged for?

4 A. Correct.

5 Q. What time is that documented?

6 A. 12:44:04.

7 Q. Now, do you recall whether that's the time you
8 asked for it or is that -- do you have any information about
9 that?

10 A. I would have asked for a stat echo right at the
11 beginning, because when you're doing the pericardiocentesis,
12 you want to make sure that the blood is going down. So I
13 would have done it at 12:39, but I can't tell you exactly
14 whether it's 12:39 or 12:40.

15 Q. We know that's when it was documented?

16 A. Correct.

17 Q. Can you turn to the next page, doctor? And does
18 that indicate when it was documented that the echocardiogram
19 machine was at the bedside?

20 A. 12:48:49.

21 Q. And you weren't watching your clock, I take it?

22 A. No. No. I wasn't.

23 Q. Do you know the exact time that any of these
24 things happened from your own memory?

1 A. I don't.

2 Q. Is it fair to say that you were focusing on the
3 patient?

4 A. Yes.

5 Q. In your memory, did you have any sense that there
6 was a long delay in the echo machine arriving?

7 A. I don't.

8 Q. And what was your impression about that?

9 A. Everything is moving very fast. I don't really
10 have an impression on it.

11 Q. All right. And then when the echo machine
12 arrived, were you informed or were you able to see some of
13 the images that there was still pericardial effusion present?

14 A. I did.

15 Q. And so what were you doing at that point?

16 A. I was withdrawing fluid from the pericardial space
17 and monitoring that to make sure that the fluid was going
18 down.

19 Q. All right.

20 A. And also monitoring the pulses to hopefully see
21 the pulses return.

22 Q. All right. And, finally, did Mr. Dechambeau's
23 blood pressure come back at some point?

24 A. It did.

1 Q. Does it indicate on the log when that was
2 documented.

3 A. 12:54:53.

4 Q. I'm not going to necessarily have this blown up,
5 but I think a page or two later in the log, did a surgeon
6 arrive to evaluate the situation at your request?

7 A. Yes. Dr. Brandell showed up.

8 Q. Who is he?

9 A. He's a cardiothoracic surgeon.

10 Q. Is that something else you would have asked for at
11 the beginning of this event?

12 A. Yes.

13 Q. Why did you do that?

14 A. If the bleeding doesn't stop, we would take
15 them -- we get the pericardial catheter in and we drain the
16 blood, but if it continues to bleed and the blood pressure is
17 still having some difficulty, he would go to the OR to patch
18 up whatever hole was causing the bleed.

19 Q. And then there's a notation in one of the records
20 that the drain was sewn into place?

21 A. Correct.

22 Q. Did you do that?

23 A. I probably did.

24 Q. And why is that done?

1 A. So that you have a catheter in the pericardial
2 space such that if there's reaccumulation of blood, that you
3 can drain it, so the patient would have a low blood pressure.
4 So you're just looking to make sure that it doesn't continue
5 to bleed.

6 Q. All right. At the end of the code, were you able
7 to go out at some point and speak with Mrs. Dechambeau after
8 things were stabilized?

9 A. I did.

10 Q. And can you tell us what you said to her at that
11 time?

12 A. I said there was a complication, that there was a
13 bleed around the heart muscle, that the blood pressure came
14 back. The suddenness of this and the seriousness of this
15 complication, we don't know how he's going to do.

16 Q. Were you upset and concerned at that point?

17 A. Of course.

18 Q. Did you try to console Mrs. Dechambeau?

19 A. I hope I did. It's 11 years ago. I'm sure I was
20 quite upset also at the time.

21 Q. All right. If she had any questions, did you do
22 your best to answer them?

23 A. I would have.

24 Q. All right. Did you then, Dr. Smith, remain at the

1 hospital for a number of hours after Mr. Dechambeau was
2 stabilized?

3 A. I believe so.

4 Q. Was Mr. Dechambeau taken from the
5 electrophysiology lab directly to the ICU?

6 A. He was.

7 Q. When he left the lab, was he on a ventilator?

8 A. He was.

9 Q. Did he have any other equipment on him at that
10 point?

11 A. He had IV lines in, he had the pericardial
12 catheter in place.

13 Q. All right. And then eventually, it was determined
14 that he had -- that Mr. Dechambeau had suffered a very bad
15 brain injury from this?

16 A. Correct.

17 Q. And at some point, a decision was made, there were
18 consultants that were brought in, Dr. Bigley, a neurologist?

19 A. Correct.

20 Q. And what was Dr. Bigley's -- why was he requested
21 to come in and evaluate Mr. Dechambeau?

22 A. He would have come in to see whether
23 Mr. Dechambeau would potentially have some kind of neurologic
24 recovery or whether he would not have neurologic recovery.

1 Generally, it takes 24 to 48 hours to determine whether a
2 patient will respond after a code situation neurologically.

3 Q. And, unfortunately, was it determined that he
4 would likely not make a recovery?

5 A. Correct.

6 MR. POLLARA: That's all I have, your Honor.
7 Thank you very much.

8 THE COURT: Thank you. Counsel. Mr. Kozak.

9 MR. KOZAK: Thank you.

10 CROSS EXAMINATION

11 BY MR. KOZAK:

12 Q. Dr. Smith, in the pericardiocentesis package, is
13 there a syringe?

14 A. There is.

15 Q. And isn't that syringe 60 milliliter, not 20?

16 A. I don't know.

17 Q. You don't know?

18 A. I don't. Because there's more than one syringe in
19 the package.

20 Q. Which one were you using?

21 A. I don't recall. It was 11 years ago. Generally,
22 I would use the 20 cc one, because that one is easier to pull
23 back on and a little more efficient.

24 Q. How long does it take to fill the syringe once you

1 get the line in place?

2 A. Each syringe, probably 5 to 10 seconds.

3 Q. Okay. So how long did it take you to get the
4 pericardiocentesis line in place?

5 A. All I know is it was in place between 12:39 and
6 12:54. So it was in place as fast as I could. It's done
7 blindly, meaning that you put a needle in and sometimes you
8 put the tube in after, or sometimes you just leave the needle
9 in and pull back. And it was 11 years ago. I can't recall
10 when I switched to that from the needle to the tube, which is
11 a plastic tube.

12 Q. So it's your testimony the pericardiocentesis line
13 was in place sometime between 12:39 and 12:54?

14 A. I just know that the responses that the patient
15 had blood pressure at 12:54. I had to drain it. It takes a
16 little while to drain it. I had to make sure that the
17 pericardiocentesis line is in place in the proper location,
18 not within the ventricle. So it probably was in 12:43,
19 12:44, but I can't tell you. This was 11 years ago. It
20 takes a little while to drain it out.

21 Q. So is it your testimony it takes from 12:39 to
22 around 12:44 to put the line in place?

23 A. That's not my testimony.

24 Q. What is it?

1 A. My testimony is that basically he coded. I did
2 the pericardiocentesis tray. I don't have my watch on. And
3 I'm basically trying to save the patient and get the blood
4 out of the pericardial space.

5 Q. So your testimony is you really don't know at what
6 time you actually got the pericardiocentesis line in place?

7 A. I know -- I wasn't looking at my watch. I can
8 tell you that I got all the blood out such that the blood
9 pressure came back by 12:54 and it would have taken some time
10 to get all of that blood out of the space, especially if
11 there's ongoing bleeding.

12 Q. Eventually, there was only 300 ccs of blood
13 removed, isn't that correct?

14 A. That's an estimate.

15 Q. How long would it take you to fill syringe? You
16 said it's only seconds, right?

17 A. 5 to 10 for each 20 cc syringe.

18 Q. So you would have been able to evacuated the 100
19 ccs in a matter of a minute, isn't that true?

20 A. You got to make sure that the catheter is in the
21 right location. As you pull back, you want to make sure
22 you're not lifting the ventricle. You have to look at the
23 echocardiogram also to make sure you're in the right space,
24 that you're not in the ventricle, that you're in the

1 pericardial space. So you have to do all that in a rapid
2 succession.

3 Q. You said you had to look at the echocardiogram to
4 make sure you were in the right space. Did you wait until
5 the echocardiogram got there and looked in there and then saw
6 you were in the right space?

7 A. I was drawing back blood. I didn't know if I had
8 30 ccs of blood in the pericardial space. I didn't know
9 whether I had 300 ccs of blood in the pericardial space. I
10 did not know whether the needle was within the ventricle or
11 within the pericardial space. It turns out it was in the
12 pericardial space, but I had to drain a lot of blood out and
13 it takes some time.

14 Q. So is it your testimony that it took you from the
15 time you got the pericardiocentesis tube in place until 12:54
16 that you finally evacuated all the blood?

17 A. That's when the pulse came back. I don't know if
18 all the blood was evacuated at that point. I can just tell
19 you that enough was evacuated that the pulse came back.

20 Q. So the pulse will come back just with a partially
21 evacuation, correct?

22 A. It varies. It depends on how fast the blood is
23 accumulating. If you had only 30 ccs, you can hang on 25 ccs
24 and get a pulse back. But if you have 450 ccs, it may take

1 300 to 400 ccs. There's no rule on it.

2 Q. But it is absolutely vital, isn't it, to evacuate
3 that blood as soon as possible, because if the heart stays
4 inactive for a period of, in this case, 15 minutes, you've
5 got a very high risk of anoxia, do you not?

6 A. It's vital that you evacuate the blood.

7 Q. And in this case, because the blood was not taken
8 out fast enough, Mr. Dechambeau suffered a severe case of
9 anoxia, isn't that true?

10 A. I don't know how long the blood was in there. I
11 know the pulse went down at that time, 12:39. So that's when
12 it was realized that the patient had cardiac tamponade. He
13 did have severe anoxia, that's true.

14 Q. Let me take a look at the code note. It's
15 Exhibit 5.

16 A. Is that in which binder?

17 Q. Number six, I guess.

18 A. Is it the white binder or the green binder?

19 MR. LUSIANI: White.

20 BY MR. KOZAK:

21 Q. Now, in looking at the code note, you do agree
22 this is the blow-by-blow that describes pace of the
23 operation, correct?

24 A. I agree.

1 Q. Do you see anywhere on that code note where it
2 says that you did a pericardiocentesis?

3 A. I do not. But I didn't write this code note, but
4 I don't see it.

5 Q. Is there any explanation why that wouldn't appear?
6 That's the most important procedure in this whole operation,
7 right, when you have a code blue and you're doing a catheter
8 ablation?

9 A. I think at 12:44 it says tamponade. It would be
10 expected that if someone was doing pericardiocentesis if you
11 saw a tamponade on that. It says cardiac tamponade. So you
12 would not write cardiac tamponade and not do a
13 pericardiocentesis.

14 Q. So it's your testimony that it would not be
15 customary to document the pericardiocentesis just because you
16 have a note there that there was a cardiac tamponade?

17 A. If you write cardiac tamponade, you would do a
18 pericardiocentesis. I didn't do the code note, but that's
19 kind of a given that you would have done a
20 pericardiocentesis.

21 Q. It is true that you testified under oath that you
22 don't remember the exact sequence of all these measures you
23 took after the code blue was sounded, is that correct?

24 A. That is correct.

1 Q. There was no undue delay as far as getting blood
2 back once you inserted the needle, right?

3 A. 11 years, I don't think so, but it's 11 years ago,
4 sir.

5 Q. But you did testify to that under oath, did you
6 not, there was no undue delay?

7 A. I don't recall any undue delay. Are you talking
8 from the deposition?

9 Q. Yes.

10 A. That was closer to the time of the event, but I
11 don't believe there was any undue delay.

12 Q. Now, just so we're clear, the Prucka tape that we
13 heard a lot of conversation had absolutely nothing to do with
14 this cardiac arrest, did it?

15 A. Correct.

16 Q. Isn't it more difficult to do a pericardiocentesis
17 when you have CPR ongoing at the same time?

18 A. I would have stopped the CPR at the time of the
19 pericardiocentesis by a few seconds.

20 Q. Okay. May we have the next exhibit, the
21 anesthesiology, Exhibit 6 or 5. Number five. Second page.
22 Now, if we look at this record here. So that says there that
23 at 12:50, we had the cardiac arrest, correct?

24 A. Correct.

1 Q. But actually the cardiac arrest occurred at 12:39,
2 right?

3 A. Correct.

4 Q. So this is approximately ten minutes behind the
5 time, right?

6 A. Correct.

7 Q. Then he says that the transthoracic echo arrived
8 at 13:00, correct?

9 A. I can't read the last number, but I think so.

10 Q. Echo. And then it says large pericardial
11 effusion, correct?

12 A. Correct.

13 Q. Now, it says at the end of the ablation, can you
14 start there and enlarge it? The patient had evidence of
15 hemodynamic compromise and hypotension, brachycardia. Stat
16 echo was performed, which showed a fairly large pericardial
17 effusion. That's the same pericardial effusion that Dr. Kang
18 is referring to, isn't it, in his anesthesia report that he
19 said was observed at 13:00?

20 A. I don't understand. It was a pericardial
21 effusion. I assume it's the same page.

22 Q. He's referring to the same event, correct?

23 A. Yes.

24 Q. And then you say CPR was performed, ten minutes.

1 Removed approximately 300 millimeters of frank blood from the
2 pericardial space after doing a pericardiocentesis. So
3 you're referring to the same thing Dr. Kang was referring to
4 when he said there was a large pericardial effusion and there
5 was 300 ccs of blood removed, correct?

6 A. It's an estimate, but that's true.

7 Q. What we have here is Dr. Kang is about ten minutes
8 behind, isn't he, in his timing? He said the thing was
9 resolved at 13:00, it started at 12:50. That's ten minutes,
10 right?

11 A. That is ten minutes.

12 Q. You say the -- or the code note said it started at
13 12:39 and it was resolved by 12:54, correct?

14 A. Correct.

15 Q. So the spacing is the same, it's just that Dr.
16 Kang is about ten minutes behind, correct?

17 A. I don't really understand. That's 14 minutes.

18 Q. 14 minutes?

19 A. Yeah.

20 Q. He says ten minutes. So his timing is off
21 somewhat, correct?

22 A. Yeah, and he's not the scribe. He's really
23 participating in the code. He might have done the
24 documentation after, because he's really putting lines in and

1 giving fluids and pressers. So I don't know if -- he's a
2 good anesthesiologist. I don't know when he actually put
3 these down, but it's very likely after the code was done.

4 Q. Okay. Now, he said several ccs aspirated and then
5 he says pericardial drain placed, right?

6 A. Correct.

7 Q. So he's saying that pericardiocentesis took place
8 after the thoracic echocardiogram was taken, isn't that
9 correct?

10 A. I don't think so. I think he's just saying that
11 the echo was there and I was aspirating blood and the drain
12 was placed. I don't know that you could actually jump to
13 that conclusion.

14 Q. That's what's documented in the record, right, the
15 drain was placed and there was a pericardiocentesis
16 procedure?

17 A. On his record, yeah.

18 Q. On his record.

19 A. Yes. The times are still really --

20 Q. But regardless of the time, we're talking about
21 the events that are described, right?

22 A. I understand.

23 Q. And the event described here is a
24 pericardiocentesis took place at 13:00. Now, it might have

1 taken at 12:54 or just before that, because that's when the
2 blood pressure was restored, correct?

3 A. There's no way it could have been done at 12:54.
4 I couldn't get the blood out that fast. And it was probably
5 ongoing bleeding. There's no way I could have aspirated. I
6 don't think anybody could have aspirated that amount of blood
7 in that period of time.

8 Q. So your testimony is that the effusion was so
9 severe that you could not aspirate the blood quickly enough
10 to save Mr. Dechambeau's life, is that correct?

11 A. I'm not testifying to that.

12 Q. You said it took you approximately 15 minutes?

13 A. It takes a few minutes to get the blood out. And
14 you don't know, when you have tamponade, you don't know
15 whether it's a liter of blood, you don't know whether it's 30
16 ccs of blood or whether it's 300. The 300 is an estimate.

17 When you first take the blood out, you do it with
18 a needle, it gets kind of put to the side. You only really
19 count the blood once you actually get it to into the
20 pericardial catheter and then you drain it and it goes into a
21 thing that collects. So it's really an estimate.

22 Q. So it's your testimony that the blood was so
23 copious in the pericardial sack that you just simply couldn't
24 aspirate fast enough to save Mr. Dechambeau's life even

1 though you started the pericardiocentesis immediately?

2 That's basically what I'm getting from your testimony.

3 A. It was 11 years ago. I know that the outcome was
4 terrible. And I know the code started at 12:39. And in the
5 documentation of the code note was that there was tamponade
6 at 12:42. And I'm basically doing the pericardiocentesis at
7 that time and it takes some time to get the blood out.

8 As I kind of said, you don't know whether the
9 catheter is in the right chamber. You don't know whether
10 it's in the pericardial space. That's why you bring an
11 echocardiogram machine there to monitor that the blood is
12 going away, that you're not draining the actual chamber of
13 the heart, you're draining the area around the heart.

14 Q. But you were getting blood immediately. There was
15 no problem start the pericardiocentesis. So you're getting
16 blood, right?

17 A. I'm getting blood.

18 Q. You don't need to know through a stat echo whether
19 -- you've already got blood, you don't need to know through
20 the stat echo whether you're getting the blood or not, isn't
21 that correct?

22 A. That's not correct.

23 Q. You need a stat echo in order to determine whether
24 or not --

1 A. You need an echo there to make sure that you're
2 actually putting the catheter in the right location and it's
3 not within the ventricle, that you're not draining the heart,
4 as opposed to the pericardial space. Because, again, it's a
5 blind stick. You're getting blood, but if you go a
6 centimeter or so too far, you put the catheter into the
7 ventricle. So you need a monitor. It would be standard care
8 to have an echo there watching the pericardial fluid going
9 away.

10 Q. So I guess what you're telling us is that you just
11 weren't capable of managing this adverse reaction in a timely
12 enough manner to save Mr. Dechambeau's life, even though you
13 conformed to the standard of care by doing an immediate
14 pericardiocentesis? That's what I'm getting at.

15 A. It was a bad outcome.

16 Q. Pardon me?

17 A. It was a bad outcome.

18 Q. I wouldn't argue with you there. Did you tell
19 Mr. Dechambeau that if he has a cardiac arrest of that
20 nature, that there's a very high degree of morbidity if you
21 can't -- if it's too much in the pericardial sack?

22 A. I did go through the risks and benefits of the
23 procedure. And one of the risks is pericardial effusion and
24 death. Did I say that specific scenario? I don't know.

1 Q. So in your own mind, is there anything that you
2 could have done differently in order to save Mr. Dechambeau's
3 life?

4 A. I think we did everything we could. It was just a
5 terrible situation.

6 Q. And it was a terrible situation, because there was
7 such a large pericardial effusion, is that your testimony?

8 A. It was a terrible situation, because he passed
9 away.

10 Q. But was it a terrible situation medically, because
11 the effusion in the cardiac sack was so large?

12 A. No. That's one of the complications, but the
13 complication of passing away from that is a terrible
14 situation. It's one of the risks of the complications. It's
15 a one percent risk that you can get a tamponade. And I've
16 had them before, and we've gotten good responses to it. This
17 was not a good response.

18 MR. KOZAK: I have no further questions.

19 THE COURT: Thank you, counsel.

20 MR. POLLARA: Yes, just briefly.

21 REDIRECT EXAMINATION

22 BY MS. POLLARA:

23 Q. If you could go to Exhibit 11 in the white binder,
24 please? This is was shown you to by Mr. Kozak. Dr. Smith,

1 this is where you're discussing the complication that
2 occurred. It's Exhibit 11, the second page, and my question
3 simply is, were you intending this, Dr. Smith, to be a
4 specific chronology step-by-step of what happened, or what
5 was your intention in documenting the procedure and the
6 arrest in this way?

7 A. It was not a chronology. It's just what had
8 happened during the procedure and it's from your memory of
9 what happened three hours before when you dictate.

10 Q. Okay. And so in this case, you didn't put down
11 specifically what time you did the pericardiocentesis,
12 correct?

13 A. I did not.

14 Q. All right. And you weren't able to write things
15 down at the time, were you?

16 A. I was not.

17 MR. POLLARA: All right. Thank you, your Honor.
18 That's all I have.

19 THE COURT: Mr. Kozak, does that raise any other
20 questions?

21 MR. KOZAK: Just one question or two.

22 CROSS EXAMINATION

23 BY MR. KOZAK:

24 Q. Doctor, in writing up your procedure report, the

1 chronology of events is important, is it not?

2 A. Yeah. But as you say, the documentation is not
3 perfect there. So it's -- you sometimes don't have the
4 complete reports at that time. You really try to remember
5 exactly what you did.

6 Q. But, nevertheless, the chronology is somewhat
7 important when you're writing down a procedure report, right?

8 A. I do procedures all the time and I don't write
9 down that this happened at 12:52, this happened at 12:54, and
10 this happened at 12:58. I just don't and nobody does.

11 Q. Well, exact times, maybe, but as far as the events
12 are concerned, you would want to put them in the right
13 chronology, would you not?

14 A. In the best case scenario, that's true.

15 MR. KOZAK: No further questions.

16 THE COURT: Ms. Pollara.

17 REDIRECT EXAMINATION

18 BY MS. POLLARA:

19 Q. Dr. Smith, at the time that you were preparing
20 that note that day, were you thinking you were going to be
21 here 11 years later?

22 A. I was not.

23 MR. POLLARA: Thank you.

24 THE COURT: All right. Doctor, thank you very

1 much. Watch your step going down.

2 THE COURT: Ms. Pollara, anything further for
3 today?

4 MR. POLLARA: Not today, your Honor.

5 THE COURT: All right. Ladies and gentlemen, that
6 concludes the testimony today. We have one more witness
7 tomorrow morning. I'm going to be working with the attorneys
8 this afternoon on the jury instructions. So you can expect
9 to have closing arguments tomorrow and the case will be in
10 your hands, which makes the admonition all the more
11 important.

12 Please don't discuss this case amongst yourselves
13 or with anybody else. Don't allow anybody to talk to you
14 about the case. Don't form any conclusions until you've
15 heard all of the testimony and the arguments of counsel.
16 Don't read any newspaper account, listen to any radio,
17 television, conduct any social media or any Internet
18 research. Don't conduct any independent investigations or
19 experiments. Just keep an open mind I'll see you tomorrow at
20 9:00. Jury may retire.

21 (The following proceedings were had outside the
22 presence of the jury.)

23 THE COURT: Please be seated. You want to come
24 back at 11:00 and go through our jury instructions?

1 MR. KOZAK: That's fine with us.

2 MR. POLLARA: That would be great, your Honor.

3 THE COURT: Let's do that. Court's in recess.

4 (A short break was taken.)

5 THE COURT: So what we do here at this stage is
6 we'll go off the record and I'll read -- we'll go through the
7 jury instructions, just make sure we're all in the same
8 order.

9 And at that time, if you flag something you've got
10 an objection to or we run across something that we can deal
11 with off the record, let's just do it then. If there's
12 duplicates, there aren't any here, but sometimes the parties
13 will submit duplicate instructions and we can take those off.

14 MR. POLLARA: Your Honor, actually, there is, I
15 did put in both of the cause instructions, proximate cause
16 and legal cause, because I wasn't sure which the Court
17 preferred. So they're both in there. One of them needs to
18 come out.

19 THE COURT: I saw that. But we can deal with that
20 off the record, and then we'll go back on the record, I'll
21 number them. If there's any formal objections, we can do it
22 at that time. That way the record is kept. And I'll sign
23 off on it and that will be it. We can go off the record.

24 (Discussion off the record.)

1 THE COURT: We are back on the record in
2 CV12-00571 for purposes of settling jury instructions. The
3 Court has provided counsel with a packet of prepared jury
4 instructions. The Court and counsel have conferred and the
5 Court will give the following instructions as numbered.

6 Ladies and gentlemen of the jury, it is my duty to
7 instruct you in the law that applies to this case is
8 instruction number one.

9 Next, if in these instructions any rule, direction
10 or idea is repeated or stated is number two.

11 Next, the masculine form as used in these
12 instructions, if applicable, is number three.

13 Next, the evidence which you are to consider in
14 this case consists of is number four.

15 Next, you must decide all questions of fact in
16 this case from the evidence is instruction number five.

17 Next, although you are to consider only the
18 evidence in this case in reaching a verdict is number six.

19 Next, if during this trial I have said or done
20 anything is number seven.

21 Next, there are two kinds of evidence, direct and
22 circumstantial, is number eight.

23 Next, in determining whether any proposition has
24 been proved is number nine.

1 Next, the credibility or believability of a
2 witness should be determined by is number ten.

3 Next, discrepancies in a witness' testimony or
4 between his testimony is number 11.

5 Next, a question has been asked in which an expert
6 witness was told is number 12.

7 Next, whenever in these instructions I state that
8 the burden is number 13.

9 Next, the preponderance or weight of the evidence
10 is not necessarily is number 14.

11 Next, the plaintiff has the burden to prove that
12 the plaintiff is number 15.

13 MR. POLLARA: Your Honor, I think there's a typo.

14 THE COURT: Yes.

15 MR. POLLARA: Defendant as, it should be was. I
16 think the W is missing.

17 MR. LUSIANI: Yes.

18 THE COURT: Yes, line two. We're off the record.

19 (Discussion off the record.)

20 MR. POLLARA: Your Honor, in the same instruction,
21 it says both proximate and legal as alternatives. I think
22 legal needs to be stricken.

23 THE COURT: Yes. As corrected, the instruction,
24 which reads, the plaintiff has the burden to prove that the

1 plaintiff sustained damage will be number 15.

2 Next, the plaintiff seeks to establish a claim of
3 negligence is number 16.

4 Next, the proximate cause of injury, damage, loss
5 or harm is a cause is number 17.

6 Next, in this case, liability for personal injury
7 or death is number 18.

8 Next, it is the duty of a physician who is a board
9 certified specialist is number 19.

10 Next, a physician is not necessarily negligent is
11 number 20.

12 Next, the mere fact that there was an accident or
13 other event is 21.

14 Next, in this case, you have heard medical experts
15 express opinions is 22.

16 Next, plaintiffs Angela Dechambeau and Jean Paul
17 Dechambeau is 23.

18 Let's go off the record.

19 (Discussion off the record.)

20 THE COURT: We're back on the record and the
21 merged instruction will be numbered 23. It reads, plaintiffs
22 Angela Dechambeau and Jean Paul Dechambeau are the heirs.
23 That's number 23.

24 Next, no definite standard or method of

1 calculation is prescribed by law is number 24.

2 Next, whether any of these elements of damage have
3 been proved by the evidence is 25.

4 Next, the Court has given you instructions
5 embodying various rules of law is number 26.

6 Next, it is your duty as jurors to consult with
7 one another and to deliberate is 27.

8 Next, if during your deliberations you should
9 desire to be further informed is number 28.

10 Next, now you will listen to the arguments of
11 counsel, who will endeavor to aid you is number 29.

12 When you retire to consider your verdict, let's
13 hold off on numbering those until we get the other
14 instructions on the record.

15 Plaintiff has submitted two instructions for
16 consideration. The first one reads, in a medical negligence
17 case, there are two components. The first is what is the
18 standard of care in a given situation. The standard is
19 established by the medical profession. In this case, the
20 uncontroverted evidence is that when an electrophysiologist
21 is performing a catheter ablation procedure and his patient
22 undergoes cardiac arrest, he must first execute to the best
23 of his ability a pericardiocentesis. The defendant objects.

24 MR. POLLARA: Yes, your Honor. Thank you. It is

1 my position that this is an improper argument of the facts of
2 the case. And so for that reason, it is improper. I also
3 believe this is better served to be argument of counsel. So
4 I do not think it's a proper legal instruction to give.

5 THE COURT: Mr. Kozak.

6 MR. KOZAK: We do think it's proper. We think the
7 jury is not under any duty to determine what the medical
8 standard of care is. And in this case, everybody agrees that
9 the standard of care is a pericardiocentesis when you're
10 undergoing a catheter ablation and you have cardiac arrest.
11 That's the only issue the jury has to decide in this case.

12 THE COURT: All right. The Court will reject
13 this. It is argumentative. It certainly is a proper subject
14 for argument. So this, Ms. Clerk, will be plaintiff's number
15 one.

16 THE CLERK: Thank you.

17 THE COURT: The next one submitted by the
18 plaintiff reads, your sole duty is to determine under the
19 facts of this case whether or not Dr. Smith performed a
20 pericardiocentesis in a timely manner in order to meet the
21 standard of care of a electrophysiologist under the
22 circumstances of the case. The defense objects.

23 MR. POLLARA: Yes, your Honor. We do object to
24 this instruction as well for the same reasons as previously

1 stated.

2 THE COURT: All right. Mr. Kozak.

3 MR. KOZAK: We think it's a proper instruction,
4 because it focuses the jury on the only fact that they have
5 to consider in this case and prevents them from straying to
6 other issues, which everybody agrees aren't relevant. The
7 only standard here is whether or not Dr. Smith met that
8 standard by performing properly as an electrophysiologist
9 under the circumstances.

10 THE COURT: All right. The Court will reject this
11 as argumentative and it certainly is a proper subject for the
12 plaintiff to argue to the jury. It's not a proper
13 instruction. Ms. Clerk, this will be plaintiff's second.

14 THE CLERK: Thank you, your Honor.

15 THE COURT: Which leaves the final instruction,
16 which reads, when you retire to consider your verdict, you
17 must select one of number to act as foreperson. That will be
18 instruction number 30.

19 Finally, we have a special verdict form, which has
20 been agreed to by counsel. Other than that previously
21 submitted and argued to the Court, Mr. Kozak, do you have any
22 further instructions?

23 MR. KOZAK: No, we don't.

24 THE COURT: Ms. Pollara.

1 MR. POLLARA: Nothing else, your Honor. Thank
2 you.

3 THE COURT: All right. We withdrew this
4 instructions, which reads, although you must determine if
5 there was negligence on the part of Dr. Smith, you must
6 understand that Dr. Smith is not the real party in interest
7 in the case. We withdrew this with the understanding that
8 counsel certainly is free to argue this.

9 MR. POLLARA: Yes, your Honor.

10 THE COURT: 9:00 tomorrow morning. Court's in
11 recess.

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1 STATE OF NEVADA)
) ss.
2 County of Washoe)

3 I, STEPHANIE KOETTING, a Certified Court Reporter of the
4 Second Judicial District Court of the State of Nevada, in and
5 for the County of Washoe, do hereby certify;

6 That I was present in Department No. 7 of the
7 above-entitled Court on January 19, 2017, at the hour of 9:00
8 a.m., and took verbatim stenotype notes of the proceedings
9 had upon the trial in the matter of ANGELA DECHAMBEAU, et
10 al., Plaintiff, vs. STEPHEN C. BALKENBUSH, et al., Defendant,
11 Case No. CV12-00571, and thereafter, by means of
12 computer-aided transcription, transcribed them into
13 typewriting as herein appears;

14 That the foregoing transcript, consisting of pages 1
15 through 275, both inclusive, contains a full, true and
16 complete transcript of my said stenotype notes, and is a
17 full, true and correct record of the proceedings had at said
18 time and place.

19

20 DATED: At Reno, Nevada, this 1st day of June 2017.

21

22 S/s Stephanie Koetting
23 STEPHANIE KOETTING, CCR #207

24

EXHIBIT 5

EXHIBIT 5

1 4185
2 STEPHANIE KOETTING
3 CCR #207
4 75 COURT STREET
5 RENO, NEVADA
6

7 IN THE SECOND JUDICIAL DISTRICT COURT
8 IN AND FOR THE COUNTY OF WASHOE
9 THE HONORABLE PATRICK FLANAGAN, DISTRICT JUDGE

10 --oOo--

11 ANGELA DECHAMBEAU, et)
12 al.,)
13 Plaintiffs,) Case No. CV12-00571
14 vs.) Department 7
15 STEPHEN BALKENBUSH, et)
16 al.,)
17 Defendants.)

18 TRANSCRIPT OF PROCEEDINGS

19 TRIAL

20 VOLUME IV

21 January 20, 2017

22 9:00 a.m.

23
24 Reported by: Reno, Nevada
STEPHANIE KOETTING, CCR #207, RPR
Computer-Aided Transcription

1 APPEARANCES:

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RENO, NEVADA, January 20, 2017, 9:00 a.m.

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THE COURT: Good morning, ladies and gentlemen.

Will counsel stipulate to the presence of the jury?

MR. KOZAK: We will.

MR. POLLARA: Yes, your Honor.

THE COURT: Ms. Pollara, your next witness.

MR. POLLARA: Thank you, your Honor. At this time, we'll like to call Dr. Hugh Calkins to the stand.

(One witness sworn at this time.)

THE COURT: Ms. Pollara, your witness.

MR. POLLARA: Thank you, your Honor.

HUGH CALKINS

called as a witness and being duly sworn did testify as

follows:

DIRECT EXAMINATION

BY MS. POLLARA:

Q. Good morning, Dr. Calkins.

A. Good morning.

Q. Are you a medical doctor?

A. Yes.

Q. And what is your specialty?

A. Cardiology and electrophysiology.

1 Q. Can you tell us where do you hold licenses to
2 practice medicine?

3 A. In the state of Maryland.

4 Q. Were you contacted at some point in 2008 or 2009
5 by an attorney here in Reno who was representing Dr. Smith
6 asking if you would be willing to review this case for him?

7 A. Yes, I was contacted.

8 Q. Did you agree to do that?

9 A. Yes, I did.

10 Q. And did you subsequently receive and review
11 records from Washoe Medical Center and Dr. Smith's office and
12 the primary care doctor?

13 A. I did.

14 Q. Based upon your background, experience and
15 training and your review of those records, did you reach any
16 conclusions when you reviewed the records back at that time?

17 A. Yes, I did. I felt that Dr. Smith met the
18 standard of care.

19 Q. And then at some point, were you advised that that
20 case was terminated or over in some fashion?

21 A. Yes, I was.

22 Q. And then later were you once again contacted at
23 that point by an attorney representing Mr. Balkenbush to ask
24 if you would again review the record?

1 A. I was.

2 Q. Did you rereview the records at that time?

3 A. Yes, I did.

4 Q. Did you also review Dr. Smith's deposition
5 transcript?

6 A. I did.

7 Q. Did you review Dr. Morady's deposition transcript?

8 A. Yes.

9 Q. And as a result of that review and your background
10 and experience and training, what opinions did you have at
11 that time?

12 A. My initial opinion was that Dr. Smith met the
13 standard of care, and after rereviewing it, after reviewing
14 the depositions, I still felt he met the standard of care.

15 Q. And do those remain your opinions today?

16 A. Yes.

17 Q. Are the opinions that you're going to express here
18 today to a reasonable degree of medical certainty?

19 A. They are.

20 Q. Thank you. When you reviewed the records, and
21 focusing now on your current opinions, do you conclude that
22 Dr. Smith acted reasonably and prudently after Mr. Dechambeau
23 developed cardiac tamponade in the way that he handled the
24 situation, including performing the pericardiocentesis?

1 A. Yes, I did.

2 Q. I want to talk with you a little bit about your
3 background and your education. Dr. Calkins, where did you go
4 to medical school?

5 A. I went to Harvard Medical School.

6 Q. What year did you graduate?

7 A. 1983.

8 Q. And then after that, did you complete an
9 internship and residency?

10 A. Yes. It was Mass General Hospital in Boston.

11 Q. What was that in?

12 A. In internal medicine.

13 Q. Can you tell us when you completed that program?

14 A. 1986.

15 Q. Now, after you completed your internship
16 residency, did you then complete a fellowship?

17 A. Yes. I went to Johns Hopkins and did my
18 cardiology and electrophysiology fellowships.

19 Q. And how many years were those?

20 A. Three years.

21 Q. Are you board certified in any specialties?

22 A. Yes. I'm board certified in internal medicine,
23 cardiology, and electrophysiology.

24 Q. Can you tell us approximately when you were first

1 board certified in those areas?

2 A. Well, internal medicine would have been 1986,
3 cardiology would have been about 1990, and electrophysiology
4 in about 1992 or 3.

5 Q. All right. Thank you. Have you maintained your
6 board certifications?

7 A. Yes, I have.

8 Q. Does that require -- are you grandfathered in,
9 I've heard that term, or do you take the exams again?

10 A. So for internal medicine and cardiology, I'm
11 grandfathered in so I don't have to retake the exams. For
12 electrophysiology, I do, and I last took it three or
13 four years ago and passed.

14 Q. And where are you currently working?

15 A. I'm currently at Johns Hopkins.

16 Q. And that the School of Medicine or the Medical
17 Center or both?

18 A. It's all the same, but it's at the Hospital and
19 University and School of Medicine.

20 Q. And can you tell us, what professional
21 appointments do you currently have at Johns Hopkins?

22 A. I'm director of the electrophysiology laboratory
23 and the arrhythmia service.

24 Q. How long have you been director of the

1 electrophysiology lab?

2 A. Since 1992.

3 Q. Quite a while?

4 A. Yes.

5 Q. Do you know Dr. Fred Morady?

6 A. Yes, I do.

7 Q. How do you know him?

8 A. My first faculty job, I left my training in 1999,
9 I went to University of Michigan to work with Dr. Morady. He
10 was one of the pioneers of cath ablations in its broader
11 sense. I wanted to work with a world expert at that time, so
12 I was successful in getting my first doctor appointment at
13 the University of Michigan.

14 Q. How long were you at the University of Michigan?

15 A. I was there for three years.

16 Q. Now, we're here, as you understand it, about
17 Mr. Dechambeau, who had atrial fibrillation as an underlying
18 condition, correct?

19 A. Correct.

20 Q. We've heard a lot about this, but can you just
21 explain to us briefly what is atrial fibrillation, and then
22 tell us what has been the evolution of the treatment of that
23 disease from an electrophysiology standpoint, if you could
24 tell us about that?

1 A. So atrial fibrillation is the most common
2 arrhythmia there is. It's a total irregular and rapid
3 beating of the upper chamber. So the upper chambers are sort
4 of like a bag of worms. They're sort of fibrillating.
5 They're going extremely fast and not pumping effectively.

6 It turns out this is the most common arrhythmia
7 that is age-related. Rare before 50, by the time you're 80,
8 one in ten people have it. It's significant because can it
9 can cause symptoms, palpitations, shortness of breath --

10 Q. Doctor, let me tell you, slow down a little bit
11 for our court reporter.

12 A. It also increases your risk of having a stroke
13 five-fold. It also increases your mortality. It increases
14 your risk of dementia. Increases your risk of heart failure.
15 So it's a very significant and very common arrhythmia, but
16 it's very, very complex. It's not one single circuit. It's
17 not one single mechanism. It's sort of the most complex of
18 all the arrhythmias we deal with.

19 Right now, there's about two and a half million
20 Americans with atrial fibrillation. By 2050, it will be
21 about 12 million. So as we all age, the tsunami of afib is
22 increasing and also obesity plays a role. So as we all get
23 older and fatter, we're going to have more atrial
24 fibrillation.

1 Q. And so is catheter ablation a fairly recent
2 technique or manner in which atrial fibrillation is treated?

3 A. Well, it was first -- the current technique we
4 use, the underpinnings of that were first described in 1998.
5 So it's actually been around for about 20 years. And it
6 keeps getting better and the tools keep changing. Right now,
7 it's the most commonly performed ablation procedure in the
8 world.

9 So most electrophysiology laboratories, this is
10 how electrophysiologists spend their time performing this
11 procedure, which started about 20 years ago and it keeps sort
12 of advancing. We aren't perfect yet, but we keep trying to
13 get there.

14 Q. And so what was used before the current
15 technology?

16 A. It started out with open heart surgery to treat
17 atrial fibrillation. That was in the early '80s. Jim Cox, a
18 surgeon at Duke, developed that technique where you would
19 open a patient up, cut their chest, cut their atrium into
20 many different pieces and sew it back together. He showed
21 that you could treat atrial fibrillation with this huge
22 surgery, but it didn't catch on, because the surgery had a
23 huge complication rate, and very few surgeons were skilled
24 enough to perform it.

1 The next thing that happened is that
2 electrophysiologists like myself tried to replicate that
3 procedure from the inside with a catheter by cauterizing the
4 heart, cauterizing precise areas, and that didn't work very
5 well.

6 And then in 1998, a group in Bordeaux, France,
7 Michel Haissaguerre, discovered that afib is triggered from
8 the pulmonary vein. Pulmonary veins bring blood from the
9 lungs back into the heart. It turns out that afib is started
10 in those veins. It's like the starter for your snowblower,
11 which you'll be starting up this afternoon.

12 That starter is in the pulmonary veins. There's
13 little muscle fibers, there's nerves that extend around these
14 veins, the nerves go crazy, the muscle fibers start firing,
15 then that starts afib where you have multiple circuits going
16 in the entire atrium. But it's all about pulmonary veins,
17 and if you can get rid of the starter, if you can get those
18 pulmonary veins isolated, then you can control atrial
19 fibrillation in most patients.

20 Q. You said it's the most common ablation procedure
21 performed today. Take us back, you were doing these
22 procedures in 2006?

23 A. Yes.

24 Q. Compare 2006 to today. Has it continued to evolve

1 as far as the number of ablations that are being done? How
2 frequently was it being done in 2006?

3 A. If you think about it, in 1998, there was about
4 two hospitals in the world doing it. And then very quickly
5 over the next three years, most major leading medical centers
6 started to do it.

7 So I'd been performing it for a while, but using
8 the new technique started in 1999, 2000, and then it very
9 quickly caught on. So by the mid 2000's, the time we're
10 talking about, it had moved to smaller community hospitals
11 and was really catching on, you know, everywhere.

12 But it was compared to today, we have better tools
13 today, we have better techniques today, we have better
14 appreciation of all the aspects of the procedure. So I would
15 call that the early days of catheter ablations, atrial
16 fibrillation. It wasn't experimental. It was commonly
17 accepted, commonly performed. We had standard indications
18 for the procedure, but it was the early days.

19 Q. All right. And at the University of Michigan when
20 you were there, was that one of the centers where they were
21 working on and developing these techniques?

22 A. No. I was there from '89 to '92. So at the
23 University of Michigan then, they were the main center
24 developing catheter ablation for the simple arrhythmias where

1 there's one circuit, one pathway. So Fred Morady, Mel
2 Scheinman from San Francisco were the two world leaders and
3 they were doing arrhythmias where there's one, single burn,
4 you get one burn and the patient is cured.

5 That started at the University of Michigan in 1989
6 when I got there, but afib didn't start until about ten years
7 later as we moved on to more complex arrhythmias.

8 Q. Got it. Thank you. So while you were at the
9 University of Michigan, were you a professor there, an
10 attending?

11 A. Yeah. I was an attending and assistant professor
12 of medicine.

13 Q. Okay. Have you remained in touch with Dr. Morady?
14 Do you see him from time to time at meetings?

15 A. Yes. I see him intermittently at meetings.

16 Q. Have you ever talked with him about this case?

17 A. Never.

18 Q. Now, after you left the University of Michigan, is
19 that when you went to Johns Hopkins?

20 A. Yes. They recruited me back to be director of
21 electrophysiology at Johns Hopkins.

22 Q. In addition to being the director of
23 electrophysiology lab and the arrhythmia service, do you also
24 hold any teaching positions?

1 A. Well, I'm a Nicholas Fortuin Professor of
2 Medicine, so I have an endowed chair that supports my time to
3 teach and do research and things like that.

4 Q. Tell us a little bit about what your duties and
5 responsibilities are as a professor in that position.

6 A. Well, you know, I have teaching responsibilities,
7 clinical care responsibilities, and administrative
8 responsibilities. So from a teaching perspective, for many
9 years, I give the lectures to the medical students on the
10 cardiac arrhythmias. And after about 20 years, I let one of
11 my junior colleagues take that on.

12 Mainly, I teach the cardiology fellows, the people
13 training to be cardiologists, and the electrophysiologists,
14 people training to electrophysiologists, and it's really an
15 apprenticeship where they work by your side, work with you,
16 watch you, help you. So they learn by sort of working with
17 us. They do a lot of the -- it's sort of it works well.

18 I also give a lot of lectures both to the fellows,
19 to the residents and so forth. So education wise, I do a
20 fair amount of teaching within Hopkins and mainly it 's
21 teaching as I take care of patients and they sort of
22 participate and watching.

23 Administratively, I direct the EP lab, so I'm
24 responsible on the whole EP service, the schedules, the

1 monthly complication report, the volumes, the budgets, things
2 like that. And then I have, you know, research
3 responsibilities where I also do research.

4 Q. And so then as director of the electrophysiology
5 lab, do you also have meetings where you're reviewing cases
6 and you're looking at complications and things like that?

7 A. There's ten electrophysiologists in my group, so
8 it's a pretty big group, and we have four procedure rooms.
9 But every morning we meet every morning from 7:30 to 8:00 and
10 we go over patients we're doing that day, their history, what
11 we're planning to do. We go over the patients the day
12 before, how did the procedure go? Were there any
13 complications? And we go over the procedures the next day,
14 what's coming up? Is there anything that we need to think
15 about now and so forth? And then every month we -- so I hear
16 about complications as they occur. And then every month we
17 review all complications together in a separate one-hour
18 conference.

19 Q. And then are you also, it sounds like you've got a
20 lot on your plate, but are you also actually doing these
21 ablation procedures yourself?

22 A. Anyone in academic medicine, everyone has to pay
23 their way. Either you have grants from the NIH and that's
24 how you pay your way, or you pay your way by taking care of

1 patients, which is what I do. I go to clinic on Monday and
2 Fridays and see about 20 to 30 patients each day. And then I
3 do procedures Tuesday, Wednesday and Thursday. Usually, I'll
4 do two atrial fibrillations ablations each of those days. So
5 in an average week, I'll see about 50 patients in clinic, do
6 six procedures of which probably four are atrial fibrillation
7 procedures, and then the academic stuff is done nights and
8 weekends and things like that.

9 Q. Can you give us an estimate, Dr. Calkins, of how
10 many atrial fibrillation ablations you've done up to the
11 present time, just a ballpark?

12 A. Over 2,000.

13 Q. Now, is it your opinion in this case, Dr. Calkins,
14 that Dr. Smith is a well-trained and experienced
15 electrophysiologist?

16 A. Yes. He got very good training.

17 Q. Did you see any indication from anything that
18 you've reviewed that he just didn't know what he was doing on
19 September 7th of 2006?

20 A. No. He had completed his training years earlier
21 and he had a lot of experience. I would consider him a
22 well-trained and experienced electrophysiologist.

23 Q. Just very quickly, was Mr. Dechambeau an
24 appropriate candidate for the procedure?

1 A. Yes, he was. The indications for catheter
2 ablation at that time were symptomatic afib, refractory
3 medical therapy. The best results were if he had
4 intermittent afib. So he did exactly what the class one
5 indication, symptomatic atrial fibrillation having failed, he
6 had tried two or three different medications, so he would be
7 considered an optimal candidate for the procedure.

8 And then there was also the question about whether
9 he had a separate SVT arrhythmia which would be a further
10 reason to do the procedure.

11 Q. Ultimately, he didn't have that, but Dr. Smith
12 checked for it?

13 A. Yes.

14 Q. And he was given appropriate informed consent?

15 A. Yes.

16 Q. And let's talk about the ablation procedure
17 itself, Dr. Smith, and there is a couple of points in
18 particular. I know we saw some drawings the other day. Your
19 Honor, could I have your permission to have Dr. Calkins step
20 off the stand?

21 THE COURT: Absolutely. Mr. Kozak, you can come
22 around over here. Don't worry about the Court, just make
23 sure the jury can see.

24 THE WITNESS: Okay. I'm going to give you a

1 little tutorial on afib ablation.

2 BY MS. POLLARA:

3 Q. Let me ask a question first so we can have a good
4 record. Okay. Can you just start out and tell us, give us a
5 diagram of the heart and give us a little atrial fibrillation
6 refresher here.

7 A. Yes. So here's the heart. Let me get you
8 oriented. This is the right atrium, the right up chamber,
9 your own body's pacemaker. The sinus nodes are there. This
10 is the right ventricle, the right lower chamber where the
11 blood comes from the legs and from the head back into the
12 right atrium.

13 Q. Could you just put an RV and RA there?

14 A. RV and there's the RA. And then here's the AV
15 node. That's the normal connection system that brings the
16 impulse from the upper chamber down to the lower chamber.
17 There's special wires the impulse goes through.

18 Now, when you think atrial fibrillation, you have
19 to think about the left atrium. So this is the left
20 ventricle and this structure is the left atrium. And these
21 tubes are the pulmonary veins. I told you that afib is
22 triggered by the pulmonary veins. So there's little muscle
23 fibers in those veins, in each of the four veins. And then
24 there's nerves that sit outside the veins that have tentacles

1 that sort of extend over these veins like this that.

2 Here's the nerves that sort of -- and the
3 discovery in 1998 that the group in France discovered was
4 that afib is multiple reentry circuits swirling around the
5 atrium. But it's triggered, it starts from these veins.
6 These veins start firing about 300 beats a minute, bop, bop,
7 bop. And then in susceptible individuals that are of a
8 certain age, when you're young your atrium can handle it, as
9 you get older, your tissue gets a little older and saggier
10 and scarred and then that starts the afib.

11 So the catheter ablation of afib, initially, when
12 the group in France described it, they described doing little
13 burns around these veins of areas that seemed to be
14 irritable. And then very quickly over the next three years,
15 it was discovered that the better procedure was to put a
16 roadblock around the entire pulmonary veins.

17 And so the way -- so here's the roadblock here.
18 This roadblock is created by doing a sequence of burns. Each
19 burn is the size of a small marble. And you basically will
20 get line up of burn after burn after burn after burn after
21 burn and you go around burning all of these areas until you
22 create this rim of dead tissue.

23 So the dead tissue muscle is left, it's like a
24 wire, the dead tissue scar is like an insulator like rubber.

1 So you in essence you put a rubber gasket around the veins to
2 insulate -- you aren't blocking the blood flow, but the
3 electrical impulses that go crazy then can't get into the
4 atrium to give you afib and you also do the same thing on the
5 other side.

6 Now, to accomplish that, let me just show you the
7 catheters that we use. I'll need a different color. So to
8 do this, it was not an easy procedure. So you put a number
9 of catheters from the leg up to the heart, these catheters
10 are called sheathes are put up. And what you do is you poke
11 the septum and the sheathes go into the left atrium. So you
12 put two different sheathes from the leg. And here's another
13 sheathe coming up from the leg. And you put two sheathes
14 into the left atrium. And these sheathes are like tubes that
15 have a little gasket, a little door where we can put a
16 catheter in.

17 The patient is there, they're fully asleep. You
18 anticoagulate them, you put in your various catheters, and
19 then you poke from one side to the other side. There's a
20 natural door here that's open before we're born. So you poke
21 through that door, you reopen it, in order to do the
22 procedure.

23 And then through these tubes, you'll put two
24 catheters. One is the ablation catheter. So the ablation

1 catheter is the catheter that you use to do the actual
2 burning. And that catheter you can move with your thumb and
3 twist and this is guided by an electro anatomic mapping
4 system or GPS system. So you have sort of this GPS system
5 showing exactly where you are in free space and an X, Y and Z
6 coordinates.

7 And then the other sheathe, you put in what's
8 called a lasso catheter. It's a catheter that looks like a
9 lasso. It's a circular catheter that has 20 electrical poles
10 on it, and you put that on the veins. And the end point of
11 the procedure is having all the electrical impulses on that
12 circular catheter disappear, because you've gotten a complete
13 roadblock.

14 When you have the complete roadblock, the impulses
15 that were flowing into the veins are then blocked and there
16 will be no signals on this catheter. So this catheter you'll
17 move from this vein, this vein and this vein, as you do the
18 procedure. And between the GPS mapping system and this
19 catheter, you have what allows us to do the procedure.

20 So it takes, the procedure will typically take,
21 you know, two to four hours, three to four hours is the usual
22 length of the procedure. Some patients also have an atrial
23 flutter as Mr. Dechambeau did, which is a circuit that goes
24 around the right atrium like that.

1 When someone has that, you put in another
2 catheter, you know, into the right atrium called a decapolar
3 catheter that tells you where the circuit is, and then you
4 end up cauterizing. Again, you're down here, so the
5 procedure that Mr. Dechambeau underwent was he had these
6 veins isolated and then Dr. Smith had just completed or was
7 working on this last little flutter line, this little
8 two-inch piece.

9 One other comment, in order to kill the tissue,
10 here's the heart muscle tissue here and here's your catheter
11 against the tissue. And the way catheter ablation works is
12 you give radio frequency energy of 500,000 cycles per second,
13 very fast current, through this catheter to a patch that's on
14 the patient's back. And as the current goes through the
15 tissue, the tissue, the muscle of your heart acts like
16 resistant element. When you look at your toaster, you have
17 resistors that turn red. In the catheter ablations, it's the
18 muscle that the resistant element that starts to warm up.

19 When you get to over 50 degrees, then the tissue
20 is dead. If you get it too hot, if you get above 100
21 degrees, you'll have what's called a steam pop. You'll boil
22 the fluid and you'll have a small explosion. And I think one
23 of the hypotheses of why this tamponade occurred is as the
24 burning was going on, an area may have overheated and had a

1 steam pop, a little hole in the heart, and that's what caused
2 the tamponade. And the catheters can also poke a hole in the
3 heart at some critical parts. But that's the gist of the
4 procedure.

5 Q. Great. And, doctor, you can retake the stand.
6 We'll come back to this in a few moments.

7 Are you familiar with something called an
8 intracardiac echo catheter? We've also heard it called an
9 ICE catheter.

10 A. Yes.

11 Q. What is that?

12 A. Typically it's made by a company called Acuson.
13 It's a little ultrasound transducer that you place in the
14 heart. It's like a bread slicer where it will show you the
15 image of the heart in one view, and then by twisting it, you
16 can get a broader view of the heart. And the catheter is
17 deflectable where there's a way to manipulate it and you get
18 it up there.

19 And, typically, you know, many people use it to
20 guide the transseptal to help get from one side of the heart
21 to the other side. When this procedure was performed, it was
22 also used to help guide the procedure, because you could see
23 where the ablation catheter was relative to where you were
24 burning.

1 And I would say back when this procedure was done,
2 probably half of the centers used it and half the centers
3 didn't. I never used it, maybe once a year. More recently
4 in the last three years, I started using it more frequently.

5 Q. There's been some testimony the other day that
6 when Mr. Dechambeau arrested, that all Dr. Smith had to do
7 was turn or twist that catheter where it was located in the
8 right atrium, and he would have been able to diagnose the
9 pericardiocentesis from there, is that accurate?

10 A. No, that's not accurate. In order to look for an
11 effusion, the ICE catheter was in the ventricle, not the
12 atrium. So when you're using it to guide the procedure the
13 way Dr. Smith was to sort of see where he was burning and to
14 guide the transseptal, it's in that right upper chamber, the
15 right atrium, where it says RA on the diagram.

16 In order to see an effusion, you got to put it in
17 the right ventricle, at the tip of that right ventricle. And
18 getting the catheter from the right atrium to the right
19 ventricle is not simple, because the catheter only deflects
20 to one direction, it's fairly cumbersome, you need x-ray
21 guidance. So it's not something easy to do.

22 And in this situation, someone with no blood
23 pressure, and you say, am I going to start futzing with the
24 ICE catheter, which was already out in this case, are you

1 going to put it back in or then futz with it? Or are you
2 going to do the pericardiocentesis? If course you're going
3 to start to do the pericardiocentesis.

4 Even if it was in the heart, no, it's not simply
5 twisting it. That would be only if you previously placed it
6 in the right ventricle, and it was in the right atrium,
7 because it was being used to guide the procedure. So I
8 respectfully disagree with Dr. Seifert on that.

9 Q. Now, let's talk about pericardial effusions and
10 cardiac tamponade. First of all, tell us what is a
11 pericardial effusion and what is a cardiac tamponade?

12 A. So a pericardial effusion is fluid in the sack.
13 The heart I just drew sits in a sack and a pericardial
14 effusion is an excess of fluid in that sack. Now, everyone
15 has fluid in that sack. You'll have your 50 ccs or whatever,
16 a small amount of fluid in that sack.

17 But a pericardial effusion refers to when there's
18 an abnormal amount of fluid in that sack, where the sack
19 starts to fill up with fluid or blood or something else.
20 That's what a pericardial effusion.

21 Cardiac tamponade is when that effusion gets so
22 big that it starts putting pressure on the heart where blood
23 can't get into the heart and the blood pressure starts to
24 drop. That's referred to as cardiac tamponade.

1 Q. And is there an exact amount of fluid that you
2 know as a cardiologist, well, if we have 100 ccs, all
3 patients are going to get cardiac tamponade, or does it vary
4 from patient to patient?

5 A. It varies dramatically from patient to patient and
6 also on rate of accumulation. You know, some patients'
7 pericardial sack is relatively stiff. Other people, it's
8 much more floppy. Depending on how floppy or how stiff it is
9 will depend how much fluid you need to get in the sack to
10 start affecting the filling of the heart. So it's highly
11 variable.

12 I mean, there can be people with two liters in the
13 pericardial sack and with a normal blood pressure with no
14 tamponade. There's other patients with 300 ccs that have
15 tamponade. So it's very variable.

16 Q. And, then, doctor, is it accurate that for
17 patients who are undergoing this procedure, they are
18 typically placed on heparin?

19 A. Yes. Absolutely.

20 Q. Why do you say absolutely?

21 A. Well, one of the -- there's a number of
22 significant risks with the procedure, but, you know, one of
23 the serious ones is stroke I think is one of the more
24 important ones and that occurs in about .5 to 1 percent of

1 patients. And the way we lower that risk of stroke to what
2 we consider that low level is by aggressively anticoagulating
3 the patient.

4 So every time you put a catheter in the heart, a
5 clot can form on that catheter. It's sort of an area where
6 clots can form. So any catheter in the heart will start to
7 form clots. And we have lots of catheters in the heart for a
8 long period of time, so if we didn't anticoagulate the
9 patient, you'd have a huge risk of stroke, 15, 20 percent,
10 something like that. By aggressive anticoagulation, there's
11 guidelines as to how aggressively these patients have to be
12 anticoagulated, we can drop that risk to .5 or 1 percent. So
13 it's very important.

14 Q. So even though there's a risk of bleeding in
15 cardiac tamponade, you can't stop using the heparin because
16 of these other risks?

17 A. Correct.

18 Q. We're going to talk about the code in a moment,
19 but, first of all, I want to ask you this, doctor. Do you
20 agree that the standard of care is defined generally as
21 requiring a physician to have the knowledge and skill
22 ordinarily possessed and to use the care and skill ordinarily
23 used by reputable specialists practicing in the same field?

24 A. I do.

1 Q. Do you believe that you have the background,
2 experience and training and knowledge sufficient to discuss
3 what the standard of care is in this case?

4 A. Yes, I do.

5 Q. And why do you believe that you have that
6 background and experience in order to provide that type of
7 testimony here?

8 A. I think the most important thing is I know a lot
9 about this procedure and do this procedure. I've done over
10 2,000 of these procedures over 20, 30 years. So I do a lot.
11 I care for a lot of patients. But more importantly than
12 that, I interact with a lot of colleagues around the country
13 and around the world that do the procedure.

14 And one of the things that I've been doing in my
15 free time is I've led what's called the Heart Rhythm Society
16 Consensus Document On Catheter Ablation in Atrial
17 Fibrillation. So this is a 40- or 50-page document where
18 between 40 and 60 of the world's experts get together and put
19 together a document saying what are the standards, who should
20 get the procedure, who should not get the procedure, what are
21 the complications, what are the risks, what are the outcomes,
22 what are the best techniques.

23 So that document I first published, I was the lead
24 author in 2007, and now it was completely redone in 2012 and

1 it's going to be published again in 2017, this time with 60
2 authors and 1,500 references. So I interact. And during
3 this process, it's a consensus document, meaning we'll survey
4 the group. How many of you will give heparin before the
5 transseptal? And of the 60 people, you have to hit
6 80 percent to be a consensus. So you'll get these votes from
7 all of the world's experts, 30 experts from the U.S., 10 from
8 Europe, 10 from Japan, 10 from Hong Kong, wherever, and South
9 America.

10 So it's an international consensus document that
11 sort of defines best practices in catheter ablation. Reviews
12 the outcomes, reviews the procedure. You know, it's a big
13 effort.

14 Q. And then, doctor, can you tell us what is the
15 Heart Rhythm Society?

16 A. The Heart Rhythm Society is the leading society of
17 arrhythmia experts in the world. It has about 6,000 members.
18 It's based in the United States. And it's basically a
19 society of electrophysiologists, people like myself and
20 Dr. Smith, I think Dr. Seifert is also a member.

21 Q. And Dr. Morady?

22 A. And Dr. Morady is a member. Pretty much I'd say
23 90 percent of electrophysiologists in the U.S. are members
24 and probably 20 percent around the world are members. So

1 it's a professional society of electrophysiologists.

2 Q. And you're a member?

3 A. Yes.

4 Q. And were you the president of the society in the
5 past?

6 A. Yes. About three years ago, I was the president
7 of this organization.

8 Q. All right. So, now, let's talk about pericardial
9 effusions and cardiac tamponade in the setting of atrial
10 fibrillation ablation. In this specific case, and in the
11 surgery involving Mr. Dechambeau, do you have an
12 understanding that this event occurred suddenly and without
13 warning?

14 A. Yes.

15 Q. Is that the typical or the usual manner in which
16 cardiac tamponade occurs in this setting with atrial
17 fibrillation ablation?

18 A. No. I'd say this is an extremely uncommon
19 presentation of an uncommon complication. So cardiac
20 tamponade occurs between 1 in 100 and 1 in 200 patients who
21 undergo catheter ablation atrial fibrillation. So a busy
22 electrophysiologist will do about 100 of these procedures a
23 year, meaning about every two years, they'll have one of
24 these complications.

1 And most cardiac tamponades take place in slow
2 motion, meaning the blood pressure gets lower, the
3 anesthesiologist person says the patient's blood pressure is
4 60, I'll give them some ephedrine to get their blood pressure
5 up. You'll call for the echo. And you'll have an hour and
6 the patient never will get a blood pressure below 60 or 50 or
7 something like that. This was extraordinarily rare where the
8 blood pressure basically went to zero almost instantly.

9 So it was an uncommon presentation of an uncommon,
10 but known, everyone knows that cardiac tamponade is a
11 complication of catheter ablation atrial fibrillation and of
12 patients who die from the procedure, it's the most common
13 cause of a patient dying from the procedure.

14 Q. All right. But in this case, it was unusually
15 rapid?

16 A. Extremely unusually rapid. I've never seen it
17 this rapid.

18 Q. And you work with ten other electrophysiologists
19 in your group and so forth. At Johns Hopkins, based upon
20 your review of cases over the years, have you ever seen one
21 present like this?

22 A. No.

23 Q. Now, can you give us a sense, explain to us, Dr.
24 Calkins, let's just talk about performing a

1 pericardiocentesis, whether it's fast or slow. First of all,
2 let's talk about the pericardiocentesis tray or kit. Can you
3 tell us, what is in the kit? When Dr. Smith or some other
4 electrophysiologist says, I need the pericardiocentesis kit
5 or tray, what do they typically get?

6 A. So the tray is prepackaged from one of several
7 manufacturers. It has about ten different things in the
8 tray. In the tray, you'll have, if you think about it,
9 you'll have antiseptic solution to clean the skin before you
10 do it. You have a scalpel, because you have to nick the skin
11 before you put the needle in. You have the needle which is
12 what's called a spinal needle. It's not just a needle with a
13 point on the end. It's a needle that with an obturator, a
14 tube in the middle, a solid tube. So as you stick it in,
15 tissue doesn't fill up the tip of the syringe and block it.
16 So it has an obturator. It's a special kind of needle. So
17 it has a spinal needle.

18 You then have alligator clips so you can hook the
19 needle up to the EKG machine. You have a 20 cc syringe, no
20 bigger, just 20 cc syringe. You have the actual drain that
21 has multiple side ports. You have a stopcock to hook the
22 drain, the bag up to the needle. And, yes, I think it's, and
23 then you have lidocaine to numb the skin. So you have many
24 different things that are in this kit.

1 Q. So take us through how a pericardiocentesis is
2 performed, whether it's done rapidly, or when you have more
3 time. Just take us through the steps that you do to get that
4 done.

5 A. So, normally, you suspect a patient is in cardiac
6 tamponade, the first step is to pull all the drapes off that
7 area where you need to stick the sub xyphoid area. This
8 might be electrical cables and patches. You do, put down a
9 drape. You then get the antiseptic solution and clean the
10 skin.

11 Once the skin is cleaned, you get the lidocaine,
12 you inject the lidocaine to numb the skin. Meanwhile, you
13 felt for the landmarks. Where's the xyphoid process, the
14 bottom of your sternum? Where are the ribs? So you're
15 feeling these areas. And then you nick the skin.

16 And at that point, you get the needle, the spinal
17 needle and you hook it up to an alligator clip and you hook
18 it up to the EKG machine and then you start sticking it in.
19 And, typically, you'll stick it in about two and a half,
20 about five centimeters aiming from the left shoulder from the
21 bottom of the xyphoid process.

22 So you stick it in about five centimeters, but the
23 needle right now is a spinal needle, so it's not that the
24 blood comes spurting out, because you've blocked it. It has

1 this solid tube in the middle, this solid piece of metal in
2 the middle. You then pull out the obturator, hook it up to
3 the 20 cc syringe and see if you can pull anything back. If
4 you can't, that means you haven't gone far enough. So then
5 you put the spinal needle, the metal shaft back in and push
6 it another centimeter, then you pull it out. So you repeat
7 this process until you get blood.

8 Once you get blood, then you hookup the syringe,
9 the 20 cc syringe, and start pulling back the blood and
10 you're always watching the blood pressure. Initially, you'll
11 just pull it back and squirt it on the drapes or somewhere
12 else and you expect the blood pressure to rise.

13 If the blood pressure is not rising -- and usually
14 it's done, you've had plenty of time, you've called the echo
15 people, the echo people are there. So you have the benefit
16 of an echo image to tell you that it was then getting
17 smaller. But in a blind situation, you pull back, you look
18 at the blood pressure, nothing has happened. Then the
19 question is, well, maybe it's not -- the blood pressure might
20 not be going up, because you're in the right ventricle. You
21 go through the pericardium into the right ventricle, so
22 you're just pulling blood out of the heart.

23 So then you've got to reposition the needle, pull
24 it back. And then, you know, the way you know for sure

1 you're in the pericardial space is you put a very long wire
2 through that needle that wraps around the entire heart. If
3 you see it around the entire border of the heart, then you
4 know you're in the pericardial sack. And at that time, you
5 take the drain, this pigtail drain with many side poles, you
6 thread it over the wire, but first you have to dilate. So
7 the wire's in there. Then you have the stiff dilator that
8 you go to dilate the way. Then you put in the drain, then
9 you get the drain positioned, then you hook that up to the
10 stopcock, you hook it up to the bag, you get a syringe, and
11 then you keep pulling.

12 So there's many different steps and I'd say
13 typically it takes between 20 to 30 minutes to do a
14 pericardiocentesis.

15 Q. I was going to ask you that, it seems like there's
16 a lot of steps here.

17 A. And you'll also, one other thing is you'll have
18 the patient -- you'll want the patient partly sitting up. So
19 you'll put a support behind the patient's back. It gets
20 closer and easier to do if the patient is at a bit of an
21 angle.

22 Q. And so, Dr. Calkins, obviously, in this type of a
23 dramatic code situation where the patient doesn't have any
24 blood pressure or very little blood pressure, you don't have

1 20 minutes?

2 A. No.

3 Q. So when the pericardial effusion or the cardiac
4 tamponade is occurring more slowly, is there more time to go
5 through all of these steps?

6 A. Yes. You have usually takes half an hour, it goes
7 a while to go through and get it done carefully.

8 Q. And is there any -- as far as you know, is there
9 any standard of care as to how long it should take as a
10 minimum for an electrophysiologist to successfully do a
11 pericardiocentesis? Is there any time?

12 A. No. There's no standard of care that you have to
13 get it done in a minute, two minutes, three minutes,
14 four minutes, five minutes. The standard of care is you need
15 to recognize the tamponade and you need to do everything you
16 can to take care of the patient and get rid of it and do the
17 pericardiocentesis. That's the standard of care.

18 The standard of care is not five minutes versus
19 ten minutes. Every patient is different. Every situation is
20 different. And I think it's also important to say, I told
21 you this happens, in my case, about one in 200 procedures. I
22 do about 200 procedures a year. But the average person does,
23 we'll say, 100 a year, maybe 50 a year. That means every two
24 to three years, this happens.

1 You know, so if they're a good
2 electrophysiologist, they're doing this procedure about once
3 every two or three years. Usually, it's in slow motion. So
4 it's once in a career or never that you have this kind of
5 emergency, catastrophic, blind pericardiocentesis.

6 If you're a bad electrophysiologist, maybe you
7 poke a hole three in 100 times. Even then, it's only three
8 times in two years. But a good electrophysiologist, I've
9 done it about five times, and never in this kind of dramatic
10 situation.

11 Q. All right. So you've actually never been in the
12 same exact situation as Dr. Smith was in this case?

13 A. No.

14 Q. Thankfully?

15 A. Thankfully.

16 Q. And is cardiac tamponade always successfully
17 treated?

18 A. No. As I told you, it happens in 1 percent, .5 to
19 1 percent. It's the most common cause of death from this
20 procedure. Death is very rare. Less than one in a thousand
21 patients that die from the afib ablation. But when they do,
22 you say, what are the top causes? Cardiac tamponade is
23 number one. If it's so easy to do a pericardiocentesis, no
24 one would die from it. But it in fact is the number one

1 killer. Number two is massive stroke. Number three is
2 what's called an atrial esophageal fissure, burning a hole in
3 the esophagus, which is a different topic.

4 Q. Can we have Exhibit 6 up, please? There's a
5 little glass of water there right to your right. There's a
6 green binder and you can move that out of the way, because
7 we're not going to use the green binder.

8 If you could, Dr. Calkins, in that white binder,
9 if you could turn to Exhibit 6 for us? Do you recognize that
10 document?

11 A. Yes.

12 Q. I've blown up on the screen a small part of this
13 document down in the lower right hand corner and it says code
14 team. Do you see that?

15 A. Yeah.

16 Q. First of all, what is a code record or a code blue
17 record? What is that document?

18 A. It's a documentation of everything that happens
19 during a code, you know, who is there, the time, what
20 happens, what time does it start, what time does it end. So
21 it's a very important document, but you can see there's a lot
22 of members in this team.

23 Q. And is there a specific member of the team who is
24 called the recorder?

1 A. Yes. In this case, it was someone named Newton, a
2 nurse named Newton.

3 Q. And what is a recorder and what is the
4 significance of that position on the code team?

5 A. So that's the person on the code team that is not
6 responsible for doing anything. They're responsible for
7 documenting everything, what happens in what order. They're
8 the person that is not there taking care of the patient.
9 They're there with a clock writing down what is going on. So
10 that person specifically does not have patient care
11 responsibilities.

12 Anyone else in a procedure room has patient care
13 responsibilities, meaning you got to do everything you can to
14 take care of the patient. This nurse is documenting the
15 times and what is going on.

16 Q. The upper part of this document, do you see
17 there's a column next to oxygen saturations where there's a
18 word written in?

19 A. Yes.

20 Q. And what does that say?

21 A. Tamponade time.

22 Q. And are you able to tell whether the time is 12:42
23 or 12:41?

24 A. It looks like tamponade time is 12:41, and it says

1 12:41.

2 Q. And does this document also up at the top indicate
3 what the time of the CPR starting was?

4 A. Yes. It says the code blue started at 12:39 and
5 CPR started at 12:39.

6 Q. And you've also looked at the cath lab log, which
7 we have as Exhibit 4 in evidence. Is that fairly consistent
8 with the code record as far as when CPR was started?

9 A. Yes. I think the start of these various time
10 things is quite similar.

11 Q. Now, if you could turn to Exhibit 5 for a moment
12 in the book. Now, on the first page, doctor, now, under the
13 graph portion, this is on the first page, do you see that
14 there is a line for IV fluids?

15 A. Yes.

16 Q. And this is the first page of the anesthesia
17 record from the beginning of the procedure?

18 A. Correct.

19 Q. And does this indicate to you how much IV fluids
20 Mr. Dechambeau got leading up to the point of the code, which
21 is on the next page?

22 A. Yeah. I mean, it tells you that he has a 20-gauge
23 angio cath in his left arm and it shows you the rate at which
24 fluids is being given.

1 Q. So he either got 2000 ccs or 3000 ccs depending on
2 how the notation is interpreted?

3 A. Yes.

4 Q. And then go to page two. And so, then, does this
5 record on page two indicate that additional fluids were given
6 to Mr. Dechambeau during the code in this case?

7 A. Yeah. I mean, it tells you during the code
8 multiple extra lines were started and he got six to
9 eight liters total. So he had gotten about three, but during
10 this code, he got another five liters, it looks like, three
11 or four liters from the extra lines that were put in.

12 Q. And the extra lines would be put in by the
13 anesthesiologist?

14 A. Yes.

15 Q. Is it appropriate to give IV fluids like this
16 during the code?

17 A. Absolutely.

18 Q. Doctor, I want to ask you a little bit more about
19 your background, if I could. In addition to the teaching you
20 do at Johns Hopkins, do you also lecture from time to time
21 outside of the institution?

22 A. Yes, quite frequently.

23 Q. And, in fact, the reason you couldn't be here
24 yesterday is you were flying in from a talk you were giving

1 in Europe?

2 A. Correct.

3 Q. And you're a visiting professor in various places,
4 not only in this country, but also I think you've traveled
5 and spoken all over the world on different topics, including
6 atrial fibrillation ablation?

7 A. That's correct.

8 Q. You talked about taking the board examination to
9 become board certified. Have you also been involved in
10 actually writing the exam that the board certifies
11 electrophysiologists?

12 A. Yes. For six years, I was a member of the
13 American Board of Internal Medicine exam writing committee.
14 So I wrote the exam and my signature is on every one that
15 passed on the diploma. Now, I'm head of the ABIM SEP exam
16 committee. So there's another exam for recertification and I
17 head that committee.

18 Q. All right. And then you've written or cowritten,
19 I think it's somewhere in the order of 500 articles,
20 thereabouts, on various topics involving electrophysiology?

21 A. Yes.

22 Q. And quite a few of those are on atrial ablation
23 and atrial fibrillation ablation?

24 A. Yeah. I would say about 200 to 300.

1 Q. So we talked about this a little bit, but can you
2 explain what the standard of care is for a cardiologist, an
3 electrophysiologist who is performing an atrial fibrillation
4 ablation procedure who has a patient develop cardiac
5 tamponade? What is the standard of care in that situation?

6 A. The standard of care is to suspect it, to
7 recognize it, to -- and then do everything you can to treat
8 it. So the typical standard of care would be someone's blood
9 pressure drops during an atrial ablation procedure. You
10 suspect cardiac tamponade. It could be other things. It
11 could be an anesthesias reaction or other things.

12 But you suspect cardiac tamponade, you call for an
13 echocardiogram, you call for the pericardiocentesis tray, you
14 start doing the pericardiocentesis. If the patient's blood
15 pressure is low and there's no detectable pulse, you begin
16 CPR. There's a whole bunch of steps. And the standard of
17 care is you got to go through those steps. You got to be
18 alert. You got to go through those steps and try to take
19 care of the problem.

20 Q. Could you see from your review of Dr. Smith's
21 deposition, which was taken in about 2013, at the point he
22 testified he couldn't remember the exact sequence of steps at
23 that point?

24 A. Yes.

1 Q. Does that cause you to have any concern or
2 criticism about what he did in this case?

3 A. No.

4 Q. Would you expect someone to be able to remember
5 those details that far after the event?

6 A. No.

7 Q. There's been some suggestion from Dr. Seifert the
8 other day that this is easy, it just takes a few minutes and
9 you get the drain in and the blood comes out and the blood
10 pressure is back. If that was his testimony, do you agree
11 with that?

12 A. No. That's a bit of a fairytale. That's what you
13 hope for and you dream for, but that's not what happens.
14 It's not an easy procedure, even in someone who is a super
15 skinny person with perfect anatomic landmarks. You have a
16 big patient, you're trying to do this procedure, you don't
17 want to hit the liver, because you can lacerate the liver.
18 You don't want to go too deep, you can lacerate the bowel.
19 You can go too far and be in the RV instead of the right
20 atrium. So it's not easy under any circumstance.

21 And the usual circumstances, you have the luxury
22 of the echo being there, you have the luxury of the patient's
23 blood pressure. You're not doing it when someone is doing
24 CPR at the same time. Your blood pressures are going through

1 the roof. It's spooky to be there and everyone in the whole
2 room are doing everything you can.

3 So to say is this like sticking a balloon and
4 popping a balloon with a pin is a little bit naive. I mean,
5 it takes a lot of time. Even when you get it in the right
6 spot, you start pulling back, well, depending on how much
7 blood there is, it can take you a while to get the blood off
8 and depending on how quickly the blood is coming in. It's
9 sort of, how much is coming in versus how much is going out?

10 You could be in the right ventricle, the blood
11 could be clotted, it could be posterior, it could be a
12 loculated posterior effusion where you can't get to it from
13 the front. So it's by no means simple or easy where you just
14 pop a balloon like that.

15 If that was the case, no one would ever die from
16 this complication. That wouldn't be the number one killer in
17 atrial fibrillation procedures.

18 THE COURT: Doctor, slow down just a little bit.
19 Go ahead.

20 BY MS. POLLARA:

21 Q. I know you're passionate. Stephanie is going to
22 be killing us here at the end of the day. In this case,
23 based upon looking at the code record, where you look -- can
24 you put the code record up, please? That's Exhibit 6, then,

1 please.

2 So when you see this notation on the code record,
3 where it says tamponade time, what does that tell you about
4 Dr. Smith's thought processes at that point?

5 A. Well, you know, he appropriately recognized this
6 was a cardiac tamponade as the overwhelming likely cause.
7 The cardiac tamponade, he started everything in process in
8 terms of ordering the kit and ordering the echo and so forth.

9 Q. Let me ask you about this, because we understand
10 that at the time of the code, the echo machine was not in the
11 electrophysiology suite where this was happening. Back in
12 the 2006 time frame, Dr. Calkins, was it standard of care to
13 have that machine sitting there at the ready in case
14 something like this happened?

15 A. No. So at that time, it was not the standard of
16 care. I think it was a minority of labs that had an echo
17 machine in the room. And actually over time, if you ask
18 today what's the standard of care, things have changed. So
19 now most EP labs will have an echo machine in the room. But
20 back when this procedure was done, we didn't have an echo
21 machine in the room nor did most EP labs have an echo machine
22 in the room.

23 Q. So you're not critical of anyone in this case for
24 there not being an echo machine at the point of the code, are

1 you?

2 A. No.

3 Q. Was it appropriate for him to call for one?

4 A. Yes. I mean, that's what you do is you call for
5 an echo machine. You have to realize, back in this era,
6 these procedures weren't performed two times a day every day.
7 An echo machine is a very expensive piece of equipment. You
8 need an echocardiographer to run it. So this was something
9 that was sort of specialized equipment that in rare
10 situations you'd call for it. They would come within 10 or
11 15 minutes, as quick as they can, depending on where the
12 machine was.

13 Now, over time, it's become clear that, you know,
14 now that every EP lab, this is the main procedure they're
15 doing, and everyone recognizes now more than they did in the
16 past, the whole tamponade issue. That's why EP labs today
17 have it in their room. That's -- looking back at it, it's
18 unfortunate, but we keep learning, we keep getting better and
19 we keep trying to correct, and this is one of the things that
20 has changed.

21 Q. Well, if he's doing the pericardiocentesis -- let
22 me ask you this first. Is there any indication from anything
23 that you've seen in this case that he waited to perform the
24 pericardiocentesis until the echocardiogram machine was

1 present?

2 A. Yeah, I've seen nothing. I think there was some
3 suggestion that he just sat there sitting on his hands
4 waiting ten minutes for the echo machine to come up. And to
5 look at his deposition, he's very clear, absolutely not.
6 Plus no one in their right mind, of course you wouldn't do
7 that. No electrophysiologist would sit there with a patient
8 getting CPR and do nothing.

9 You would get the needle and you would start
10 sticking it in there and try to take care of the problem. So
11 to say that he just sat and waited ten minutes. And he's
12 very clear that he --

13 Q. Slow down.

14 A. He's very clear in his deposition, that comes
15 through right away. And I remember in my early discussions
16 with the attorney, when I was contacted way back when, I
17 asked that question. I said, what does Dr. Smith tell you
18 about what he did during the procedure, during that time?
19 And the attorney said, absolutely, he was doing the
20 pericardiocentesis. He didn't wait for the echo machine. It
21 was at that point that I wrote my initial letter of support.

22 Q. So, Dr. Calkins, when the echo machine got there,
23 do you understand that it showed that there was a persistent
24 pericardial effusion with tamponade?

1 A. Correct.

2 Q. Well, doesn't that tell you that Dr. Smith wasn't
3 doing the procedure correctly?

4 A. No. It just tells you that there still was a
5 persistent effusion. Whatever amount of blood he was pulling
6 off either was the right ventricle, from the wrong chamber,
7 or it was coming in as fast as he was pulling it off. So it
8 doesn't tell you, was he doing the right thing? Was he
9 pulling the blood off? It just tells you there was still
10 blood there and it wasn't all pulled off. That's all it
11 tells you.

12 Q. All right. Dr. Calkins, I'll represent to you
13 that Dr. Smith testified here yesterday and that he testified
14 that he was drawing blood off, but the patient wasn't
15 responding initially. And does that indicate to you that he
16 wasn't acting appropriately or within the standard of care in
17 this case?

18 A. No. I mean, pulling blood off, it's not going to
19 come shooting out at 100 miles an hour. You got to fill the
20 syringe, empty the syringe, rehook it up, fill the syringe,
21 empty the syringe, rehook it up. It's not until you get that
22 drain in and the stopcock that you can do it a little bit
23 more faster.

24 But, no, it takes a while depending on how much

1 blood there is to get it off and all the different steps
2 involved with pulling it out, ejecting the blood, rehooking
3 up the syringe, pulling it out again and all of these things.

4 Q. Is there a standard of care as to a certain number
5 of minutes to alleviate a cardiac tamponade? Is there some
6 standard that you must have this done within two to
7 five minutes or five minutes or less than eight minutes or
8 something like that?

9 A. No. No, there's not.

10 Q. All right. Are all the opinions that you've
11 expressed here today, Dr. Calkins, to a reasonable degree of
12 medical probability?

13 A. Yes, they are.

14 Q. I am paying for your time in being here today, am
15 I not?

16 A. Yes, you are.

17 Q. Your hourly rate is \$485 an hour?

18 A. That's correct.

19 Q. And I paid you or going to pay you to come here
20 from Maryland and go back?

21 A. Yes.

22 Q. Is this the first time you and I have worked
23 together?

24 A. Yes.

1 MR. POLLARA: Thank you, your Honor. I have
2 nothing further.

3 THE COURT: Thank you, Ms. Pollara. Mr. Kozak.

4 MR. KOZAK: Thank you.

5 CROSS EXAMINATION

6 BY MR. KOZAK:

7 Q. Dr. Calkins, you gave an initial expert report to
8 Mr. Lemons, is that right?

9 A. That's correct.

10 Q. Would you turn to Exhibit 16?

11 A. Okay.

12 Q. And that is your initial report?

13 A. That's correct.

14 Q. When you rendered that report, you had reviewed
15 the records of David Smith, correct?

16 A. That's correct.

17 Q. And you had reviewed the records of Washoe Medical
18 Center, correct?

19 A. That's correct. Yes.

20 Q. And you had not reviewed Dr. Smith's deposition,
21 had you?

22 A. No. But I'd asked the attorney about his actions
23 during the arrest.

24 Q. So when you wrote this report, you were relying

1 strictly on the records of David Smith, correct?

2 A. That's correct.

3 Q. And the records of Washoe Medical Center?

4 A. And the attorneys, what the attorney told me that
5 Dr. Smith is going to say when he is deposed, because we were
6 expecting a relatively soon deposition.

7 Q. Okay. But then after that case was over, you were
8 asked to do additional work?

9 A. That's correct.

10 Q. And I know you told me what you reviewed. What
11 did you review after and why did you feel it was necessary to
12 review other material?

13 A. Well, it had been so many years, I hadn't kept the
14 material, so I had to rereview everything. So I was sent the
15 original material, plus I was sent Dr. Morady's deposition,
16 plus I was sent Dr. Smith's deposition.

17 Q. Did you see Dr. Morady's affidavit?

18 A. Yes, I did.

19 Q. Would you turn to Exhibit 12? That's Dr. Morady's
20 affidavit, is it not?

21 A. That's correct.

22 Q. Dr. Morady stated in paragraph ten some of his
23 opinions, did he not?

24 A. That's correct.

1 Q. And one of his opinions was that Dr. Smith failed
2 to timely perform a pericardiocentesis on Neil Dechambeau, do
3 you see that?

4 A. Yes.

5 Q. And then he said that --

6 THE COURT: Counsel, just a minute. Do you want
7 16 into evidence?

8 MR. KOZAK: Yes, I do.

9 THE COURT: Any objections?

10 MR. POLLARA: Yes, your Honor, it's hearsay.

11 THE COURT: It's Dr. Calkins, number 16.

12 MR. POLLARA: I apologize, your Honor, no
13 objection to that.

14 THE COURT: Ms. Clerk, 16 is admitted. Mr. Kozak,
15 12 is not in.

16 MR. KOZAK: Okay.

17 THE COURT: So you can ask him if he relied upon
18 the information in Dr. Morady's affidavit, you just can't
19 read that into evidence. Go ahead.

20 BY MR. KOZAK:

21 Q. Now, in paragraph ten E states a trans --

22 MS. POLLARA: Your Honor --

23 THE COURT: You just can't read it in. Just ask
24 him if he relied upon those statements.

1 BY MR. KOZAK:

2 Q. Did you rely on the opinion expressed in paragraph
3 ten E of Dr. Morady's affidavit?

4 A. No, absolutely not. That was his opinion. I was
5 rendering my independent opinion of what I thought about the
6 procedure.

7 Q. But your opinion differed from his opinion in this
8 affidavit, correct?

9 A. It looks like it did.

10 MR. KOZAK: Your Honor, I'd like this admitted
11 into evidence, the affidavit of Dr. Morady, Exhibit 12.

12 MR. POLLARA: Your Honor, I object. It's hearsay.

13 THE COURT: Objection is sustained.

14 BY MR. KOZAK:

15 Q. Doctor, did you read paragraph ten E of Dr.
16 Morady's affidavit?

17 A. Yes, I did.

18 Q. Did you agree with that opinion?

19 A. I just read it when I was sent it in the last week
20 or two. Do I agree with it? No.

21 Q. Why do you disagree with it?

22 A. Yeah. It becomes clear that Dr. Morady, when he
23 rendered this opinion, was under the opinion -- was under the
24 impression that Dr. Smith did not start the

1 pericardiocentesis until the echo machine arrived and he
2 found fault with that.

3 What is clear in Dr. Smith's deposition and also
4 in the evidence I reviewed is that Dr. Smith did not wait
5 until the echo machine arrived, as he stated in the
6 deposition, he's very clear about this, and that's why Dr.
7 Morady has changed his opinion.

8 Q. Well, did you read the code sheet that Nurse
9 Newton dictated?

10 A. Yes.

11 Q. And that code sheet doesn't say anything about a
12 pericardiocentesis being initiated, does it, at 12:41?

13 A. Well, it says cardiac tamponade. It doesn't
14 essentially say at 12:41 pericardiocentesis starting. But
15 when you read Dr. Smith's deposition and, you know, he's very
16 clear that he started doing the pericardiocentesis
17 immediately, which, of course, he would do.

18 Q. Why do we have medical records? What's the
19 purpose?

20 A. The purpose is to document things.

21 Q. And so the pericardiocentesis was not documented,
22 isn't that correct?

23 A. Medical records -- that's correct, but medical
24 records are imperfect. They don't document everything that

1 we would want to have documented. It's only in hindsight
2 that oftentimes we wonder, why wasn't this documented or why
3 wasn't that documented? As I think you know, this is a
4 common issue, medical records aren't perfect.

5 Q. Would you agree if the time line that is stated in
6 the medical records is this, that there was a cardiac arrest
7 between 12:35 and 12:39, correct?

8 A. I think 12:39 is when it -- I think the start
9 time, 12:39, 12:41, something like that.

10 Q. 12:41, CPR commenced?

11 A. Correct.

12 Q. Doctor, what is the purpose of CPR when you have a
13 cardiac tamponade?

14 A. Well, you always do cardiac CPR. Cardiac CPR is
15 to help increase the blood pressure, get profusion to the
16 brain by moving blood around the heart. It's not perfectly
17 effective in any situation, particularly in cardiac
18 tamponade. But it's not that if you have cardiac tamponade,
19 you shouldn't do CPR. You of course do CPR. Any patient
20 that doesn't have blood pressure, that is unresponsive, you
21 do CPR. Anyone who didn't, that would be negligent, but
22 absolutely you do CPR.

23 Q. Do you do CPR when your patient goes into a
24 cardiac tamponade at Johns Hopkins Hospital?

1 A. If I had this situation with no blood pressure,
2 absolutely.

3 Q. Have you ever done it in your career?

4 A. I told you that of the five tamponades I've had to
5 deal with, none of them did I have this kind of cardiac
6 arrest situation. Cardiac arrest equals CPR.

7 Q. So your answer is you've never done CPR when you
8 have a cardiac tamponade, have you?

9 A. I've never been in that situation where I had to,
10 no, where there was no blood pressure.

11 Q. What possible benefit could there be to massaging
12 the heart when the heart can't pump and the heart is frozen
13 because of the pericardium being filled with blood?

14 A. Well, there's never been a study of the efficacy
15 of CPR in cardiac tamponade. You're suggesting that there's
16 been studies and data showing that CPR is of no benefit in
17 the setting of tamponade. That has never been studied. And
18 certainly the standard of care is to perform CPR in patients
19 with cardiac tamponade.

20 You know, I suspect it's not of tremendous
21 benefit, because you have problems getting blood into the
22 heart when you have tamponade, it's a filling problem. But I
23 think there's some value, just by the mechanical pressures of
24 the heart, pressure in the chest goes up, pressure of blood

1 that goes in the great vessels will go up. But, no, there's
2 never been a study about the relative efficacy of CPR in
3 tamponade versus non tamponade or not, but of course you
4 would do it.

5 Q. Dr. Morady stated in his affidavit there was no
6 benefit.

7 MR. POLLARA: Excuse me, your Honor, it's hearsay.

8 THE COURT: Sustained.

9 BY MR. KOZAK:

10 Q. You did read Dr. Morady's --

11 A. Everyone is entitled to their opinion. He had his
12 opinion. I have a different opinion.

13 Q. Let's get back to the time line here. 12:44 stat
14 echo was called for. Do you agree with that from the medical
15 records?

16 A. That's what the medical record said. Exactly when
17 it was called for, I'm not sure. That's when it was
18 documented.

19 Q. 12:49, a stat echo was hooked up, correct?

20 A. Yeah.

21 Q. And they observed a large pericardial effusion,
22 correct?

23 A. Yes, that's correct.

24 Q. And we know that the pericardial effusion in this

1 case was 300 milliliters, correct?

2 A. That was the number that was documented. I don't
3 think anyone was precisely measuring how much blood was taken
4 off. But that was the estimate.

5 Q. That's Dr. Smith's own record, isn't it?

6 A. Yes. That was his estimate.

7 Q. So he's telling us that there's 300 milliliters of
8 blood that was evacuated from the pericardium, isn't that
9 true?

10 A. That's correct. That's what he estimated.

11 Q. That's not a large effusion, is it? That's a kind
12 of a medium effusion, right?

13 A. I would consider that to be a large effusion. 300
14 ccs is a large effusion.

15 Q. Now, assuming that the large pericardial effusion
16 was observed at 12:50, because they had to hookup the
17 machine. How long does it take to hookup the stat echo
18 machine?

19 A. Well, it takes a while. Depending on the machine,
20 you have to turn it on, it takes a minute or two for it to
21 rev up. Then whether you put the patient's information in,
22 you start imaging and you got to find the window, it takes a
23 little bit of time.

24 Q. Would it take a couple of minutes?

1 A. A minute or two, yes.

2 Q. So once the pericardial effusion was observed,
3 then the 300 ccs of blood was drawn off by a pericardial
4 drain, correct?

5 A. We know the echo -- when the first echo images
6 were done, there was still considerable blood in the
7 pericardial space. And the last echo images, they aren't
8 time stamped, shows that the fluid is gone. So, yes, during
9 that period of time, we have documentation of blood in the
10 sack and then no blood in the sack. We don't have a precise
11 time line, because the echo images aren't time stamped.

12 We also don't know how much blood originally was
13 in the pericardial space. It might have been 500 ccs
14 initially and then that was down to 300. I don't know.

15 Q. Well, at 12:54 was when the pulse was restored,
16 correct?

17 A. That's correct.

18 Q. So it took approximately three minutes to draw off
19 the blood that was in the pericardial sack and restore the
20 pulse, correct?

21 A. Somewhere around -- I mean, during that, I think
22 we certainly know whenever the echo was first done, there was
23 fluid in the sack, and then when the pulse was back, that's
24 when the fluid was gone. So that's the time period.

1 Exactly what the time stamps are, since the echo
2 images unfortunately aren't time stamped, I don't think we
3 can say precisely when that was. We have some times to put
4 in the chart. But, again, everyone in the room, their main
5 effort is to save the patient. It's not to document things
6 for 15 years later when we're sitting here today in a
7 snowstorm going over these records.

8 Again, people were taking care of the patient.
9 Those are the times we have. The echo images aren't time
10 stamped. The fluid eventually was evacuated and the
11 patient's blood pressure came up.

12 Q. It's Nurse Newton's job to record things as they
13 occur in the cath lab, correct? She's not involved in
14 actually treating the patient at that point, is she?

15 A. No. She's there to be documenting. But exactly
16 how well she was doing her job, we don't really know.
17 Whether she documented everything contemporaneously, I just
18 can't speak for her.

19 Q. So getting back to my time line from 12, say, 52,
20 to 12:55, that 300 milliliters of blood was evacuated from
21 the pericardial sack and the pulse returned, correct?

22 A. Again, I think we're putting too much emphasis on
23 the times. We know that the medical records don't all jive
24 in terms of the time. If you look at the anesthesia record,

1 it wasn't until 1:15 that the patient had a blood pressure.
2 We know that wasn't true, because we know at 12:54, he did
3 have a pulse. So all the times are a little bit confusing.
4 So I think we have to take that with that in mind. That,
5 again, everyone's attention is on the patient. It's not on
6 documenting. There's no timer that is set. Everyone's
7 watches are somewhat different. The echo images aren't time
8 stamped. That's too bad. I wish they were, then I could
9 agree with you on your proposed time lines.

10 Q. We don't know that the time lines are incorrect.
11 We have Nurse Newton and the defense counsel referred to the
12 code sheet, she's assuming those time lines are correct,
13 right?

14 MR. POLLARA: Your Honor, that calls for
15 speculation.

16 THE WITNESS: It's clear that you have your
17 opinion about the time line and you're entitled to hold your
18 opinion. I place less emphasis on the time line, because
19 what I've seen is that different people's clocks were
20 differing. And in my experience, when you have this kind of
21 cardiac arrest, again, people are taking care of the patient.
22 They're not talking care of the clock or the timing.

23 BY MR. KOZAK:

24 Q. Well, there's no doubt in your mind that if

1 Dr. Smith waited for the stat echo machine to get into the
2 cath lab before he did the pericardiocentesis, he was acting
3 beneath the standard of care, isn't that correct?

4 A. Well, if he had sat there for ten minutes doing
5 nothing, not trying to do the pericardiocentesis, that would
6 be negligence. But he's very clear in his deposition, and I
7 don't know what he said yesterday, but certainly his
8 deposition makes it very clear that he immediately started
9 the pericardiocentesis.

10 Q. That's just his testimony. There's nothing in
11 this medical record to substantiate that, is there?

12 A. No. But it's also, I mean, it would be -- any
13 physician would absolutely -- you know, he knew it was
14 tamponade. He knew how to treat tamponade. You get the
15 needle, you get the kit, you stick it in, and, you know,
16 that's what he's testified to. That's what any reasonable
17 physician would do. And that's what I believe occurred. But
18 I agree that documentation is less than perfect.

19 Q. In fact, it's very poor in this case, isn't it?

20 A. I wouldn't say it's very poor, but it's imperfect.
21 And exactly, you know, why was it that when we saw the fluid
22 go from a certain amount of fluid to no fluid, and how that
23 corresponds with the echo machine, was the drain adjusted,
24 was a bigger syringe used, exactly what was done differently

1 at that point that allowed, you know, there's blood coming
2 in, there's blood going out to sort of win the race. I don't
3 know.

4 Q. Well, Dr. Smith testified yesterday that he didn't
5 have any problem placing the needle and the drain and he got
6 a return of blood and a lot of blood immediately. Were you
7 aware of that?

8 A. I wasn't here for his testimony yesterday.

9 Q. You're not aware of that?

10 A. No.

11 Q. Then Dr. Smith testified that he took the
12 20-milliliter syringe and it would only take him five to
13 ten seconds to fill syringe. Were aware of that testimony?

14 A. No.

15 Q. So he's in there very quickly with his
16 pericardiocentesis tube. He's extracting blood very rapidly.
17 He's got a 20-milliliter syringe. Wouldn't you expect all of
18 that blood to be aspirated if there's just 300 milliliters
19 within three minutes at the most?

20 A. It depends, again, how much blood is coming in
21 versus how much was going out. That was his estimate of
22 time. But, again, people's sense of time in this situation,
23 your time stamp really goes to the wind as you're worrying
24 about the patient.

1 You know, all you can say is he was pulling the
2 blood out as fast as he can. Was he initially in the RV
3 instead of the pericardial space, so some of the blood was
4 from the RV and not the pericardial space? I just can't say.
5 But it's clear from what you're telling me that he was doing
6 the right thing. He was pulling blood off as fast as he
7 could and that's what you expect someone to do.

8 Q. So if he was pulling off blood as fast as he could
9 and he was evacuating it properly, you would expect the pulse
10 to be returned in five minutes, wouldn't you, at the most?

11 A. Again, it would depend on how much blood was
12 coming in. At 20 ccs every ten seconds is coming in, 20 ccs
13 going out, then you're even.

14 Q. If you're having that kind of cardiac tamponade,
15 you wouldn't expect that at 12:54 when they looked in there
16 and they saw 300 milliliters of blood and they extracted that
17 out, and there's no further bleeding, you would have to have
18 a major effusion, wouldn't you, to have 300 milliliters of
19 blood extracted and have blood still coming in? You would
20 have to call the surgeon?

21 A. It has to do with how big of a tear or hole or
22 whatever, and then a clot is forming on the hole, so at one
23 point, the clot finally plugged the hole in the heart, and
24 then he was able to get ahead of the race and get the fluid

1 off.

2 Q. Well, doctor, isn't it true, you don't have to get
3 all the fluid off before the pulse returns, do you?

4 A. That's correct.

5 Q. You just have to get a certain fraction of the
6 blood off and the pulse starts going up, correct?

7 A. How much that is varies patient by patient, varies
8 considerably. But, no, you don't have to get every last cc
9 of blood out before you see some response.

10 Q. So you would expect to see a pulse after three
11 minutes of the type of pericardiocentesis that was being done
12 by Dr. Smith, wouldn't you?

13 A. I would say you would hope to, but whether you do,
14 again, depends on all of these other factors.

15 Q. But we know that the pulse returned almost
16 instantaneously when he extracted the 300 milliliters at
17 12:52, isn't that correct?

18 A. We certainly know that a pulse eventually was
19 restored and the echo eventually showed no fluid. Exactly
20 the relative timing of those two things, again, we don't
21 know, because the echo wasn't time stamped. But there's some
22 relationship between the two, that's correct.

23 Q. Dr. Calkins, this is from the procedure report by
24 Dr. Smith and he wrote this. Did you review that?

1 A. Yes, I did. I've seen this.

2 Q. And he states that stat echo gram, echocardiogram
3 was performed, which showed a fairly large pericardial
4 effusion. That's not a massive one, is it, fairly large?

5 A. No. It's significant. It's not 2,000 ccs.

6 Q. CPR was performed and we removed approximately
7 300 milliliters of frank blood from the pericardial space
8 after doing a pericardiocentesis. A common sense reading of
9 that would indicate that when he saw the effusion, because he
10 called the stat echo to observe the effusion, right?

11 A. Correct.

12 Q. And then he drew off 300 milliliters of frank
13 blood in the pericardial space after doing a
14 pericardiocentesis. So the common sense reading of that
15 would be that he looked in the echo machine, he saw what he
16 needed to see, and he evacuated the blood at that point,
17 right?

18 A. Well, that's your interpretation of what this
19 says. I think what he said and what his deposition says is
20 that he started the pericardiocentesis well before the echo
21 machine arrived.

22 Q. I know what he said in his deposition. But
23 according to his record, that's the chronology, correct?
24 That's the record we have to deal with?

1 A. Well, it doesn't state in this note when he
2 started the pericardiocentesis. So it doesn't say -- you
3 know, there's no sentence saying, I started the
4 pericardiocentesis after the echo arrived and showed a large
5 effusion. I don't see that sentence. That sentence isn't
6 there.

7 And what he's told us is, I started the
8 pericardiocentesis blindly before the echo machine arrived.
9 When the echo machine finally arrived, there still was a
10 residual 300 ccs of fluid, and eventually we got the fluid
11 off, and the patient's blood pressure came up.

12 Q. That's part of the problem here, isn't it? We
13 don't have a good complete record by Dr. Smith as to the
14 consequence of events that happened. And this was written a
15 day after the operation, correct?

16 A. That's correct.

17 Q. Wouldn't you expect he would be able to remember
18 with a little more detail and specificity about that
19 particular -- since it led to a morbidity?

20 A. Well, again, he's documenting what went on. The
21 purpose of a procedure note is not some legal defense note.
22 You know, the purpose of a procedure note is to document what
23 happened. And certainly in procedure notes, I don't document
24 in minute detail every little step of what happened first and

1 what happened second and what time it was. Again, that's for
2 the medical records. That's for the CPR log and other things
3 to document that. I wouldn't expect that to be in here and
4 he certainly doesn't include that in his report about what
5 time the pericardiocentesis was started.

6 Q. Isn't one of the purposes of the medical records
7 to guard against liability in case of a malpractice situation
8 like this?

9 A. Yes.

10 Q. Now, the heart stops beating, every minute that
11 goes by, the brain is not getting proper oxygen, isn't that
12 correct?

13 A. Yes. There's a certain amount of oxygen left in
14 the blood initially, but, yes, that oxygen gets consumed and
15 time matters.

16 Q. So after five minutes, isn't it true that there's
17 a very high risk of anoxia for a patient?

18 A. It varies tremendously on each patient. There's
19 patients that have been in cardiac arrest for 45 minutes and
20 woken up completely. There's patients who have been in
21 cardiac arrest for three minutes that have had severe damage.
22 It's highly variable depending on other factors.

23 Q. If it's over five minutes, you're getting into the
24 area where there's an extremely high risk, correct?

1 A. Well, whether it's five minutes, 10 minutes,
2 15 minutes, certainly the longer a cardiac arrest goes on,
3 the higher the chance of injury to the brain.

4 Q. In this case, we know that there wasn't any oxygen
5 to the brain for approximately 15 minutes, correct?

6 A. Well, to say there wasn't any oxygen to the brain,
7 I think is a bit of an overstatement. There's oxygen in the
8 blood. At the time someone has a cardiac arrest, the blood
9 that's in the head or in the vessels has oxygen in it. And
10 by doing CPR, you move other oxygenated blood to the brain.

11 So it's not that the oxygen suddenly disappears
12 from the blood. The oxygen that is in the blood is being
13 consumed and cells are beginning to get hypoxic, but it's a
14 dynamic process. It's not you have a lot of oxygen and then
15 you have no oxygen. The oxygen gradually gets burned up over
16 time.

17 Q. At 15 minutes, you would expect brain damage,
18 would you not?

19 A. I think 15 minutes is a pretty long cardiac
20 arrest. I've had patients go through a cardiac arrest that
21 lasted 15 minutes and do fine and others have severe brain
22 damage.

23 Q. Now, you stated there's oxygenated blood going
24 through the body during a cardiac arrest when you're doing

1 CPR? That's not correct, is it?

2 A. There's some blood movement from doing CPR by
3 changing the intrathoracic pressure. There's a certain
4 amount of blood, oxygen in the blood. And once you have a
5 cardiac arrest and the blood flow slows or stops, the oxygen
6 that is there gradually gets consumed. So it takes so many
7 numbers of minutes for all it to be used up.

8 Q. How many minutes?

9 A. Somewhere between five and 15. I mean, it's -- I
10 mean, I think the general number is starting at about five
11 minutes. I think then you're concerned about hypoxia and not
12 enough oxygen, and then more than ten minutes, more than 15
13 minutes, more than 20 minutes, more than an hour.

14 Q. Well, when you have a cardiac arrest as a result
15 of a cardiac tamponade, isn't it true that what is going on
16 is the heart can't fill with blood, right, because it's not
17 pumping? You have a filling problem?

18 A. Yes. The pressure in the pericardiac sack is
19 greater than the pressure in the inferior vena cava. So the
20 blood that comes from the head and the feet doesn't flow
21 because you have a dam upstream pressure.

22 Q. So CPR isn't going to circulate oxygenated blood,
23 is it?

24 A. It will circulate some blood just by the

1 mechanical force by the chest squeezing in, the pressure in
2 the chest goes up. That means the blood that is outside the
3 chest gets a sudden pulse, a sudden increase in pressure that
4 moves some of the other blood around.

5 Q. Certainly not enough to stave off anoxia?

6 A. Again, it depends on all these different
7 variables. But to say it's unhelpful and you shouldn't do
8 it, I think is a misstatement. I think that's incorrect.
9 You always do CPR in any arrest situation where you have no
10 blood pressure.

11 Q. Doctor, you would be extremely concerned if you're
12 not restoring the pulse during a cardiac tamponade within
13 five minutes?

14 A. You want to do it as quickly as possible. You
15 hope to do it with five minutes, 10 minutes, 15 minutes,
16 20 minutes. You do it as quick as you can.

17 Q. You've never had a situation where you didn't
18 restore the pulse within five minutes when you have a cardiac
19 tamponade, have you?

20 A. I've never had a situation where I've completely
21 lost the pulse.

22 Q. No. My question was, you've never had a situation
23 where you did not restore the pulse within five minutes when
24 you had a cardiac tamponade and you were doing a catheter

1 ablation, correct?

2 A. That's because I've never experienced this
3 situation. But in patients that are hypotensive, I told you
4 it takes between 20 and 30 minutes to do the
5 pericardiocentesis, typically.

6 Q. So your statement is if it takes 20 or 30 minutes
7 to do a pericardiocentesis, that's acceptable?

8 A. That's the standard, yes. It takes that long to
9 do it. It depends on the clinical situation. What I'm
10 referring to are patients where their blood pressure is 60
11 and then you give them pressers, you get their blood pressure
12 up to 90. This was a really unusual case where the blood
13 pressure was literally zero or 20 and it was an emergency and
14 you had to -- everyone was moving as fast as they could.

15 Q. So Dr. Seifert testified that he's had about 20 of
16 these situations where there was a very sudden drop in blood
17 pressure and he was able to resuscitate the patient within
18 five minutes. Would you agree that that's probable?

19 A. Well, I'm shocked by his high complication rate.
20 It's a little bit worrisome if he's had so many of these.
21 I've had zero and he's had 20, I don't know what that says
22 about his skills and experience as an electrophysiologist.
23 I'm glad he was successful in resuscitating all of these
24 patients, but he should be a little bit more careful when he

1 does the procedure.

2 Q. Regardless of that, doctor, if he was able to
3 resuscitate the patient, that's the issue in this case, isn't
4 it?

5 A. I suspect those were not patients with no blood
6 pressure where CPR was going. That's what I suspect. I
7 think he's the most experienced person in the world dealing
8 with this, then. He's really a world's authority on this,
9 but he also has the highest complication rate of any
10 electrophysiologist that I've heard of.

11 Q. You know Dr. Seifert, don't you?

12 A. Yes. I knew him many years ago.

13 Q. He's respected physiologist, isn't he?

14 A. I have no knowledge of his -- what his reputation
15 is now. I know 30 years ago, he was a nice guy training at
16 Hopkins. But I have no idea about what kind of
17 electrophysiologist he's become. But this data you just told
18 me makes me a little concerned about his skills.

19 Q. He's done thousands of these operations just like
20 you have, hasn't he?

21 A. I don't know. I wasn't here for his testimony and
22 I haven't seen him in probably 10, 15 years.

23 Q. So, really, the basis of your opinion here is the
24 testimony of Dr. Smith, not the medical records, is that

1 correct?

2 A. No. That's not correct. What the medical records
3 say is that we have somewhere between, whatever, 12:42 and
4 12:54, so it's about 12 minutes that this whole thing took
5 place from CPR to returning a pulse. And I think 12 minutes
6 is doggone acceptable to restoring the pulse within 12
7 minutes. I think he did a very good job. It didn't turn out
8 the way we all would hope and I think we all feel terribly
9 sorry about that.

10 But I think to say, you have an unbelievably rare
11 situation occurs, and within 12, 13 minutes you've restored
12 the pulse, despite having to call for the echo machine,
13 despite the patient being obese, despite all the other
14 problems, I think this is very respectable and certainly well
15 within the standard of care.

16 Q. So did you review that anesthesiology report and
17 the statements there by Dr. Kang?

18 A. I did.

19 Q. Now, Dr. Kang says that the cardiac arrest
20 occurred at 12:50, chest compression, and then he
21 administered atropine and vasopressor, whatever it is?

22 A. Yeah.

23 Q. Would you do that in a situation of a cardiac
24 arrest in this situation? Would you prescribe those drugs?

1 A. Yes.

2 Q. Then he says at 13:00, they had the transthoracic
3 echo, correct?

4 A. Correct.

5 Q. And then he says they observed a large pericardial
6 effusion, correct?

7 A. Yeah.

8 Q. And then there was several hundred ccs aspirated
9 and there was a pericardial drain in place, right?

10 A. Yes.

11 Q. So apparently Dr. Kang supports the record that
12 says that the echo machine was used to observe the
13 pericardial effusion and then we had the pericardiocentesis,
14 correct?

15 A. That's not correct. I mean, one, you can see they
16 have problems with the time stamp. So here the
17 anesthesiologist states that at 12:50 the cardiac arrest
18 occurred. We've heard earlier, it's 12:41 or 12:42, so he's
19 off by eight minutes. And then he's saying by 1:00 the echo
20 machine arrives. We know by 12:54, he already had a pulse,
21 so we know these times are way off, and the echo machine
22 arrives and you got to hook it up and do all these other
23 things.

24 So, again, I think the anesthesiologist was

1 focused on the patient. He was getting the lines in, he was
2 getting the fluid in, and he was giving these medications,
3 and then retrospectively he went in and put the rough times
4 down. We all agree they don't jive. He didn't say
5 transthoracic echo, pericardiocentesis then started to be
6 performed. You know, it doesn't say anything about when did
7 the initial attempts at pericardiocentesis start. That's not
8 mentioned in this anesthesia note. Just like it's not
9 mentioned in the procedure note. So that time point is not
10 documented in these medical documents with variable clocks
11 going.

12 Q. Aside from the time, which we agree is off, the
13 events is what we're talking about here. And he describes
14 the events just the way Dr. Smith did in his procedure notes,
15 right? These were the same events he's talking about that
16 Dr. Smith was talking about in his procedure note?

17 A. Yeah. I think the question at hand is whether
18 Dr. Smith sat there for ten minutes and didn't try to do a
19 pericardiocentesis waiting until the echo machine showed up.
20 I know your perspective and Dr. Seifert's perspective is that
21 he sat on his hands and waited ten minutes.

22 Certainly, Dr. Smith is very clear and any prudent
23 physician, you would start doing it. Whether he was
24 successful or not, that's another story. But, again, this

1 note doesn't document the time of initial attempts at
2 pericardiocentesis. And the standard of care isn't that you
3 be successful, it's that you try. And that's the time that
4 is not documented in these notes.

5 Q. And neither is it documented that there was a
6 pericardiocentesis initiated at 12:41, isn't that correct?
7 That's not in the records?

8 A. Yes, I agree.

9 MR. KOZAK: No further questions.

10 MR. POLLARA: Just a couple of questions.

11 REDIRECT EXAMINATION

12 BY MS. POLLARA:

13 Q. You would agree, Dr. Calkins, the code note
14 actually says cardiac tamponade at either 12:41 or 12:42,
15 depending on which number you're looking at?

16 A. Yes. It's very clear that it says cardiac
17 tamponade, 12:41. And any electrophysiologist, you know
18 cardiac tamponade, you got to do a pericardiocentesis. It's
19 a largely mechanical problem.

20 Q. All right. And what you're saying is it would be
21 unreasonable to think that Dr. Smith was not being honest
22 when he gave his deposition about the fact that when he made
23 that diagnosis, he immediately initiated that process?

24 A. Correct.

1 Q. One last point -- well, two last points. The
2 anesthesiologist, is he generally documenting as the code is
3 going?

4 A. No. The anesthesiologist, he's a member of the
5 team caring for the patient. So in this case, we knew he put
6 in extra lines, he got three liters of fluid in, gave all
7 these medications, so he's working hard. He's not sitting
8 there writing down the times. He's taking care of the
9 patient trying to save his life.

10 Q. Lastly, with regard to Dr. Morady, you understood
11 that he had one opinion at the time that he authored or
12 signed the declaration, correct?

13 A. Correct.

14 Q. But you later learned, did you not, and you read
15 his deposition, where you testified that he changed that
16 opinion, correct?

17 A. That's correct.

18 Q. And, in fact, when he changed his opinion, he
19 concluded Dr. Smith complied with the standard of care in all
20 respects, just like you did?

21 A. Correct.

22 Q. Seems reasonable to you?

23 A. Yes.

24 MR. POLLARA: Thank you. That's all I have.

1 THE COURT: Mr. Kozak.

2 RECROSS EXAMINATION

3 BY MR. KOZAK:

4 Q. Doctor, Dr. Morady never said why he changed his
5 opinion, did he, in his deposition?

6 A. No, he didn't.

7 Q. Okay. And you testified you haven't talked to Dr.
8 Morady at all, right?

9 A. That's correct.

10 Q. As we sit here today, we don't know why Dr. Morady
11 changed his opinion, do we?

12 A. No. We just know he changed his opinion.

13 MR. KOZAK: Thank you.

14 THE COURT: Thank you, doctor. Just leave that
15 there and watch your step going down. Good time to take a
16 break?

17 MR. POLLARA: It's a wonderful time.

18 THE COURT: We'll take the break here. I'm going
19 to work with the attorneys. During the break, just remember
20 the admonition.

21 (The following proceedings were had outside the
22 presence of the jury.)

23 THE COURT: Ms. Pollara, is that your last
24 witness?

1 MR. POLLARA: It is, your Honor.

2 THE COURT: You want to rest on the record when we
3 come back?

4 MR. POLLARA: I'm happy to do that, or I can do it
5 now. If the Court would like me to do it formally, I'm happy
6 to do that.

7 THE COURT: It's up to you.

8 MR. POLLARA: Your Honor, then the defense rests
9 as to the medical malpractice portion of the case.

10 THE COURT: All right. We need about 30 minutes
11 to program the computer for our jury instructions. Would
12 that give everybody enough time to get ready for closing
13 arguments? Mr. Kozak.

14 MR. KOZAK: I'm wondering if we should start maybe
15 at 1:00 on that.

16 THE COURT: The problem is with the weather, I'm
17 going to send these people home by 5:00. And what I was
18 hoping to do is argue through lunch, buy them lunch and have
19 that waiting, so about 1:00 they can begin their
20 deliberations and we can get some traction under them. Would
21 you like 11:30 or maybe 12:00?

22 MR. KOZAK: That would be all right.

23 THE COURT: Ms. Pollara.

24 MR. POLLARA: How about 11:30, your Honor. I'm

1 concerned about the weather.

2 THE COURT: I'll tell you what I'm going to do,
3 I'm going to make it 11:45, split the difference.

4 MR. KOZAK: Before we close, your Honor, I would
5 like to move Dr. Morady's affidavit into evidence.

6 THE COURT: Okay. Let me hear from Ms. Pollara.

7 MR. POLLARA: Your Honor, it's hearsay. It's not
8 an appropriate document for this portion of the case.

9 THE COURT: And we have a problem with foundation,
10 so the motion is denied. All right. Would you check with
11 the clerk to make sure your exhibits are in?

12 THE CLERK: Your Honor, I met with counsel this
13 morning about that, and they felt that based upon my
14 understanding that everything is in with the addition today
15 of Exhibit 16.

16 THE COURT: Okay. All right. See you at 11:45.

17 (A short break was taken.)

18 (The following proceedings were had in the
19 presence of the jury.)

20 THE COURT: Will counsel stipulate to the presence
21 of the jury?

22 MR. KOZAK: We will.

23 MR. POLLARA: Yes, your Honor.

24 THE COURT: Thank you very much. Ladies and

1 gentlemen, this is the time set for the Court to instruct you
2 on the law that you are to apply to this case. Rather than
3 make nine copies of this packet, we're trying to save our
4 precious resources, what we'll do is we'll send the original
5 package back with you to the jury room, but we'll -- yes, Mr.
6 Kozak.

7 MR. KOZAK: Your Honor, I have a motion to make
8 before you get into the instructions.

9 THE COURT: Okay. Ms. Pollara.

10 MR. POLLARA: Not in front of the jury, your
11 Honor. If he has a motion, we should take it outside the
12 presence of the jury.

13 THE COURT: That's fair enough. Ladies and
14 gentlemen, remember the admonition. The jury may retire.

15 (The following proceedings were had outside the
16 presence of the jury.)

17 THE COURT: Mr. Kozak.

18 MR. KOZAK: Your Honor, for the record, we'd like
19 to make a motion for an opportunity to present rebuttal
20 evidence. As you know, this witness, Dr. Calkins, was
21 brought in after the scheduling order was issued by yourself
22 and, of course, that's been the subject of many arguments and
23 motions. But we would like to have the opportunity to call
24 Dr. Seifert as a rebuttal witness in this case due to the

1 fact that we just didn't have a chance to do the out-of-court
2 discovery on Dr. Calkins.

3 And Dr. Calkins' testimony was so highly
4 improbable. For instance, he testified that the incidence of
5 severe drop in blood pressure is one in a thousand and the
6 medical literature is contrary that. It's like six in a
7 thousand. Just things of that nature that we feel we'd like
8 to be able to present some rebuttal evidence on that, Dr.
9 Calkins' testimony.

10 THE COURT: Let me hear from the defense.

11 MR. POLLARA: Your Honor, I absolutely disagree
12 and I would oppose that motion. It's not proper rebuttal
13 testimony in this case. And under the circumstances, we're
14 here, the parties have rested at this point, we're moments
15 away from instructing this jury. I just think it's improper.
16 It's not proper rebuttal testimony.

17 THE COURT: All right. Mr. Kozak, anything
18 further?

19 MR. KOZAK: Nothing further, your Honor.

20 THE COURT: I'll Dr. Seifert is in Arizona? Is he
21 still here?

22 MR. KOZAK: No. He had to go back, your Honor.
23 He has a very busy schedule. He as a full slate of patients.

24 THE COURT: When we would be able to get him back?

1 MR. KOZAK: If we could, what we'd like to do is
2 have him testify by video. It would be a lot more
3 convenient. He wouldn't have to -- he has to give his
4 employer 30 days notice to -- so but he would be able to do a
5 video testimony.

6 THE COURT: When? Monday? Tuesday?

7 MR. KOZAK: Yeah, he can do it on Monday.

8 MR. POLLARA: Your Honor, I simply object. It's
9 improper rebuttal testimony at this point. We have a very
10 tight schedule that we are keeping in this case. I
11 appreciate counsel's continued comments about Dr. Calkins,
12 but that has been a decision that was made by the Court
13 before. Mr. Kozak had every opportunity to depose Dr.
14 Calkins and chose not to do that.

15 And so now to suggest that he should be able to
16 reopen the door and bring Dr. Seifert back is completely
17 inappropriate and we object to it.

18 THE COURT: All right. Well, Dr. Calkins'
19 appearance here was known to all parties when this Court
20 granted the motion. Actually, it was the subject of a
21 Supreme Court writ. We are at the end of this trial. So I
22 think weighing the prejudice to the parties with the Court's
23 management, with the proffered testimony, just does not seem
24 that Dr. Seifert's testimony would assist the trier of fact.

1 MR. KOZAK: Thank you. Ladies and gentlemen of
2 the jury, we couldn't help but notice the attention you've
3 paid to this case and we appreciate it and so do the
4 Dechambeaus.

5 Well, I want to start by narrowing, if I can, the
6 issues in this case and what's really being argued here by
7 the parties. Now, Dr. Seifert and Dr. Calkins have been the
8 two experts in this case and they've given their opinions.
9 The question is, who has got the better opinion? Who is more
10 credible? What's the evidence that they relied on?

11 Well, Dr. Seifert and Dr. Calkins do agree, and
12 this is important, that if Dr. Smith did not perform the
13 pericardiocentesis before the stat echo got into the catheter
14 lab, he was negligent. That is the time line we need to
15 focus on. Did he do that before that stat echo machine got
16 into the catheter lab? Because if he didn't, that means
17 there was a delay of about 11 minutes, which resulted in
18 cardiac -- excuse me -- anoxia to Mr. Dechambeau.

19 Here's the time line. I think you've all seen it
20 over and over. But what happened here is at 12:39, we had a
21 cardiac arrest. At 11:42, we had CPR and the drugs being
22 administered. At 12:44, we had a stat echo brought into --
23 or ordered. And at 12:49, we had the stat echo arriving.

24 Then at 12:50 to 12:55, we had the effusion

1 observed and we had 300 milliliters of blood extracted and
2 the pulse was restored. And there was no surgeon needed.
3 The bleeding had stopped on its own.

4 We then have the code note, which I've just
5 recited to you, and you've seen it up on the screen many,
6 many times. It says that there was a cardiac tamponade
7 diagnosed and then it says CPR started to be administered.
8 But there's absolutely no record of any pericardiocentesis in
9 that record, and that's critical, because it shows that
10 Dr. Smith did not initiate pericardiocentesis at 12:39.

11 And what information do we have that he did?
12 Well, his argument is, and it's strictly an argument, because
13 there's nothing in the record to support it, that he
14 immediately went into a pericardiocentesis.

15 So if you look at the procedure note that
16 Dr. Smith wrote, and these are his own words after the
17 procedure, the day after the procedure, he says, at the end
18 of the ablation, the patient had evidence of some hemodynamic
19 compromise, which means cardiac arrest. Stat echogram was
20 performed, which showed a fairly large pericardial effusion.
21 CPR was also performed for approximately ten minutes. We
22 removed approximately 300 milliliters of frank blood from the
23 pericardial space after doing a pericardiocentesis. That's
24 his own statement one day after this operation.

1 So you're not required to abandon your common
2 sense. What's the common sense reading of that? That's what
3 happened and that's the order in which it happened. And if
4 that's the way it happened, Dr. Smith was negligent, because
5 he waited that 11 minutes before he did that critical
6 operation.

7 Now, we heard a lot of testimony from Dr. Calkins.
8 He had a lot of opinions about what's the standard of care
9 and so on and so forth. And he's testifying that, well, if
10 you get it done within 28 minutes, that's fine. This is so
11 complicated, we have to allow for -- he went through a long
12 diatribe of how you have to hook up all the apparatus to get
13 the needle in properly and then you have to check it with the
14 echo.

15 Well, that's simply not true, because why? We had
16 Dr. Smith testify there was no problem getting that needle in
17 there, there was no problem starting the pericardiocentesis.
18 Well, if that's the case and he was drawing 20 milliliters of
19 blood out of there every 20 seconds, which is what he
20 testified to, he had 11 minutes of doing that procedure.
21 That means he had the opportunity, I've done the math, but
22 you can, too, he had the opportunity to withdraw
23 600 milliliters of blood in that 11 minutes.

24 Now, at 12:54, he sees 300 more milliliters of

1 blood, according to his own testimony. What they did then
2 was the actual pericardiocentesis and they took out the extra
3 300 milliliters. If you add those three together, there had
4 to be 900 milliliters in that pericardial space. Nobody
5 describes that type of huge effusion. This was a moderate
6 effusion of 300 milliliters, and that is Dr. Smith's own
7 note, 300 milliliters.

8 Also, if you take a look at the anesthesia record
9 and I know you've seen this one over and over, so I won't
10 throw it up in your face again, but what did Dr. Kang say in
11 his anesthesia record? I know the timing is off, but what
12 did he say? He said 12:50, there was a cardiac arrest. He
13 said ACS was initiated, there was a chest compression, plus
14 ETI of five amps of atropine.

15 And then at 13:00, the transthoracic echo was
16 brought in and hooked up and a pericardial effusion was
17 observed and several hundred ccs were aspirated and the peri
18 cardio drain was placed. That confirms exactly what
19 Dr. Smith said, same timing, a little bit off on Dr. Kang is
20 about ten minutes behind, but it's the event that counts.
21 He's describing this event absolutely clearly, just the way
22 Dr. Smith did and the way they described it shows that
23 Dr. Smith was negligent. He didn't get that
24 pericardiocentesis done until 12:54.

1 Now, let's look at what Dr. Smith had to say on
2 the stand. I asked him, but it is absolutely vital, isn't
3 it, to evacuate that blood as soon as possible, because if
4 the heart stays inactive for a period of, in this case
5 15 minutes, you have a very high risk of anoxia, do you not?
6 He said, it's vital that you evacuate the blood. So he knew
7 he had a duty to get that blood out of there absolutely as
8 fast as he could, but he didn't accomplish that.

9 And I asked him, now, in looking at the code note,
10 you do agree this is the blow-by-blow that describes the pace
11 of the operation, correct? He said, I agree. And I asked
12 him then, was there any undue delay in getting that tube
13 installed to do the pericardiocentesis? And here's what he
14 said, I don't recall any undue delay. Are you talking from
15 the deposition? I said, yes. That was closer to the time of
16 the event, but I don't believe there was any undue delay.

17 So all of this talk by Dr. Calkins who expanded on
18 how difficult this operation is, is just that, argument, and
19 argument of counsel is not evidence.

20 And for Pete's sake, we know that this thing was
21 accomplished in 15 minutes. I mean, that's late, but
22 28 minutes? If that was the standard of care, we know that
23 the brain is dead within 12 minutes, 15 minutes is extremely
24 high risk as we've seen in Mr. Dechambeau's case. So what

1 kind of testimony is that from this awesome expert? That he
2 thinks it's okay to go ahead with 28 minutes. That's just
3 sheer death.

4 Who would agree to that operation if they knew if
5 they had an effusion, which happens infrequently, but it does
6 happen, if you knew that there's a possibility or a strong
7 probability you're going to have a little hole in the heart,
8 a cardiac tamponade, and the doctor's standard of care is
9 only to repair that 28 minutes? And all of the steps he went
10 through to get this thing set up and to get it all done,
11 nobody would have that operation. It's not worth it. The
12 risk would be way too high. So it's just basically common
13 sense and you're not required to abandon that, as the judge
14 has instructed you.

15 Now, let's take a look at Dr. Calkins and his
16 testimony. He has wonderful credentials. He went on and on
17 about all of the societies he belongs to and all the
18 conferences he attends to and all of the cases that he
19 handles. But this particular case, this particular case,
20 what is he relying on? He's relying only on Dr. Smith's
21 testimony and he repeated that over and over. There's
22 nothing in the record that supports that Dr. Smith was not
23 negligent, except his own testimony.

24 And is Dr. Smith's testimony unbiased? Is he in

1 here as a neutral witness? No. Dr. Smith has a real ax to
2 grind here. He doesn't want to be admitting that he for some
3 reason, and who knows, people have bad days, Dr. Smith may
4 have had something going on in his life he may have gotten
5 into that room and he had -- he said this is the first time
6 he had ever encountered this kind of procedure that needed to
7 be done. So what why didn't he react? Well, we don't know.
8 We'll probably never know.

9 But the fact is, he didn't. It's like somebody
10 that is driving down the street, they go through an
11 intersection, they don't see the car. Why didn't they see
12 it? We just don't know. But these things happen and they
13 happen every so often. And there's no explanation. He just
14 didn't see it.

15 But in this case, he was not prepared. This is an
16 unusual situation that he needed to be skilled enough to
17 handle. A sudden drop in blood pressure, he knows he's got
18 to get busy and do the pericardiocentesis. Instead, what
19 does he do? He initiates CPR, he initiates the drugs being
20 injected, and then he orders a stat echo, and then he waits
21 for the stat echo to get there so he can look in there and
22 see what's going on. Because apparently he doesn't have his
23 ice catheter. Remember that? He took that out, he said. He
24 took it for some reason, who knows. But when he needed it,

1 it wasn't there.

2 So you have to look, I think, in this case at all
3 of the facts that we do know, what really happened, and what
4 we do know is what's in that record. And that record shows
5 the time line I just described to you. The fact that
6 Dr. Smith's testimony is not evidence in the sense that it's
7 unbiased, it's self-serving.

8 And if you look at all the evidence, particularly
9 with regard to the size of the infusion. Now, Dr. Calkins
10 wanted to make that effusion huge, because it gives Dr. Smith
11 more time. He started at, say, 12:39 or 12:40, 12:41, and if
12 the effusion was so huge, that gives him 11 minutes to be
13 working on the effusion when they observed 300 milliliters at
14 12:54, that means it's reasonable.

15 But what did Dr. Smith say? I asked him, so your
16 testimony is that effusion was so severe that you could not
17 aspirate the blood quickly enough to save Dechambeau's life,
18 is that correct? What was his response, I'm not testifying
19 to that.

20 And I asked him, it is absolutely vital, isn't it,
21 to evacuate the blood? He agreed it was. And then I asked
22 him, question, eventually, there was only 300 ccs of blood
23 removed, isn't that correct? He said, that's an estimate.
24 So he's not disagreeing with me. He's saying that's an

1 estimate and that's his own note.

2 And then I asked him about the syringe and he says
3 it's 20 milliliters that he can get out of there every 20,
4 10 seconds or so. And I asked him, if it was a large
5 pericardial effusion -- excuse me. I said, so, initially was
6 the patient responding as you expected that he would as you
7 were drawing the blood out? His answer was, if it was a
8 large pericardial effusion, it would just take time to get
9 all the blood out. It may take a few minutes to get the 300
10 ccs or 400 ccs of blood that was accumulated within the
11 pericardial space.

12 So he's not saying that he had a 900-milliliter
13 huge effusion. He's saying it was 3 to 400 milliliters. He
14 had plenty of time if he started his pericardial effusion at
15 12:41, as he maintains, by 12:54, that entire effusion would
16 have been dissipated. It would have been gone. But when
17 they looked in the echo, they saw 300 milliliters of blood.
18 That tells you that's when they did the pericardial effusion.

19 If you look at the record, you'll see that the
20 pulse started at 12:54. So between 12:52 and 12:54, they did
21 the effusion, they did the pericardiocentesis, and that's why
22 the pulse returned. Remember, both doctors agreed, you don't
23 have to get all of the blood out of the space in order for
24 the pulse to return, just get some of the blood out and the

1 pulse is going to start and that's exactly what they did.

2 I think if you look at all the evidence and you
3 disregard or give lighter weight to Dr. Smith's testimony in
4 view of the self-serving nature, you're going to come to the
5 conclusion when you look at this cold record, there was
6 negligence on the part of Dr. Smith. He had plenty of time
7 to do this procedure. For whatever reason, he just blanked
8 out. It was new to him. He was hit from the blind side, but
9 that doesn't excuse him.

10 Now, if you do decide in our favor, of course, we
11 are asking for damages, compensation. I think those are
12 pretty straightforward. You've heard Mr. Teichner's
13 testimony that there's probably around \$400,000 in lost
14 income.

15 And then, of course, you have the complete
16 discretion to decide on loss of love and affection and
17 consortium of Jean Paul and Angela.

18 So I'll be back after I hear what the defense has
19 to say. Thank you.

20 THE COURT: Thank you, Mr. Kozak. Ms. Pollara.

21 MR. POLLARA: Thank you, your Honor. All right.
22 Ladies and gentlemen, it's been a short week for attorneys;
23 we usually go Monday through Friday, but it's been a long
24 week for you, because you've been listening very attentively

1 to everything that has been happening and I really
2 appreciate, as does my client, your attention to this.

3 This is my opportunity to talk with you about what
4 you've heard and seen here this week and to talk with you
5 about what I believe the evidence shows in this case. As you
6 know, as judges of the facts in this case, it is your
7 responsibility to deliberate on the facts and make decisions
8 from the evidence that you've heard in this courtroom.

9 You probably remember this slide from my opening.
10 So this is the box of evidence that we're talking about for
11 this particular part of the case. And when we started out,
12 it was empty, and now it's gotten filled up over the last
13 couple of days and now it's as full as it's going to be at
14 this point.

15 And your job is to come together as the judges of
16 the facts in this case and deliberate to determine what the
17 facts are from the evidence that you've received in the case
18 and then apply the law that Judge Flanagan has given you just
19 now to the facts as you find them. And to do that coolly and
20 deliberately without allowing sympathy, passion or prejudice
21 to sway you or affect you as judges in the case.

22 So the question is, how do you go about doing
23 this? You will be given, as the judge has told you, a
24 special verdict form. And it is actually, I have a copy of

1 it here, you'll take it in with you. It's a three-page form
2 and it has a number of questions on it. And the questions
3 are numbered 1, 2, 3, et cetera.

4 And so what I would say to you is that this is the
5 first question that you're going to see. I know it's a
6 little bit small, but I can read it for you. The first
7 question is -- it says, first of all, special verdict form.
8 We the jury in the above-entitled action find the following
9 special verdict on the questions submitted to us. Question
10 number one, was David Smith, MD, negligent in his care and
11 treatment of the decedent Neil Dechambeau?

12 And underneath that, there's another instruction
13 for you. So that's the first question. And then the
14 instruction says, if you answered question number one no, in
15 other words, that he was not negligent, stop here, answer no
16 further questions, and have the foreperson sign and date and
17 return this verdict. If you answered question number one
18 yes, please proceed to question number two. And then there's
19 another question, and then another question after that.

20 And so what I would suggest or what I would
21 proffer to you, ladies and gentlemen, is that really this is
22 the first question that you would look at in this case, which
23 is a question of whether Dr. Smith was negligent. As you
24 know from when we started out with this case in opening

1 statements, and you've heard evidence from a number of
2 witnesses, including Dr. Seifert, including Dr. Calkins here
3 today, there are a number of things that are not in dispute
4 in this case. I'm not going to read back through them.

5 But, really, the plaintiffs, the Dechambeaus have
6 conceded all of the points, that Mr. Dechambeau is an
7 appropriate candidate, et cetera, et cetera. And there's no
8 question that cardiac tamponade is a recognized risk of this
9 procedure and death as a result of it, thankfully, it's rare,
10 but it is a recognized risk.

11 And that is not, when I say that, ladies and
12 gentlemen, it is not at all to minimize what has happened,
13 what this family has gone through, the fact that this has
14 caused a loss to them. I'm not trying to minimize that at
15 all. There is no dispute at all that this is a very, very
16 sad tragedy and there's no dispute that even though the risk
17 of this complication is very low, I think Dr. Calkins said
18 it's less than one percent, that when it happens to you or it
19 happens to a family member, it's 100 percent. We know that.
20 And so it is a tragedy.

21 So let's talk about what is disputed here and what
22 are the issues or perhaps the sole issue that you as the
23 judges of the facts are to decide with regard to this issue
24 of Dr. Smith and whether he was below the standard of care,

1 whether he was negligent, and how do you go about answering
2 that question.

3 Well, the judge has given you a number of
4 instructions. You are going to take these and have them with
5 you. But I want to, first of all, talk with you about them
6 and how I think the law may apply to the facts. Of course,
7 you will make the final determination.

8 But instruction number 19 gives you some
9 instruction on how you go about making this decision about
10 whether Dr. Smith was negligent or not. And the law is that
11 it is the duty of a physician or surgeon who is a board
12 certified specialist to have the knowledge and skill
13 ordinarily possessed and to use the care and skill ordinarily
14 used by reputable specialists practicing in the same field
15 and a failure to perform such duty is negligence. That is
16 instruction number 19.

17 Now, number one, Dr. Smith has the duty to have
18 the knowledge and skill of other ordinary practitioners. And
19 I think there's no dispute in this case that he does.
20 There's been no question about that at all.

21 Number two, he has the duty to use the care and
22 skill ordinarily used by reputable specialists practicing
23 electrophysiology. That's the law. And so, ladies and
24 gentlemen, what I would say to you is that the evidence has

1 shown in this case that Dr. Smith exactly did that. I think
2 that when you look at the evidence, the evidence is
3 overwhelming, and surely by a preponderance of the evidence
4 that he did in fact use the care and skill ordinarily used by
5 reputable electrophysiologists who are practicing, who are
6 confronted with this emergency situation.

7 I would submit to you, ladies and gentlemen, it is
8 a fact that he recognized promptly that there was cardiac
9 tamponade. You can look on the code sheet record. It's
10 Exhibit Number 6. And you've heard testimony about that. It
11 says, time of tamponade. We don't know whether it's 12:41 or
12 12:42, but right in that time frame, there is no one else who
13 is going to make that diagnosis, other than Dr. Smith, who is
14 in the room. So that's number one.

15 Number two, he has testified here under oath that,
16 and he testified in his deposition as well, there's been no
17 impeachment of Dr. Smith that he testified one way in his
18 deposition and he testified a different way here. He's been
19 very consistent in what his position has been under oath when
20 he's testified about this. That he immediately took steps to
21 perform the pericardiocentesis.

22 And I disagree with Mr. Kozak when he says that
23 both Dr. Seifert and Dr. Calkins have testified that the
24 standard of care requires that it be completed. That's not

1 what Dr. Calkins told you this morning. Dr. Calkins told you
2 that the standard of care is to recognize when you have a
3 cardiac tamponade, number one, and number two, that you take
4 steps to relieve it, to get the blood out. He talked to you
5 at length and I'm not going to repeat it, because I'm not
6 going to do it as fast as he did, that in fact, you know, it
7 takes time to do this. And there's no specific standard that
8 says, well, you must do it in two minutes, you must do it in
9 five minutes. You do your best in an emergency situation.
10 That's what he testified to today.

11 Now, ladies and gentlemen, you as the judges of
12 the facts in this case, it is your province, solely your
13 province to decide who is a credible witness and who is not a
14 credible witness. It is not up to me to tell you who is
15 being truthful and who is lying. That is not my role as an
16 officer of the Court, as an attorney in this case. You guys
17 do the heavy lifting on that as the judges of the facts and
18 you have an instruction on that.

19 When you look at the code record, you look at the
20 note from the scribe, you look at that in conjunction with
21 what Dr. Smith testified to, it makes sense. And, ladies and
22 gentlemen, you don't leave your common sense at the door.

23 Let's go back to Dr. Seifert for a moment. He did
24 spend a lot of time talking with you the other day about how

1 easy it is to remove blood from the pericardial space. You
2 heard from Dr. Calkins that that's not the case. There are
3 steps that need to be taken in order for that to be done.

4 When you listen to Dr. Seifert's testimony very
5 carefully, he talked about starting the pericardiocentesis,
6 but when you really listen to him, I do not believe, and you
7 have to go by your own memories and your notes, I don't
8 believe that he testified that there was a specific standard
9 of care as to how long a physician had to complete that
10 procedure.

11 And you'll have to search back in your notes and
12 your memories for that. But if you listen very carefully, he
13 talked about how easy it was, how you just put it in, you
14 take it out. And he talked about, oh, how fast you can do
15 it. But he never testified that the standard of care
16 required that it be done in a certain time frame. And I
17 would suggest to you, ladies and gentlemen, because he knows
18 there is no standard of care on that, and you heard
19 Dr. Calkins talk with you about that today.

20 So you have these two experts who have some
21 conflicting testimony. This is instruction number 22. And
22 I'm not going to read the whole thing, but it basically gives
23 you some guidance as the judges of the facts as to how you
24 weigh the credibility of the expert witnesses. As the judges

1 of the facts, you can take into consideration their demeanor
2 on the stand, how they approach the questions. You can take
3 into account what they reviewed. And I would submit, ladies
4 and gentlemen, you can also take into account what they
5 didn't tell you and what they did tell you when they were
6 testifying.

7 So let's talk about Dr. Seifert, because it's been
8 a couple of days. Well, ladies and gentlemen, as I told you
9 in my opening statement, the only person that came into this
10 courtroom and testified who was actually there was Dr. Smith.
11 Unfortunately, Mr. Kang is not available, because he's
12 deceased. So he could not be here.

13 But what did Dr. Seifert do? He conveniently, I
14 would submit, cherry picked little snippets from the records
15 that supported his theory in this case. And I would suggest
16 through a sleight of hand tried to divert your attention to
17 from information, important information that was in the chart
18 that did not fit in with what he was telling you.

19 So, for example, he spent all of this time talking
20 about this intracardiac echo catheter and how easy,
21 suggesting that all Dr. Smith had to do to diagnose this was
22 to just turn that catheter around a little bit and, oh, he'd
23 have the diagnosis. Right.

24 Well, at the very least, Dr. Seifert knew that was

1 in the atrium. It wasn't in the ventricle. You couldn't
2 diagnose. If you recall what Dr. Calkins said today, you
3 can't diagnose a pericardial effusion or cardiac tamponade
4 with the catheter in the atrium. It has to be threaded into
5 the ventricle to do that and it wasn't there. At the very
6 least, he conveniently left that out.

7 In addition, he looked at the cath log record. He
8 could have seen that the halo was in there. Did he indicate
9 to you, well, maybe it was taken out? He did say, if you'll
10 recall, that sometimes it is taken out, that it can be taken
11 out, because it may not be working or may can be taken out
12 because there's another reason you need the sheathe. But he
13 didn't tell you it was taken out in this case. Maybe he just
14 didn't carefully look at the records. Maybe it wasn't
15 convenient for him. That's up to you to decide.

16 Then what he told you is that, and this is one of
17 the first things he said about the code, maybe you remember
18 this, there were no fluids given during this code. That's
19 what he told you. And then he spent all of this time
20 reviewing the anesthesia records, the second page, and
21 directing your attention to that box where Dr. Kang made had
22 his handwritten notes, when right above that it says,
23 multiple lines started, total IV fluids, 6 to 8 liters.
24 Totally ignored that.

1 And it's because it didn't fit in, ladies and
2 gentlemen, with his theory of the case. He knew it wasn't
3 true that this patient didn't get intravenous fluids. He
4 totally ignored that and tried to divert your attention away
5 from that. So you have the right as the judges of the facts
6 to take that into consideration when you're weighing his
7 opinions.

8 He then told you that Dr. Kang really didn't have
9 anything to do during this code, that he was pushing some
10 drugs, that would just take a few seconds. But he told you
11 when I was asking him questions that he was sitting there
12 very carefully, you know, documenting the blood pressure.
13 Well, ladies and gentlemen, you can see by his own notes that
14 he's starting multiple lines. You heard from Dr. Calkins,
15 you heard from Dr. Smith, people aren't sitting around
16 documenting.

17 The only person who is charged with that
18 responsibility is the scribe, the recorder. And to think
19 that Dr. Kang as a good anesthesiologist would be sitting
20 there making notations when people are trying to save this
21 patient, you can use your common sense and you can decide
22 what you think about that argument.

23 So going back to the instruction on experts and
24 how you evaluate them. That's up to you. And you heard

1 Dr. Calkins this morning. I'm not going to go back through
2 his testimony in any great detail, because I'm sure it is
3 fresh in your mind and I'm sure that you're going to be ready
4 for me to sit down as soon as possible.

5 All right. Dr. Seifert when he was winding up his
6 testimony said, he did all the right things, he just didn't
7 do them fast enough. I thought that was interesting.

8 Mr. Kozak -- and ladies and gentlemen, it's true,
9 what I'm saying to you right now, this is not evidence, and
10 I'm doing my best to convince you, it's my job to try to
11 convince you to support the case and find that Dr. Smith is
12 not negligent. That's my job here today. And I'm going to
13 do my best to do that. Just like Mr. Kozak is going to try
14 to convince you the other way. But while what we say is not
15 evidence, we do have an obligation to be forthright with what
16 we say to you.

17 So when Mr. Kozak gets up and says, Dr. Smith just
18 blanked out, that he didn't know what he was doing, that he
19 wasn't prepared, you know, ladies and gentlemen, I would
20 submit to you, you saw Dr. Smith on the stand, you listened
21 to him talk, it is up to you as the judges of the facts to
22 weigh his credibility.

23 I think the insinuation, the insinuation here is
24 that Dr. Smith is lying, lied in his deposition, lied here in

1 front of you. That's for you to decide. That's for you to
2 decide looking at all of the evidence and making a decision
3 about that.

4 And, really, you as judges of the facts in this
5 case, ask yourself, does it make sense that a board certified
6 cardiologist, a board certified electrophysiologist is just
7 going to stand there for ten minutes and do nothing while his
8 patient is dying on the table? Ask yourself, ladies and
9 gentlemen, if that makes sense to you.

10 And I would say, it is really easy for a hired
11 expert or for a lawyer to sit in their comfortable office
12 after the fact and pick through a record and put together a
13 story. That is easy. It is another thing to be that person
14 that is with the patient in an incredibly rare situation in
15 an emergency trying to save that person's life. That is
16 heavy lifting.

17 And so I could sit here and be dramatic about this
18 and we could wait for ten minutes to go by, I'm not going
19 to do that, because we have limited time here. But ask
20 yourself, think about how long ten minutes is. And do you
21 really think that makes sense from a common sense standpoint?

22 He testified, Dr. Smith did, that he recognized
23 that he thought about it right away and he was doing
24 everything as fast as he could. He was not looking at the

1 clock. He was not stopping to write things down. He was not
2 stopping to write things down to cover himself. And who do
3 you think would have loved to have had someone write down
4 pericardiocentesis at 12:41 or 12:42? We wouldn't be here
5 11 years after the fact that someone had done that.

6 That's not what health care providers do. They
7 take care of the patients. They document later when they
8 have a chance and they do the best they can, but no record is
9 perfect. That's just not the way it is.

10 So instruction number 20, and this is important,
11 ladies and gentlemen, Dr. Seifert, he just didn't do it fast
12 enough. Right. A physician is not necessarily negligent
13 because his efforts prove unsuccessful. He is negligent if
14 his lack of success is due to a failure to perform any of his
15 duties as defined in these instructions.

16 Ultimately, sadly, and you could see how upset
17 he -- how upset Dr. Smith is still about this 11 years later.
18 This is a tragedy, not just for the family, but for him as
19 well.

20 Is he happy about what happened? Absolutely not.
21 Does he wish he was successful? Of course he does. But the
22 fact that he wasn't successful in getting Mr. Dechambeau's
23 heart back fast enough to prevent the injury that occurred,
24 that does not mean that he was negligent in this case, ladies

1 and gentlemen. It does not.

2 And then there's another instruction, which is
3 number 21, which is in your packet. The mere fact that there
4 was an accident or other event and someone was injured is not
5 of itself sufficient to predicate liability. Negligence is
6 never presumed, but must be established by substantial
7 evidence.

8 So there's no dispute here that he wasn't
9 successful. You know, that is a given here. It's very, very
10 sad, but that is not the end of the analysis here. The fact
11 is if you listen to Dr. Calkins and you'll recall the
12 standard is to recognize it and to try to relieve it and
13 that's what Dr. Smith was doing.

14 Just really quickly, you've seen this a little
15 bit. But you can see that the time frame here, and you've
16 heard, and I'm just going to put it up so that -- let me
17 click through this really quickly. We have a couple of times
18 that we know are fairly accurate. And as you heard
19 Dr. Calkins this morning, the times are off. You know, the
20 anesthesia record has a lot of errors in it, as far as, you
21 know, the V tack and the times and so forth.

22 But there are some general perimeters, because we
23 have the code note where we have someone who is writing
24 things down. So we know there's no pulse at 12:39:50. And

1 then we know that earlier on, 12:41, 12:42, the cardiac
2 tamponade is suspected. And then there's a whole series of
3 things that happen at that point. Dr. Smith talked about it.

4 And he said, if you'll recall, that things are
5 happening simultaneously. They're calling the code, asking
6 for CPR, asking for the pericardiocentesis tray, opening it
7 up, ripping the drapes off, prepping the patient, pushing
8 fluids, et cetera, et cetera, and I won't keep on going with
9 that. But all of those things are occurring and then there's
10 a pulse detected at 12:54.

11 What I would suggest to you, ladies and gentlemen,
12 is when you look at that entire sequence of events, that that
13 is reasonable, that is within the standard of care as
14 described for you.

15 Now, I want to go back to one more instruction and
16 this is number 13. And this is the burden of proof
17 instruction. I call it the I don't know instruction. And so
18 let's go back and talk about what this instruction says,
19 because it's important. So I'm going to read it to you in
20 case you can't see it there and you'll have it again.

21 Whenever in these instructions I state that the
22 burden or the burden of proof rests upon a certain party to
23 prove a certain allegation made by him, the meaning of such
24 an instruction is this, that unless the truth of the

1 allegation is proved by a preponderance of the evidence, you
2 shall find the same to be not true.

3 The term preponderance of the evidence means such
4 evidence as when weighed with that opposed to it has more
5 convincing force and from which it appears that the greater
6 probability of truth lies therein.

7 Ladies and gentlemen, the plaintiffs have the
8 burden of proof in this case. As the defendants, we have no
9 burden of proof. We could have not put any witnesses on in
10 this case. The burden of proof is a weighty burden that the
11 plaintiffs have.

12 That is why they must go first in this case, they
13 must make their opening argument first, they must put on
14 their evidence first. In fact, you're going to be happy to
15 hear this, when I sit down, Mr. Kozak can get up and address
16 you again. The plaintiffs get to sit closer to you in the
17 courtroom. All of these things acknowledge the weight of the
18 burden that they have.

19 And so when you look at this issue of whether
20 Dr. Smith was negligent, they have to convince by a
21 preponderance of the evidence that Dr. Smith was negligent.
22 They have to convince you that he did not take steps to
23 initiate that pericardiocentesis after he recognized cardiac
24 tamponade. That's what they have to convince you of, because

1 that's what their claim is in this case. So when you look at
2 all the evidence in that box that you have before you, that
3 is where you would perhaps want to focus.

4 And if you find that they have not convinced you
5 that, you know, it's not up to me to comment on the weight of
6 the evidence, as far as what I believe. It's up to you as
7 the judges of the facts to do that. But let's say that you
8 go, you know, we just don't know. We don't know what's true
9 and what's not true.

10 Ladies and gentlemen, if that is where you come
11 out on this, they have not met their burden of proof, and you
12 are required in that situation to say, was Dr. Smith
13 negligent? Answer no. Because they have not met their
14 burden. If you don't know, you just can't decide, they have
15 not met their burden. And so at that point, you would check
16 the box no and return a verdict for Dr. Smith.

17 I'm going to sit down in a minute. There's other
18 questions on the verdict form. You may or may not get to
19 them. If you do, there are some instructions that may
20 pertain to them on damages and things like that.

21 And there's going to be a second question, did
22 Dr. Smith -- if you say Dr. Smith was negligent, the second
23 question is, was Dr. Smith's negligence a cause of injury to
24 Mr. Dechambeau? And you'll have to deliberate on that if you

1 get that far.

2 So when you go back into your deliberation room,
3 you'll get to pick a foreperson and then you'll start
4 deliberating. And remember what the judge said in his
5 instructions, it does not have to be unanimous. It has to be
6 six out of the eight of you. As long as six of you agree,
7 that's enough.

8 Lastly, as you know, this is kind of a two-part
9 case. If you do conclude that Dr. Smith was negligent, and
10 of course, you have all the time that you need to deliberate
11 on this. I know it's getting later today, but you will have
12 all the time that you need. If you conclude that he was
13 negligent, the case is not over at that point, and we'll come
14 back, I will come back on behalf of my client,
15 Mr. Balkenbush, and his law firm and you'll hear a lot more
16 about what he did and why he did it and you'll hear from
17 experts about that. That's in the second part of the case.

18 And so we may or may not get to that point, and if
19 we don't, I will thank you now for what you have done and the
20 hard work you've done here in this case.

21 Lastly, I would say, ladies and gentlemen, that
22 Dr. Smith is not a party here. It's my client,
23 Mr. Balkenbush, and his firm, but Dr. Smith has lived with
24 this event, not the same as the Dechambeaus, but he has lived

1 with this tragedy personally himself and in a way that's not
2 any less significant. And I would ask you, please, do not
3 compound the tragedy by assigning guilt where it does not
4 belong.

5 So Mr. Kozak gets to get up and talk with you at
6 this point and this is the hardest time for attorneys like
7 me, because I don't get to get up again and talk to you.
8 You're probably happy about that at this point. But I would
9 ask that as he's making his concluding remarks to you, you
10 know I would have something to say. So just kind of keep
11 that in mind and we'll go from there. Thank you, your Honor.
12 Thank you, ladies and gentlemen.

13 THE COURT: Thank you, Ms. Pollara. Mr. Kozak.

14 MR. KOZAK: Well, I just want to correct a few
15 things, obviously, in counsel's remarks. First of all, we're
16 not saying that the records confirm what Dr. Smith says.
17 We're saying quite the opposite.

18 There's nothing in the records to confirm anything
19 Dr. Smith says, except his testimony. That's it. You've got
20 to accept his testimony and weave it around what the actual
21 records say. And I won't go through the time line again,
22 you've seen it for the umpteenth time.

23 There's nothing in the record that says Dr. Smith
24 did a pericardiocentesis up until 12:54. Absolutely nothing.

1 What it shows is that the pulse was restarted between 12:52
2 and 12:54. That's when the pericardiocentesis was done.
3 There's nothing in the record to show that Dr. Smith was busy
4 evacuating blood, and, oh, it just didn't come out fast
5 enough, and by the time it got to 12:54, there were still
6 300 milliliters left in the pericardial space, and,
7 therefore, they took the rest of that blood out. There's
8 nothing to confirm that.

9 The intracardiac echo, all right, there's nothing
10 in the record to show that he withdrew the intracardiac echo
11 catheter. Nothing. That's his testimony. That's what he
12 comes up with to say that he didn't have it in the space that
13 it didn't needed to be in order to observe the effusion.

14 And it's irrelevant anyway, because he said it
15 wasn't in there. But, as a matter of fact, why did he have
16 to order the echo machine? He ordered the echo machine at
17 12:44, it wasn't there until 12:49. That delay is what's
18 critical in this case. That's why he didn't do anything
19 between 12:44 and 12:49. He was waiting for that echo. He
20 needed that echo. He couldn't use the intracardiac echo.
21 That had been removed.

22 We never said that Dr. Kang's notes were
23 contemporaneous. We don't contend that at all. He did have
24 duties to do in that operating room and he was not making

1 those notations contemporaneously, but he did make them.
2 We're talking about what the event was, and he confirms what
3 Dr. Smith says, that the pericardiocentesis was actually done
4 at 13:00, according to him. According to Dr. Smith, it was
5 started at 12:49. They both agree when it was done. I'm
6 sorry -- 12:59 -- 12:55. They both agree that the event
7 occurred and it was the last in the procedures.

8 Now, Dr. Smith also said on the stand, if you
9 remember, that he wasn't clear on exactly the sequence of
10 events, because this happened 11 years ago. So he wasn't
11 talking with a great deal of clarity about the sequence of
12 these events.

13 Now, I want to make it very clear about
14 preponderance of the evidence. This is 50, 49, 51, that's
15 our burden, just a little bit more than 50 percent. You
16 know, two football teams can battle on the field for
17 60 minutes, and one has a score of seven and the other has a
18 score of six, just that edge, that's all it takes for us to
19 prevail on a preponderance of the evidence. That's our
20 burden.

21 We complain, we say that the 50 percent was more
22 than met by us, because only Dr. Smith's testimony gets him
23 off the hook. The records don't substantiate anything he
24 says, except that he did do a pericardiocentesis. The

1 problem is he didn't do it until 12:54 and that was too late.

2 And the evidence for that is the damages that
3 occurred to Neil Dechambeau. If he had been working earlier,
4 working like he said he was, as we pointed out in our opening
5 argument, he would have alleviated that pericardiac effusion
6 by pericardiocentesis and Neil Dechambeau would have been up
7 and walking around in a matter of 4 or 5 minutes.

8 So we look forward to your verdict. Thank you for
9 your attention.

10 THE COURT: Thank you, Mr. Kozak. Ms. Clerk,
11 please swear in the bailiffs to take charge of this jury.

12 (Bailiffs sworn at this time.)

13 THE COURT: Thank you, ladies and gentlemen. The
14 admonition the Court has given you throughout the trial is
15 lifted. You may talk about the case amongst yourselves with
16 a view of trying to reach a verdict if you can do so without
17 violence to your individual judgment.

18 Just a couple of housekeeping matters. You'll be
19 provided all the exhibits that have been admitted. We do not
20 have a transcript of any of the testimony of the witnesses.
21 It's been a fairly short trial. I concur with both counsel,
22 you've paid close attention. Rely upon your notes, rely upon
23 your collective memory as to what the witnesses testified to.
24 We just don't have the ability to have any kind of read back.

1 As far as time is concerned, I'll let you go as
2 far as you feel is productive. I am keeping an eye on the
3 weather. I know you don't have a window in there, but we are
4 monitoring that closely, not just because of you, we have
5 other juries going in the Courthouse, too. So we're most
6 concerned about everybody's safety, including that of the
7 public and our staff.

8 So it's likely that if you're not able to reach a
9 verdict by 5:00, I'm going to send you home, maybe a little
10 bit earlier, if the weather turns, because I don't want
11 people driving at night in adverse conditions. Go as long as
12 you feel is necessary. We ordered lunch for you in there.

13 If you need any questions answered, have your
14 foreperson write that question out, put the date, put the
15 time, and give it to Deputy Bird. He'll give it to me. I'll
16 share it with counsel. We'll do our best to turn around and
17 get an answer to you just as soon as we can.

18 With that, the jury may retire. The jury may
19 retire. Mr. Brooks, if you could just remain behind just a
20 minute or so. But the jury may retire to commence its
21 deliberations.

22 (The following proceedings were had outside the
23 presence of the jury.)

24 THE COURT: Mr. Brooks, unfortunately, the

1 admonition still does apply to you. God willing, we won't
2 have anybody get sick or get into trouble coming in and out
3 of the court. But these things happen from time to time.
4 That's why the alternate is so important to this entire
5 process. You can tell the amount of work the parties have
6 put in on this case, and if for whatever reason, we have to
7 replace a juror, we'll call you in, I will instruct the jury
8 to commence deliberations right from the beginning so that
9 you'll be part of it.

10 But until we either get a verdict or we call you
11 and we tell you we need you, just remember the admonition.
12 You can back in there and pick up your personal effects. I
13 want to take the time on behalf of everybody here to thank
14 you for your service. I promised it was an interesting case
15 and you've been a great juror.

16 If we get a verdict, my clerk will call you and
17 we'll let you know what it was and if we need you likewise.
18 So, please, come up and give Ms. Oates your cell phone number
19 or whatever your contact number is and head on into the jury
20 room. Thank you very much, Mr. Brooks.

21 A JUROR: Appreciate it.

22 THE COURT: Counsel, same thing, please provide
23 Ms. Oates with your contact informations. Don't sit on your
24 cell phones. We had a lawyer go home and he sat on his cell

1 phone and turned it off. I had to send the police department
2 out to do a welfare check and he had fallen asleep in the
3 Barka lounge in his living room.

4 So, please, if I get a question, we'll contact you
5 by telephone first. I'll read the question. It will be a
6 conference call. I'll read the question to everybody, see if
7 we can't deal with it right then and there. Any
8 communications to or from the jury will be in writing and
9 you'll be provided copies of both the note and the Court's
10 response. So Ms. Pollara.

11 MR. POLLARA: Thank you, your Honor, and I'm just
12 thinking I know that obviously this is just phase one, so I'm
13 just thinking ahead. If the jury comes back -- well, let's
14 hypothetically say that the jury does not arrive at a verdict
15 today, because it's later in the afternoon, and so they come
16 back to deliberate on Monday. I'm presuming that we are
17 going to be ready if they come back with a verdict finding
18 Dr. Smith was negligent, that we are then going to
19 immediately go into the second phase of this trial on Monday
20 or whenever they come back with their verdict. Is that what
21 you anticipate?

22 THE COURT: That's correct. Now, if they come
23 back before 5:00, I'll release them, obviously, for the
24 weekend. But it's my understanding, according to the Court

1 staff and the security that's been monitoring the weather,
2 this storm that's going to hit Sunday night is something that
3 they haven't seen in a long time.

4 So I've spoken to the jury commissioner. We've
5 got a few other juries starting. They're going to start in
6 the afternoon at 1:00 and I am going to do the same.

7 MR. POLLARA: All right.

8 THE COURT: And I'll instruct the jury to monitor
9 our court's website on the Internet for further updates.
10 That's my plan is if they come back finding Dr. Smith
11 negligent, then we'll start at 1:00 on Monday.

12 MR. POLLARA: All right. And then, just so that
13 the Court knows, I mean, because I am from Sacramento, I'm
14 not going anywhere. I'm here. So we won't have the problem
15 that we had a couple of weeks ago.

16 THE COURT: That's quite all right. These things
17 happen, act of God, it occurs. All right. Mr. Kozak,
18 anything further before we adjourn?

19 MR. KOZAK: No, your Honor.

20 THE COURT: Ms. Pollara.

21 MR. POLLARA: No, your Honor. Thank you.

22 THE COURT: We are in recess until call of the
23 jury.

24 (Jury deliberating.)

1 (The following proceedings were had in the
2 presence of the jury.)

3 THE COURT: Ms. Clerk, please call roll of the
4 jury.

5 (Jury roll called at this time.)

6 THE CLERK: All are present, your Honor.

7 THE COURT: Mr. Gomez, by the folder, I assume
8 you've been selected as foreperson of the jury?

9 A JUROR: I have.

10 THE COURT: Has the jury reached a verdict?

11 A JUROR: We have.

12 THE COURT: Would you please provide the folder to
13 the bailiff.

14 All right. The clerk will read the verdict of the
15 jury. Ms. Clerk.

16 THE CLERK: Yes, your Honor.

17 (Verdict of the jury read at this time.)

18 THE COURT: Ladies and gentlemen of the jury, is
19 your verdict, so say you one, so say you all?

20 A JUROR: Yes.

21 THE COURT: Do either party wish the jury to be
22 polled?

23 MR. KOZAK: No, your Honor.

24 MR. POLLARA: No, your Honor.

1 THE COURT: Ladies and gentlemen, on behalf of
2 everybody here in the Courthouse, as well as the parties, I
3 want to thank you for your service. I said in the beginning
4 that our country is great because of the willingness of its
5 citizens to pick up the mantle of public service and to serve
6 as judges or in public office or even in the military. It's
7 what's make America great.

8 In the year 583, the Roman General Cinnacinatus was
9 farming outside of Rome when he was notified about the Roman
10 Army had been trapped in the Albin hills about 20 miles
11 southwest of Rome. A rider was able get out and rode to Rome
12 to try to raise reinforcements. He realized if he laid down
13 his plow, the farm wouldn't be seeded and most likely his
14 family would starve.

15 Nevertheless, he did just that, laid down the
16 plow, picked up the mantle of dictator, raised an army in six
17 weeks, took the army out, rescued the Roman Army, and made
18 allies of the two tribes, the Aequi and the Sabines, that had
19 trapped the Army. He then went back to Rome, took off his
20 mantle of public service, and picked up his plow.

21 Ladies and gentlemen, you have done the very same
22 thing. We have pulled you from your private life, we have
23 asked you to perform public service. You have laid down your
24 plow and you have agreed to serve. Now, you're going to go

1 back out in the community and I thank you for your service.

2 Now, throughout the proceedings, I've asked that
3 you not talk about this case amongst yourselves or with
4 anybody else. You can do that now. But if I can make a
5 personal request of each of you, up until a couple of days
6 ago, each of you were strangers to each other. Over the last
7 couple of days in the sanctuary of the jury room, you've
8 shared things amongst yourselves that you never would have
9 shared but for your service as jurors here.

10 If someone comes up to you and says, well, what
11 did you think about this case or what did you think about
12 this witness or what did you think about me, I encourage you
13 to engage in that discussion with that individual. However,
14 if they ask you, what did the other jurors think, or what did
15 the other jurors feel, what did the other jurors say, I would
16 hope that you would keep those comments as confidential as
17 the manner in which they were shared with you.

18 We will notify the jury commissioner of your
19 service here. Your names will be removed from the jury pool
20 for the next two years. And we'll put that big fat check in
21 the mail for you as well shortly. Ladies and gentlemen, the
22 jury is discharged with our thanks.

23 (The following proceedings were had outside the
24 presence of the jury.)

1 THE COURT: Counsel, do we need to pick up
2 anything before we recess? Ms. Pollara.

3 MS. POLLARA: Your Honor, I believe it would be
4 appropriate for me at this time to ask that the legal
5 malpractice case against my clients, the defendants in this
6 case, be dismissed and prepare a judgment of dismissal in
7 that regard in that the medical malpractice case, we have the
8 verdict on that, and so I believe it would be appropriate.
9 So at this point, I would move that the legal malpractice
10 case be dismissed with prejudice as to my clients.

11 THE COURT: Put it in writing, run it by Mr.
12 Kozak.

13 MR. POLLARA: Thank you. I will do that.

14 THE COURT: Mr. Kozak, anything further?

15 MR. KOZAK: No, your Honor.

16 THE COURT: Thank you very much, counsel. Court's
17 in recess.

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1 STATE OF NEVADA)
2 County of Washoe) ss.
3)

4 I, STEPHANIE KOETTING, a Certified Court Reporter of the
5 Second Judicial District Court of the State of Nevada, in and
6 for the County of Washoe, do hereby certify;

7 That I was present in Department No. 7 of the
8 above-entitled Court on January 20, 2017, at the hour of 9:00
9 a.m., and took verbatim stenotype notes of the proceedings
10 had upon the trial in the matter of ANGELA DECHAMBEAU, et
11 al., Plaintiff, vs. STEPHEN C. BALKENBUSH, et al., Defendant,
12 Case No. CV12-00571, and thereafter, by means of
13 computer-aided transcription, transcribed them into
14 typewriting as herein appears;

15 That the foregoing transcript, consisting of pages 1
16 through 402, both inclusive, contains a full, true and
17 complete transcript of my said stenotype notes, and is a
18 full, true and correct record of the proceedings had at said
19 time and place.

20 DATED: At Reno, Nevada, this 2nd day of June 2017.

21

22 S/s Stephanie Koetting
23 STEPHANIE KOETTING, CCR #207

24