IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	CRIMINAL ACTION FILE
v.	)	NO. [redacted]
	)	
[redacted]	)	
	)	BENCH TRIAL
Defendant.	)	
	)	VOLUME I OF II

BEFORE THE HONORABLE
MAGISTRATE JUDGE JUSTIN S. ANAND
TRANSCRIPT OF PROCEEDINGS
DECEMBER 4, 2017

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Monday Morning Session

December 4, 2017

9:35 a.m.

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P R O C E E D I N G S

COURTROOM DEPUTY: All rise. This United States District Court for the Northern District of Georgia is now in session, the Honorable Justin S. Anand presiding.

THE COURT: Thanks very much. You may be seated. Good morning. All right. We're here in the case of United States of America v. [redacted]. Here for the United States is Assistant U.S. Attorney Alison Prout, and here for the defendant is Molly Parmer. So we're scheduled for a trial for today. Are y'all ready to proceed?

MS. PROUT: Yes, your Honor.

MS. PARMER: We are.

THE COURT: Anything we need to take up before we get underway?

MS. PARMER: I don't think there is anything we need to take up.

MS. PROUT: No, not for the government.

THE COURT: All right. Well, since the last we met as a group, the government has dismissed the Class A misdemeanor charge, and so that's the reason why we're going to proceed on a nonjury trial, because the remaining charge as

a Class B misdemeanor does not give right to a jury trial. So it would be before myself as both the finder of fact as well as law. Given that, I'll leave it to you all.

We didn't discuss -- it occurred to me we should have discussed what y'all want to do about opening statements, and I'm happy to receive them or not. I've been on both ways in bench trials, but I'll leave that to you all what your preferences are.

MS. PARMER: I would prefer to do an opening.

MS. PROUT: I as well, your Honor.

THE COURT: Okay. All right. Very good. Would 15 minutes be sufficient a side or do you have more --

MS. PROUT: More than sufficient for the government.

MS. PARMER: I think that's about right. And the only other thing that comes to mind is that -- and I think this has already been decided. But I had filed a motion to suppress statements that were taken when the client was on a morphine drip, and I think the government has agreed just not to use it in their case. And so that's --

THE COURT: Right. I had, I think, overlooked that when I had set it down for a Daubert hearing and a Jackson-Denno hearing. I had overlooked that it had been withdrawn. So, in any event, given the posture and it's a bench trial, any issues of admissibility can be assessed as we go or wrapped up in the final decision but I did I think -- I

did overlook that that was no longer an issue. Am I right that you're not seeking to use those --

MS. PROUT: That's correct. We've withdrawn our intention to use --

THE COURT: Okay. All right. Thank you. So I take it y'all want to invoke the rule?

MS. PARMER: I do, yes, your Honor.

THE COURT: So do we have any witnesses from either side that are anticipated fact witnesses -- the rule to extend to fact witnesses and also to experts?

MS. PARMER: I would like to request to extend the rule to all witnesses in the case.

THE COURT: Okay.

MS. PROUT: We have no objection to that, your Honor.

THE COURT: All right. So I -- well, except for the case agent and any investigator -- the defendant himself and any investigator, if you have any that you have.

MS. PARMER: (Nods head.)

THE COURT: So, otherwise, I take it y'all don't have any witnesses here in the room?

MS. PROUT: No, your Honor.

THE COURT: All right. So I will rely on you all to, if you hear the door opening, just to make sure that whoever is coming in is not a potential witness. If someone testifies and then you're confident that they're done and they're not

called by -- they're not on the witness list of the other side and you don't think you'll need them, for example, in rebuttal, they'd be free to stay. But obviously you've got to be confident in that regard that they won't be needed again.

All right. That's all I had. So unless there's anything else, I'll turn it to the government for their opening statement.

MS. PROUT: Thank you, your Honor. This case is about a nurse named Etta Marie who went to work at the VA Hospital like she always did, and while trying to do her job and care for patients, she was inappropriately grabbed in the buttocks by the defendant, [redacted]

This took place on October 23rd, 2015. On that day the defendant admitted himself to the hospital for a planned surgery for a collapsed lung. He had been to the hospital before that day to review the plan and to provide his informed consent for the procedure, and so when he got there on October 23rd, he was taken to the pre-op area or the pre-operative area of the hospital where patients are prepared for surgery.

While he was there care providers discussed with him again the plan for the surgery and confirmed his informed consent for the anesthesia and for the procedure. And you will hear that in the pre-op area the defendant was acting and talking in a way that made at least some of the providers

uncomfortable.

Before he was taken to surgery he received an IV with a saline drip. And after that, he was taken to what's called the OR or the operating room. According to his medical record, he arrived at the operating room at 11:27 a.m. There is a note in the medical record that we intend to admit that says specifically patient arrives in operating room at 11:27, and according to his medical record, he received a dose of 2 milligrams of Midazolam at 11:29 a.m., in other words, after he arrived in the operating room.

Now, this case is about what happened just before he arrived in the operating room. The pre-op area is on the same floor as the operating room but several hallways away, and so as is typical, a nurse and an anesthesia resident went to pre-op to wheel the defendant in his stretcher from that area to the operating room. The nurse's name is Etta Marie. She is the victim here. And the doctor's name is Dr. Kinnari Patel. Dr. Patel was at the head of the stretcher near the defendant's head, and Ms. Marie was toward the foot of the stretcher. She was essentially going forward and steering the stretcher, and Dr. Patel was at the rear.

The defendant continued in his talkative and alert demeanor during this time, and as soon as they took the stretcher from the pre-op area into the hallway, the defendant sat up in the stretcher, reached forward, reached around the

railing of the stretcher, and grabbed the buttocks of Ms. Marie and squeezed. That, your Honor, is an assault. And Dr. Patel saw it, and that's why we're here.

This is critical. Immediately after the assault, the defendant uttered words to the effect of I waited to get the medication so I could get away with it. Ms. Marie cried out in shock partly to draw attention to them so that the defendant would hopefully not do anything further. But both she and Dr. Patel continued to take the stretcher on to the operating room, and along the way the defendant actually bragged about what he had done to an employee in the hallway named Harvey Clark. He is here today. The defendant continued to make similar remarks all the way into the operating room.

The defendant, as you know, is charged with simple battery under 18 U.S.C. 113(a)(5), and so it is the government's burden to prove beyond a reasonable doubt that the defendant was in the special maritime and territorial jurisdiction of the United States and that while there he assaulted another. The evidence will show that that is precisely what happened in this case, and that is the verdict that we will ask your Honor to find at the end of the trial. Thank you.

THE COURT: Ms. Parmer.

MS. PARMER: So over two years ago, around the fall

of 2015, [redacted] experiences a spontaneous pneumothorax, and what that is in nonmedical terminology is a spontaneous collapsing of the lung. Essentially air leaks out from the lung in between the wall of the chest cavity, and that puts pressure on the lung and causes it to deinflate and collapse. And what typically has to happen as a result of a spontaneous pneumothorax, is that you have to have a surgery wherein a tube is inserted between your rib and extracts that air and allows the lung to reinflate. It's a complex surgical procedure that requires anesthesia and typically a stay in the SICU, the serious -- the Surgical Intensive Care Unit.

The pain from a pneumothorax is excruciating. Most people describe it as a stabbing in the heart. For [redacted] it felt like liquid was moving through his chest cavity, but it was more like viscous pain rather than just fluid. And so he, as anybody would in that situation, sought medical care.

As a 40 percent disabled veteran, he gets his medical care from the VA, the Veterans Administration Hospital. So he goes to the VA on October 19th, 2015, and he is scheduled for surgery on October 23rd, 2015. He's discharged, and he's given a variety of medication, including some pain medication to assist with the extreme discomfort that he is in at that time.

Like most people he's told to come to the hospital

hours before his scheduled surgical procedure on October 23rd. Like most people when he arrives, he's taken by somebody else. He's told not to drive himself. Like most people he's going -- he goes through an intake procedure, fills out a number of forms, has some conversations, and then like most people he's moved to a pre-operative holding area.

The pre-operative holding area has a number of different beds divided by curtains and a number of different practitioners circulating. It basically is designed to provide an environment that hopefully makes a calming informative experience for the patient to help transition them into surgery. And so what typically happens in the pre-operative holding area is you change into your gown, and your information, your identifying information and your medical history, is reviewed and they start your IV.

The evidence is going to show in this case that in the preoperative holding area [redacted] was seen by no less than five or six different practitioners. And what happened in that area is partially and incompletely documented on a two-page pre-op verification form. On its face you'll see that this form has missing information and inconsistencies.

What [redacted] remembers from October 23rd, 2015, is arriving, going through intake, being taken to the pre-op holding area, having an injection, and he has no memory

after that. And the evidence in this case will show that as is typical in this type of surgical -- when it comes to this type of surgical procedure, that [redacted] received a dose of Midazolam in the pre-op holding area.

So what is Midazolam? Midazolam is a fast acting benzodiazepine hypnotic sedative. It's a central nervous system CNS depressant. So that means it's designed to affect the CNS. Well, what's the CNS? That's the brain and the spinal cord. It's the complex nerve tissues that control the activities of the body. CNS depressants are drugs that affect our neurotransmitters, the brain chemicals that facilitate communication between brain cells. And CNS depressants in particular affect the neurotransmitter gamma-Aminobutyric acid, GABA, G-A-B-A. And GABA affects the brain by decreasing brain activity. So Midazolam affects the brain. It affects your brain cells, and it intoxicates you.

Now, separate but concurrent with that it also has the effect of erasing your memory and decreasing your anxiety, and it decreases your anxiety so that you can handle a serious surgical procedure. And that's one of the reasons, your Honor will hear, it is typical to administer some Midazolam in the pre-op holding area, because the very act of being transported on a gurney down a hallway into a bright cold OR, operating room, is very anxiety inducing and stressful for a patient who knows they're undergoing a serious surgical procedure. So

often they will give it in the pre-op holding room so you have no memory and no experience of that transport. Midazolam is fast acting. Its effects are almost immediate.

I anticipate the evidence in this case will show that there are some things doctors would never do when you have a patient who has been administered Midazolam. You would never get informed consent from a patient on Midazolam. You would never allow the patient to move about freely. They must be on a gurney once they have Midazolam. You would never allow a patient to drive or operate heavy machinery on Midazolam. Patients are advised not to enter into any significant decision making up to 24 hours after having Midazolam. You would never advise a patient to drive themselves home or travel independently on Midazolam. Your brain is not normal. It's about the brain.

But what's interesting is that at the same time the drug has this effect, a patient can physically move and speak on Midazolam. So it's not like alcohol where you have these other telltale signs that someone is intoxicated, you have bloodshot eyes, slurred speech, you have an odor of alcohol. Midazolam has no sensory clues. However, like alcohol it intoxicates you, and oftentimes doctors will say this is like a very stiff drink. But you don't have any other signs that you are intoxicated to that effect.

So when it comes to October 23rd, 2015,

[redacted] remembers coming in. He remembers an injection in the pre-op room, and he remembers nothing else. So what happened then? How do we get to this point where somebody is charged with this crime? This case comes down to gaps in the medical record essentially charting deficiencies here in the VA and a sloppy, incomplete rush to judgment investigation on behalf of the VA police.

So according to the circulating nurse at Emory, at 11:20, around 11:20, as she's wheeling the gurney to the OR, [redacted] makes contact with her behind. And she says at that point, in her own words, I can't believe you grabbed my ass. And then he turns to, I believe, an employee that's maybe in the janitorial services and says, I got one up on you, guy. So conduct that seems and phrases that sound as though somebody is intoxicated.

Etta Marie, as I understand it from the discovery in the investigation, goes and tells another employee, Sheila Lee, what happened. Now, Sheila Lee, as I understand it, is not involved in any of the care or any of the drug administration or anything involving the surgery that day, and she is the one who I believe called the police. The police arrive.

So first we have Terrence Bishop. He's the responding officer. He takes three statements, and he makes an investigative report. He talks to Etta Marie, Kinnari

Patel, who is a resident anesthesiologist, and Harvey Clark, the gentleman who's in the hallway who hears this I've got one up on you, guy, statement. And the evidence is going to show that Terrence Bishop did not do a thorough investigation.

First of all, Etta Marie says, well, the patient said, I waited until I got the medication to do this. But if you look at Terrence Bishop's report, as he memorializes it in his investigative report, he writes, she said that [redacted] said I waited a long time to do this. So he conveniently leaves out this reference to medication. When he takes statements from Kinnari Patel, the resident anesthesiologist, and the nurse, Ms. Marie, he doesn't ask any questions about, well, what medication could he conceivably have been on since he's referencing medication? No questions in those regards.

He basically just takes their statements about what happened, doesn't do anything further, and he writes his report. And despite the fact this is the first -- the closest time to the incident, the first responding officer, and despite the fact that he knows somebody is going to the OR, is having a surgical procedure, and references being on medication, he does not in any way further investigate that claim whatsoever. He refers the case to Jay Dalton, a detective. That's it.

Jay Dalton comes to the hospital four days later, and

the sloppy instigative work continues. He speaks to Dr. Fisher, who's a chief anesthesiologist, and Nurse Dorsette, who is a nurse anesthetic -- anesthesia (sic). And neither of these people, you'll see in the medical records when they're introduced, were involved in [redacted] surgical procedure at all. But what these two individuals do is go ahead and print out the copies of the intra-op summary -- and I'll get to that in a second -- and the pre-op, two-page pre-op verification worksheet.

They hand over this protected --

MS. PROUT: I'm sorry. Excuse me. I'm just going to object because the government's investigation here is not relevant to any of the questions at issue, and it's not clear to me that any of this is actually even going to be coming into evidence at trial. So I'm raising an objection.

MS. PARMER: It's entirely relevant to our theory.

THE COURT: Well, I'll overrule the objection, and we'll hash out relevance as it comes. I'll overrule the objection.

MS. PARMER: So these two individuals hand over [redacted] private protected medical documents, having no personal knowledge of what actually happened that day. And Detective Dalton just writes, all caps, he was not under the influence; these two people told me it. Detective Dalton doesn't understand what he's been handed. These records are

incomplete. The evidence will show that these records, in fact, cannot indicate what possibly was given to [redacted] in the pre-op holding area. But that's it. That's what Detective Dalton does, and that's the conclusion of his investigation.

The evidence in this case is going to show that despite those minimal records, those incomplete, inconsistent records, despite the rush to judgment, sloppy investigation, that [redacted] was, in fact, as would be typical, uncontroversial in standard, given Midazolam in the pre-op area, and therefore he was involuntarily intoxicated. If he's involuntarily intoxicated, he's not guilty. This is core to our legal system, and it's terrifying to think that you could be liable for conduct when you are intoxicated, have no memory of the conduct at the time, are operating under a diminished capacity, your brain is not functioning as it normally is functioning, and here you are criminally liable with no recollection of any of this at all. You just came in to have surgery.

But it's particularly terrifying for [redacted] who for the past two and a half years of his life has lived with this accusation, this accusing from the government that he has committed an offense when, in fact, there's no crime here at all.

Finding [redacted] not guilty is not a green

light for people to act in violation of the law. It's not a green light for people to make contact of a sexual nature with somebody without their consent. It is simply following the law. And the law, when applied to the facts and the evidence in this case, is going to yield the only just verdict, which is one of not guilty because if you are involuntarily intoxicated, there is no crime, and he is not guilty.

THE COURT: All right. Why don't you call your first witness.

MS. PROUT: The government calls Etta Marie.

COURTROOM DEPUTY: Please stand and raise your right hand.

ETTA MARIE,

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

COURTROOM DEPUTY: Thank you. Could you please state and spell your name for the record.

THE WITNESS: My name is Etta Marie, E-t-t-a M-a-r-i-e.

COURTROOM DEPUTY: Thank you.

DIRECT EXAMINATION

BY MS. PROUT:

Q Good morning, Ms. Marie.

A Good morning.

Q Where do you currently work?

A I currently work at DeKalb Medical.
Q What is your position there?
A I am an RN.
Q What is an RN?
A A registered nurse.
Q How long have you been a registered nurse?
A I've been a registered nurse since 2009.
Q And did you previously work at the Atlanta VA Medical Center at 1670 Clairmont Road in Decatur?
A Yes, I did.
Q What are the approximate dates that you worked there?
A I worked there from -- I believe it was around June or July of 2015. I know I started in 2015, and I left in 2017.
Q And did you leave the VA voluntarily or involuntarily?
A No. I resigned.
Q While at the VA what was your position?
A I was an OR registered nurse.
Q And what were your duties as far as interacting with patients as an OR registered nurse?
A I would go to pre-op and take patients into the OR, prepare them for surgery, and I was more or less the eyes and ears of the patient in the operating room because they were asleep, make sure everything ran smooth and accordingly. And then from that point, once the procedure was over I would take them to the PACU and then transfer care to the PACU nurse.

Q And what is the PACU?
A That is the recovery area from surgery.
Q Do you recall providing care for a patient named [redacted]
[redacted]
A Yes, I do.
Q Do you see him here today?
A Yes, I do.
Q Can you identify where he's sitting and what he's wearing?
A He is sitting between the two ladies over there on that table. He's in the middle and I believe in a grayish colored suit.

MS. PROUT: May the record reflect the defendant has identified the defendant -- sorry. The witness has identified the defendant.

Approximately what month and year did you provide care for him?

THE WITNESS: It was sometime in October of 2015. I was relatively new at the VA.

BY MS. PROUT:
Q Why was [redacted] admitted to the hospital that day?
A He had come in for a thoracic surgery procedure.
Q Was the procedure an emergency procedure or a scheduled procedure?
A I believe it was a scheduled procedure. We don't typically do emergencies that way. A lot of times emergencies

are -- would be something that would happen more swiftly. So I know that it was definitely a scheduled procedure. We would have -- the whole mood of the OR would have been more of a rapid thing.

Q Okay. And you said -- were you working in thoracic surgery that day?

A Yes. That day I was working thoracic surgery. I was with the lead thoracic surgery nurse.

Q Okay. Did you typically work in thoracic surgery or not?

A Around that time I was orienting. I eventually moved into the lead RN, registered nurse, position for orthopedics, but we also had to learn all the areas because of being on call. You never know what procedure, what you would get if you were on call. So, yes, I was there to learn that.

Q At what point in the surgical process did you first see [redacted]

A I first encountered [redacted] in the preoperative area, holding area.

Q And can you describe generally what takes place in the pre-operative holding area.

A The pre-operative area, the patient is brought in and receives an assessment by a registered nurse, at times will also receive an assessment by a certified nurse, nurse anesthetist, and then right before, as long as they have made all their checks and balances, I will come in, assess the

patient. The anesthetist or resident or whomever is doing the anesthesia portion with me would assess the patient and as well as a supervising anesthesiologist. So we did all those things to make sure that all the checks and balances was met, and then we would take the patient to the operating room.

Q And so what was your first interaction with [redacted]

A My first interaction with [redacted] was he was in -- lying on a stretcher in the pre-op area, and I walked over to him and introduced myself to him. And I would immediately identify him, you know, asking him his name and everything per protocol.

Q Okay. And was there anything else that you did as far as interaction with [redacted]

A Well, basically I just -- I would talk to him, make sure that he was comfortable, he was in an upbeat mood. So I made sure he was comfortable as far as that goes because, you know, sometimes people are nervous or scared. And then I proceed with my assessment of asking him about allergies and different things to make sure that we were ready to take care of him.

Q Okay. What was his demeanor like at that time?

A He was very cheerful. He was upbeat. He was energetic. He wanted -- he made a point of letting me know that he was a previous VA employee, and he brought up the computer system. He said something about CPRS, which is a computer system in

the VA. And, you know, I was like okay.
Q Would you describe him as being talkative or quiet?
A Oh, very talkative. He was very talkative.
Q I'm going to show you an exhibit. This is Government's Exhibit 1. Would you like a copy for the Court? I don't know if you have a copy.
Ms. Marie, what is Government's Exhibit 1?
A This is more or less our checks and balances where different personnel would do assessment of [redacted] The first, the top area, is pre-operative, the day before surgery. It doesn't necessarily have to be the day, but it would be before surgery. And then from the lower portion on would be the day of surgery.
Q And on the second page of this form do you recognize your handwriting anywhere?
A Yes. It is the last portion of the paper.
MS. PROUT: Your Honor, I'd move to admit Government's Exhibit 1.
THE COURT: Any objection?
MS. PARMER: No objection so long as it's used solely for purposes of this litigation and destroyed and/or returned to us at the end.
THE COURT: All right. Well, the protective order is a different issue. I'll admit it as evidence in the case. And we can talk about any restrictions as we go, but I think

there's a protective order. I'll admit it for purposes of evidence in the case.

BY MS. PROUT:

Q Okay. Ms. Marie, let me ask you -- we're going to walk through this document, and I'm going to ask you to explain it. I'm looking on the first page at the upper box. Can you explain what that is and what its purpose is.

A That is preoperative, and it's like I said. It's usually taking place before the day of surgery, and that's where they will do the initial assessment and state -- find out about various labs. And as you can see, at that time it says the MD had consent, so it wasn't currently on the file. So they're basically starting the process of our checks and balances.

Q So where it says MD has consent does that mean that there had already been consent or there hasn't been consent?

A It means -- that would indicate that there is a consent, but the doctor has it. It's not with the documentation at the time that this assessment was done.

Q Okay. If I can draw your attention to the lower box now.

A Yes.

Q The second line of the lower box, can you read that and explain what that means.

A Consent completed and signed. Okay. So that is -- and the date. So that is signifying that a surgical consent was obtained by [redacted] on 10-20-2015.

Q And drawing your attention to the second to last line there --
A Yes.
Q -- could you read that and explain that.
A Pre-procedure medication given, if ordered. No. So that would indicate that the nurse -- because this was done by the pre-operative nurse in the holding area getting [redacted] ready for surgery. So that would state that there were no preoperative medications given by her or none ordered. If there was some given, she would have placed her initials on the outside box where you see her initials going down.
Q Okay. If I could have you look at the next page, please.
A Yes.
Q The upper box there, who is the person who is completing the lines on that upper box?
A The person who is completing the lines on the upper box is the surgeon, but the VA allows surgical residents to complete it as well.
Q Okay.
A So they will come in and speak with the patient the day of surgery, make sure that everything is done as if it's a surgical -- a procedure where it's like an arm or something where there's two or more, then they will also be required at that time to mark that site while the patient is awake and

alert to agree that that was the site.
Q Okay. And then what about the middle box? Who prepares those?
A The middle box was done by the nurse anesthetist, a certified nurse anesthetist. That is the -- in this case by the signature I know it was a young lady. So she came in and did the first initial, the day of surgery, anesthesia assessment. Now, even though she did an assessment and signed, a supervising anesthesiologist would still come by and greet [redacted] and verify that he, you know, he was okay.
Q And what about the last boxes?
A The last portion is my portion, and that is where I would identify him. And although I did ask things on the initial, but I would also put notes for myself so I wouldn't forget certain things, like make sure that he didn't have -- the NPO states that that was the last time he had food. So he didn't -- the last time he had food was at 10:30. That's what he told me and a different thing that of pain.
The family member, I always ask if it's okay to talk to a family member because we are abiding by HIPAA's rules, patient privacy. And he stated and he gave me the name of a Ms. Tiffany Hudson, and that's why I wrote it down, that it was okay to talk to her.
Q So this form identifies five different people who spoke to

[redacted] during the pre-op verification process. Why is it necessary to have so many different people involved in that process?

A Well, it is a safety precaution. We want to make sure that there's no wrong site surgeries, we have the correct patient. We also want to make sure that the patient is comfortable. Just because I may walk up to [redacted] and talk to him, he may not have felt comfortable to tell me something. But someone else could walk up to him, and as we talk, he may reveal something else, so whether he was comfortable to talk to me or not or he just remembered something else. I know a lot of patients, they may be annoyed by us con -- you know, the different people coming up and asking, but it is for their protection, their safety that we do this.

Q In the course of talking to [redacted] in the pre-op area, did you see something that was unusual in his hands or on his bed?

A Okay.

Q Why was that notable?

A I don't know. I wasn't there. But [redacted] did state to me that he told the nurses that he --

MS. PARMER: Objection, your Honor. I think this is getting into hearsay if she said she has no idea what actually was said. And she's referencing something that he allegedly

told the nurses, and so I think that we have hearsay within hearsay. And this is testimony that's also not relevant.

THE COURT: I think, if I recall, she was saying what [redacted] told her.

THE WITNESS: Yes.

THE COURT: So I'm going to overrule the objection as to what [redacted] told the witness.

THE WITNESS: So may I speak?

BY MS. PROUT:

Q Please.

A Okay. [redacted] stated to me that he used to be a stripper.

Q Okay.

A And the nurses threw pennies at him.

Q The nurses threw pennies at him when?

A I don't -- I guess while he was in the stretcher. I'm not -- I wasn't -- that took place before I was there, so I cannot tell you when that happened.

Q Was he referring to an incident that happened that day or --

A Yes, right then and there. Yes, that's what he was referring to.

Q Okay. At that time was the defendant on any sedatives or pre-anesthesia medicines?

A Not that I'm aware of.

MS. PARMER: Objection. Calls for speculation.

THE COURT: I'm sorry.

MS. PROUT: This is a nurse who was present. She's allowed to testify as to her knowledge of --

MS. PARMER: She wasn't asked about her knowledge. She can only testify what she knows about. She cannot testify if he was on any pre-anesthesia medication because, as she said, she only knows what she knows from that interaction.

THE COURT: I'm going to overrule the objection. If you know the answer, you may testify. You may answer the question.

THE WITNESS: I do not know if he was on sedatives.

BY MS. PROUT:

Q Did you observe him being given any medications at that point in time?

A Not at that point in time, no.

Q And during what duration were you in the preoperative area with [redacted]

A I was in the preoperative area with him. I want to say we were there approximately no more than five, ten minutes. I would do my assessment, Dr. Patel would do her assessment, and we were like the last red line you had to cross. And then from that point we went right to the OR.

Q So from the time that you did your assessments, were you in the pre-op area with [redacted] the entire time before

he left for the OR?
A Yes.
Q Before [redacted] left for the OR did he have an IV port inserted?
A Yes. That is general procedure, yes.
Q And every time a patient has an IV inserted do they receive medication in the IV at that point?
A No. At that time the IV is inserted it is just to give us a line, to give us access for when medication is given that we have -- we already have established access.
Q Is the IV unattached or is it attached to anything?
A It's usually attached to a bag of saline or a lactated ringer, and that depends on the anesthesiologist or surgeon's preference.
Q And in this case was [redacted] IV attached?
A Yes.
Q I'm sorry. So what was it attached to? Saline?
A It was attached to a bag of saline, yeah.
Q Okay. In your experience can a patient sometimes feel the saline fluid entering their body once the saline is attached to the IV?
A They may feel it at first because of the cool sensation, but then after that, it should become, you know, normal feeling, normal sensation.
Q Let's discuss what happened as you were leaving the pre-op

area. Who was responsible for wheeling the defendant from the pre-op area to surgery?

A The nurse and the anesthetist, whether it's -- with [redacted] it was myself and Dr. Patel.

Q Okay. Can you describe where you and Dr. Patel were standing relative to [redacted] stretcher.

A Okay. Dr. Patel would be at the head of the bed, and I would be at the foot of the bed because I would steer the stretcher as we go down the hall.

Q The stretcher that Dr. [redacted](sic) was in, can you show us approximately how high the side rails were of that stretcher.

A They were relatively like this. It's a typical hospital stretcher, so they come up relatively mid high so the patient can't roll off the bed.

Q Can you estimate a height from the stretcher bed?

A From -- I really -- I can't estimate an exact height, but I would say from the bed, what is that? About, about --

Q Would you say --

A -- 10 inches.

Q Now, was the defendant conscious and awake as you left the pre-op area?

A Yes, ma'am. He was -- he said good-bye to -- was very polite. He said good-bye to the nurses as we rolled out.

Q Okay. What was his mood or demeanor like?

A He was still talkative. He was still cheerful.
Q When you say he was talkative, were his words making sense or were they gibberish?
A No, he was making sense because as we were rolling -- there are double doors, and as we were rolling through the double doors, he was saying good-bye.
Q Okay. Describe the incident that occurred just as you left the pre-op area.
A Yes. Just as we left the pre-operative area, once again, I'm at the foot of the bed, so my back is to [redacted] And he grabbed my rear, my behind, and he -- so when I turned, he was starting to sit back, you know, come from where he had his hand on me and come back over the rail and sat up. At that time [redacted] stated, I waited to get the medicine so I could get away with it.

And I -- at that point I was taken back, and I immediately wanted to draw attention to what was happening. So I yelled out. And I hope it's okay that I -- I'm going to say what I said. And I said, I cannot believe you grabbed my ass. And he -- we started walking down the hall and --
Q Let me stop you for a moment. I'm going to get to that, but I want to ask you a few questions about what you just described. As you were leaving the pre-op area, was [redacted] sitting up or lying down?
A He was sitting upright.

Q When did he go from lying down to upright?
A He went from -- as we were coming out, he went from lying down to upright, reached over, grabbed me. And when I turned, because I immediately stopped and I turned, that's what he -- when he made the reply and he went back down.
Q The grab that you described, could it have been sort of an innocent brushing of that area?
A There's no way. There's no way because I was all the way at the foot of the bed on the side. There's a rail there. He is a tall man, but he could not have reached me. And he had to go over the rail to get to me.
Q Can you repeat for us what comment he made after he did that.
A He stated that he waited to get the medicine so he could get away with it.
Q These are events that happened back in 2015. Are you sure that those are the words he said?
A I will not forget what he said to me. I have never experienced that in my life. I've only been an RN since 2009, but I have been in nursing. I started out as an LPN in 2000. I have been in nursing for several years, and I have never encountered anything like that.
Q At the time that he did that act, did he appear sleepy or drowsy?
A No. His words were clear. He had full body control

because as we were -- because when he did the act, the stretcher was in motion. He wasn't like falling to the side or anything. He was well controlled.

Q Is it hard to sit up in a stretcher that is in motion?

A Yes.

Q Did he appear disoriented to you in any way?

A He did not appear disoriented. Once again, his words was clear. He had full body control. He did not say anything that would tell me he was disoriented.

Q And did his actions appear like an involuntary reflex or did they appear controlled?

A No. They were very controlled.

Q At any point in time did you give the defendant consent to touch you?

A No, ma'am. I did not to give [redacted] consent nor did [redacted] ask me.

Q You began to describe what happened next. Can you continue on.

A Yes, ma'am. I saw a co-worker down the hall, and that was part of the reason why I yelled out, to draw attention to where we were. And we proceeded to go down the hall -- because at that point in time I just wanted to get him into the operating room as fast as I could. As we passed a co-worker -- am I allowed to say his name?

Q Yes.

A As we passed Harvey, he turned to Harvey, and he pointed at him and said, I've got one on you, man. And we just kept going, and he then -- then he started to say things. He started to continue to talk because he was still very talkative, and he said that he gets sleepy and horny when he receives medicine.

Q How did you feel as the events unfolded?

A I felt completely violated. I treated [redacted] with nothing but professionalism. He's a veteran, and he deserves proper care. And he repaid my care to him with a vulgar act. He did not have permission to do what he did.

Q Where did you ultimately take the defendant?

A I took [redacted] to the OR room and --

Q How did he act when you got to the OR?

A When he got to the OR, I immediately -- the table, the OR bed, was prepared. And I lined the stretcher up next to the bed so they would be -- I removed myself, and I walked over to the nurse. I could see [redacted] turning and watching me, and he witnessed me telling another nurse what had just transpired because I removed myself from his care at that point because I felt that was the best thing to do.

Q His overall behavior and demeanor, as far as his level of activity and talkativeness, would you say that it was similar to how he was acting when you were in the pre-op area or was

it different?
A No. He maintained his cheerfulness throughout the whole time.
Q After you left the defendant in the operating room, did you tell anyone else what had happened?
A I told everybody I could find, and as I was talking to a co-worker, she said, no, you can report it and made the phone call to the police.
Q Was it you or your co-worker?
A No. The co-worker did.
Q What was her name?
A Sheila.
Q And what did the police do, if you know?
A The police came up and asked me what happened and filed a report.
Q Over the course of your career, about how many patients have you given pre-operative Midazolam to or have you seen or received pre-operative Midazolam?
A Hundreds.
Q And over the course of your career, about how many people would you estimate you've wheeled from the pre-operative area to the surgery room?
A Hundreds, hundreds.
Q And have any of those patients ever assaulted you or anyone else?

A No.
Q And have you ever witnessed any of those patients commit a crime or otherwise act inappropriately while under the effects of Midazolam?
A No, I have not.
MS. PROUT: That's all at this time.
THE COURT: Ms. Parmer.

CROSS-EXAMINATION

BY MS. PARMER:
Q Good morning, Ms. Marie.
A Good morning.
Q Specifically this would be an impolite question, but I'm going to ask. For the record how old are you, Ms. Marie?
A I am 54 years old.
Q So you, that morning, October 23rd, 2015, you transported [redacted] from the pre-op holding area; correct?
A That is correct.
Q And you testified on direct that you interacted with him over the course of about five minutes there; right?
A Yeah.
Q Okay. And there were a lot of other people that had been interacting with him in that room; correct?
A That is correct.
Q Okay. And I'm going to also reference Government Exhibit 1 and kind of go over a few things in this as well.

A Yes.
Q Do you have a copy still?
A Yes, I do.
Q Okay. Now, this is a two-page form that kind of encapsulates what happens in that pre-op holding area; right?
A That's correct.
Q Okay. And you filled out this last portion that's on page 2 of 2 --
A That is correct.
Q -- before transport? Okay. So conceivably there were at least one, two, three, four people that interacted with [redacted] who at least filled out this form before you came in; right?
A Yes.
Q Okay. Now, on the first page here we have the day of surgery, the 2nd block shaded in?
A Uh-huh.
Q And we have this individual, Patricia Wagner, who writes 10:00 a.m. Is it fair to say that that's probably the interaction, the time that she interacted with [redacted]
A That would be the time.
Q Okay. And what makes you think that?
A Because that's what we typically do. We write the time down. That would be the time that the patient -- she came

over -- the patient came in, and she came over to start care of the patient.

Q Okay. 10:00 a.m. And your testimony on direct was that you spent about five minutes with [redacted] Before the transport; right?

A Yeah, approximately five to ten minutes. I don't think it was that long, ten minutes, but, yeah, around five minutes.

Q Okay. And when you gave a statement to police, you said that you thought the transport happened at 11:20; correct?

A Just because I wasn't there at 10:00 o'clock.

Q Oh, yes, I know.

A Okay.

Q But your recollection of the time when you wheeled [redacted] out of the pre-op holding area, is that it was around 11:20 that day?

A Okay.

Q Well, let me see if this helps refresh your recollection. Are you familiar with the statement that you made to the officer?

A Yes.

Q And are you familiar with the report that he created about this incident? Have you seen it?

A I may have.

Q Let me show it to you, and if you haven't seen it, that's not a big deal. That's fine. This has been premarked Defense

4, and I may not introduce it at this time. And this other one, her statement, is premarked Defense 10. I don't think I'll introduce it at this time either.

This is your statement. Do you remember making this written statement?

A Yes, I do.

Q And have you ever seen a copy of this report?

A I do not remember seeing or recall seeing this report.

Q Okay. I'll take that one back. So with this statement you gave this to the officer when he came to talk to you about the incident; right?

A Yes.

Q Okay. And you didn't put the time anywhere on here; right?

A The time that I gave the statement?

Q Or the time that you think -- the time when the physical contact with your behind was made.

A No, I did not.

Q Do you remember what time it was?

A No, ma'am.

Q Okay. Thank you. But we do know from the form, Government Exhibit 1, that [redacted] was in the pre-op holding area at 10:00 a.m.?

A Yes.

Q And that you spent between five and ten minutes with him.

It was not a long amount of time; correct?
A That's correct.
Q And then you wheeled him to the OR; correct?
A That's correct.
Q Okay. So the time that you wheeled him to the OR would be right immediately after those five to ten minutes that you spent with him; right?
A Right.
Q Okay. Now, after the incident happened -- well, let's talk about actually what happened during the incident. [redacted] says I waited to get the medication to do this; right?
A He said I waited -- he said, I waited to get the medication so I could get away with it.
Q Okay. And you told the officer that arrived that day to interview you that's what he said; right?
A Yes.
Q Okay. And did you provide any information about what medication [redacted] might have been on?
A No, because I do not administer medication.
Q Okay. So if he had been on medication, you would not have been the one to administer it?
A No, ma'am.
Q Okay. So we know he's in the pre-op holding area starting about 10:00 a.m., dealt with by a number of different people?

A Yeah.
Q And then you see him at the end?
A Yes.
Q After this incident happens, he turns to Harvey --
A Yeah.
Q -- and says, I got one up on you, guy?
A He says, I got one up on you, yes.
Q Did he -- as far as you know, had he ever met Harvey before?
A Not that I'm aware of.
Q Okay. Who is Harvey?
A Harvey, he's a worker at the VA. He works in Environmental Services.
Q Okay. So Harvey wouldn't have been anyone who had any interaction with him or had an established relationship with [redacted]
A No, he's not.
Q And so then you drop [redacted] off in the OR, and you go back. You remove yourself from his care you say; right?
A Yes, I did.
Q Pretty soon after you leave him in the OR?
A Yes. Another nurse was there. The lead nurse was present, so I did not abandon my patient. A lead nurse was present.

Q And so then you go back, and you end up talking to Sheila Lee about what happened; right?
A That is correct.
Q What is Sheila Lee's job?
A Sheila lee is also an OR registered nurse.
Q Okay. But did she have any anything to do with [redacted] treatment that day?
A No, she did not.
Q Was she familiar at all with any medication [redacted] may have had?
A No, she is not.
Q She wasn't familiar with the procedure he was going to go under that day?
A No.
Q Okay. She knew nothing about him at all?
A No.
Q And she called the police?
A Yes.
Q You didn't call the police?
A No.
Q Okay. And then one officer arrives that day and speaks to you; correct?
A That is correct.
Q And then another officer speaks to you four days later, Officer Dalton?

A Yes.
Q Okay. Did Officer Dalton ask you anything about the potential medication [redacted] would have been on?
A Yes. I explained to him that I did not administer medication.
Q Okay. And you told him that you didn't know whether [redacted] had received any?
A Right.
Q Now, your response when the incident happened, was I can't believe you grabbed my ass; right?
A Yes.
Q Okay. Why did you use that terminology?
A Because I wanted to attract attention. I didn't know what to expect. I didn't know -- I had never been in that situation before, so I wanted as many eyes on me as possible. And I said it as loud as I could.
Q Okay. So that's why you thought if you said ass really loud, you'd get eyes on you --
A Yes, yes.
Q Who was around? Just Kinnari Patel and Harvey Clark?
A Harvey Clark, Kinnari Patel, and I'm not sure if there was anyone else. There may have been because right where we were is a room that we do -- what procedure? I'm trying to remember the procedure. Urology procedures. So there may have been urology nurses in the vicinity in one of those

rooms.
Q Did you tell the police, either of the two officers that interviewed you, about those people?
A No, because I don't know if they heard or anything, because I'm just saying that the rooms were there.
Q Okay. I'm going to refer back to again this pre-op verification form.
A Uh-huh.
Q Okay. So follow along with me. So what you're tasked with doing is following through, what you call the checks and balances, following through and then indicating that you've done things by a signature and by filling out your name; correct?
A Yes.
Q Okay. Let's go to page 2 of 2. At the top we have what's supposed to be done by the surgeon; right?
A The surgeon or the resident.
Q Surgeon or the resident. Now, here we have a space for initials, printed name, and signature; right?
A Uh-huh.
Q What do we have there?
A Nothing.
Q Why not?
A Because he didn't sign.
Q Okay. So sometimes people may not put something in a

space that's supposed to be there?
A Yes. Sometimes the physicians do not sign.
Q Okay.
A And when we get it in the back, we remind them that they have to do that.
Q What do you mean we get in the back? In the OR?
A Yeah. You know, with your next case make sure you sign.
Q Okay. You mentioned NPO status. Can you explain again what NPO is.
A That means when was the last time that they had a meal or anything to either drink. So typically we ask patients who have surgery in the morning not to eat anything before midnight (sic) because they're going to receive anesthesia. So NPO is the last time they had anything to eat or drink, and he stated 10:30 p.m.
Q And so you wrote that to the side?
A Yes, because I don't want to forget. So sometimes I would write little notes to the side.
Q Let's go to the first page now. We have Ms. Wagner, Nurse Wagner who was there at 10:00 a.m., she also has kind of halfway down in her section "Patient fasted appropriately, NPO after Midnight." And what does she have written there?
A Wait. Hold on. I'm trying to see where that is. I apologize.
Q No worries.

A Patient fasted appropriately, NPO after Midnight, 9pm.
Q Okay. So she also wanted to make a note, and she notes that he last ate at 9:00 p.m.?
A Yes.
Q But then you on the second page note the last time he ate is 10:30 p.m.; right?
A I can only go by what he tells me. I don't copy what another nurse writes.
Q Okay.
A I go by what the patient directly tells me.
Q Okay. So you can't even say which of these is correct. You're just going by what he says?
A Well, yes. But also understand he still met protocol. Regardless if he told her the correct time or he told me the correct time, he still met protocol because he fasted before midnight.
Q Right. So when it comes to the actual specifics, we can have two totally different times on here. But that's okay; right?
A That's based on the patient.
Q Yeah. And the fact that we have some of these notes written to the side, is that because there's not a place in this form to put every detail that you would like to see on this form?
A Some people write -- well, that's a nurse preference. For

me, it helps me, and apparently it helps Ms. Wagner. Ms. Wagner would also put her information -- this particular information in her computer notes, so I'm not sure why she would put hers there. I write mine because I will not place mine on my computer notes until I'm in the OR. And I don't want to forget what the patient tells me. I don't want to misinterpret what he tells me.

Q So let's talk about this computer in the OR.

A Yes.

Q So you enter by hand some things in the OR or some nurses do, not you. You enter by hand some things in an online system when you're in the OR?

A No. We all enter in the operative area online. Some of the information may be gathered at different places. This was gathered -- my information here was gathered in pre-op because that's -- I cannot bring him to the OR unless he has met these details.

Q Got it. But some nurses, it sounds like, may go to the OR and add details from pre-op in their --

A I don't know what another nurse do.

Q But you like to use the hand notes?

A Yes, I do.

Q Okay. And you put the hand notes to the side because there's no place on this form to put these details?

A Well, actually, if I'd like, I could have placed it on

this line.
Q Okay. Right. But here we have no comments, these lines --
A No, because I chose to write it here.
Q Okay. And on the front with Nurse Wagner, we see that in her notes she put pain 10 out of 10. What does that mean to you?
A That means he's stating that out of a scale of 1 to 10 his pain level is a 10.
Q So does that mean his pain is as high and as intense as conceivably it could be?
A Yes, yes.
Q Okay. And this was again an interaction with Nurse Wagner at around sometime, we think, after 10:00 a.m.?
A Uh-huh. Yes, that is correct.
Q Now, you described that [redacted] had complete and utter control of his body when he sat up; correct?
A Yes.
Q But you were in front of him; right?
A I was in front of him. What I'm referring to is when I turned around, and I witnessed him because I stopped.
Q Right. But up until that moment, when you felt that physical contact, you were faced in front of him, away from him?
A That is correct.

Q Okay. You mentioned that you were relatively new, relatively new at the VA at that time. You'd just started that summer; correct?
A That is correct.
Q And so you were still following people around; correct?
A I was -- okay. I'm not a new OR nurse. I was just new to that facility. So as far as bringing a patient back, you know, I have had many years of experience with. What I was new with was preparing the room according to that surgeon's preference.
Q Okay. And so you weren't independently making decisions as to what medication [redacted] should receive?
A Well, I wouldn't make any decisions regarding medications because that is not what an operative nurse does.
Q Right. However, it would be common for the anesthesiologist to decide to administer something like Midazolam in the pre-op holding area; right?
A That is correct.
Q And that would be the decision of the person in charge of the anesthesiology; correct?
A Yes. That would be in-house supervising anesthesiologist.
Q Supervising anesthesiologist?
A Also, because the nurse anesthetists or anesthetists are also licensed individuals, they can also give because we have a -- they have what we call standing orders. So if they felt

the patient needed it, yes, they would also have the authority to do so.

Q So you described the chief nurse anesthetist?

A No, certified -- I'm sorry -- certified nurse anesthetist.

Q Or the supervising anesthesiologist?

A And also the VA use physician residents.

Q Okay. So any of those three people could have made the decision to give him Midazolam in the pre-op holding area?

A They could have made the decision if they were under -- if they were caring for him, yes, ma'am.

Q Okay. You mentioned that [redacted] was holding onto a penny; is that right?

A Yes.

Q And made reference to being a stripper; is that right?

A Yes.

Q Okay. Did that seem to you kind of a weird thing to say?

A Well, you know, people respond to surgery in different ways. Hey, as long as he was feeling good, that was the important thing because patients who go into surgery with a good attitude usually have better results, you know. So I was fine -- I've never heard that remark before but okay.

Q Okay. And when you spoke to my investigator, Mr. Hutcherson -- I think it was maybe last summer -- he also asked if it's possible whether [redacted] could have received some medication that altered his mental state in the

pre-op holding area. And again you said, I don't know. He could have, but I don't know?

A No, ma'am, only because that's not part of my care.

Q Right. And it's fair to say -- correct me if I'm wrong, but it's fair to say that every patient responds to medication differently; right?

A That's appropriately -- but we do have -- that's why they list typical side effects, because most patients respond a certain way to certain medications. So there are typical things that we look out for when a patient is given certain medicine.

Q But it's also fair to say that not every patient will experience side effects --

A Oh, absolutely it's possible.

Q Body chemistry and maybe other medications that you may have taken earlier or a variety of factors that can effect how you respond to medication?

A Right.

Q And you're familiar with Midazolam; right?

A Yes, I am.

Q And it's fair to say that Midazolam has the effect of intoxicating somebody pre-anesthesia; correct?

A What I have witnessed with Midazolam is patients become sleepy. That's what I physically see.

Q Okay.

A So that's how I'm trying to explain to you. I usually see them relax. Many of them will lay back in a stretcher with their eyes closed. They still respond. They're not like asleep where you have to, you know, but it's more of a relaxing, putting them to sleep, get them in a calming place before they start their procedure.

Q Because the procedure can be stressful?

A Right.

Q And this was your first interaction with [redacted] right?

A Yes, my first and only interaction with [redacted]

Q Okay. So you have no knowledge about whether he's ever underwent anything like this procedure before; right?

A No. I do not know if he had this procedure before.

Q And so, again, you are limited to these five minutes before walking him down the hallway in terms of what you saw involving [redacted] that morning on 10-23-2015; right?

A I'm limited to only what I witnessed and what he did to me.

Q Right. But it seems clear from this form that he was in the pre-op holding area, it's fair to say, around 10:00 a.m.; correct?

A Fair to say, yes.

Q Okay. And I just want to follow-up again because I'm trying to understand. You referenced that there's an

electronic system where you can enter data regarding the procedure and that a lot of times people wait until they get into the OR --

A No. I didn't say that.

Q Okay. Explain that to me.

A Okay. My role is very different from the other people. The nurses in the pre-op area, if they -- whatever they do they chart it then. A nurse anesthetist or supervising anesthesiologist, when they administer medication, they chart it then because there are computers that are there for them to do that. Okay. My computer is in the intraoperative area, so I write my notes because it's further down the line. I have other checks and balances that I am trying to maintain. So no. If I was to give a medication, if that was my role, then I would have had to enter it at that time. I'm not allowed to enter medication afterwards.

Q Okay. But you would not have entered medication --

A No, ma'am. Regardless, I would have not entered any medication.

Q Okay. So that kind of takes me to this front page on Government's Exhibit 1, pre-procedure medication given, if ordered. This is Patricia Wagner, the nurse, saying she was not ordered to give medication?

A That is correct.

Q But conceivably there's a number of other people that

could have come in, interacted with [redacted] in the pre-op holding area, and administered Midazolam?

A That is correct, and they would have then put it in the computer.

Q In a computer system --

A Yes.

Q -- not this?

A No, because this is not for that.

MS. PARMER: Got it. Thank you. Nothing further.

THE COURT: Ms. Prout, any redirect?

MS. PROUT: Briefly.

THE COURT: Okay.

REDIRECT EXAMINATION

BY MS. PROUT:

Q Just to be clear, when you talked about computer systems for entering information about the patient and you mentioned there was a computer system in the OR, is there a similar computer system located in the pre-op area?

A Right. That's what I meant, that in the pre-op area there are computers right there so that they can, if it's the CRNAs, supervising anesthesiologists, whomever it was, or the nurse, when they administer, they have the systems there to enter it at that time.

Q Okay. And in your experience have you ever known a nurse to wait more than -- well, how long would a nurse typically

wait between administering medication and entering it into the system?
A We are required to do it at the time of administration because everything goes -- medication have half lives. It has a certain duration. So we want to know how long this patient has been having this medication in their system. So I would enter it then. So then I would know when it would peak and when they were coming down.
Q You explained that it's not your role to administer Midazolam. But in your role as a nurse in the pre-op area, have you had occasion to observe it being given to patients?
A Yes.
Q At what point in the pre-op process is it typically given? Is it typically given near the beginning of that process, near the end or something else?
A It is -- if it's going to be given, the nurse anesthetist would give it right before we would walk out the door so -- because it's fast acting. So by the time we got from the pre-op area to the OR, they would then start to be relaxed.
Q And so that time period, is that the same time period that you were in the pre-op area with [redacted]
A It would have -- no. Kind of. But it would have been right before we left, I mean, immediately before we left the door to go out.
Q And were you with [redacted] right before you left?

A Yes, I was.

MS. PROUT: Okay. Nothing further.

RECROSS-EXAMINATION

BY MS. PARMER:

Q Just briefly, you keep referencing like an electronic system where they would have electronically -- entries that electronically distinguish what medication was given. This is not it; right?

A No, ma'am. That is not it.

Q Okay. And you mentioned that a nurse anesthetist could give the Midazolam right before the transport. But, also, there's, I think you mentioned, two other people that also could have given it; right?

A Yes. And typically that is -- the reason for the Midazolam, it's given to relax a patient who is agitated and before we get to the OR. It's typically not given until right before we leave. It can -- you know, anything is possible, but it's typically not given until right before we leave so by the time we get the OR its effects are starting to work.

Q It's fast acting; right?

A Yes.

Q And so you described [redacted] as cheerful; right?

A Yes.

Q And yet we have Nurse Wagner describing his pain as being excruciating; right?

A Yes. But he also told me he had pain, but he did not act as if he was -- he didn't act as someone typically in a lot of pain, you know, holding themselves or anything. He was very cheerful.

Q Do you remember who the nurse anesthetist was in this case?

A Who did the -- okay. So he had a resident who was in the OR with me, a physician resident, Dr. Patel. The nurse anesthetist who did the -- who's on the second page in that yellow box there, her name is Zauphia.

Q Okay. And who was supervising Patel?

A Dr. Jackson would have been that day.

Q Okay. And what about this name at the top of Government 1, Fernandez, who's Fernandez?

A That is the surgeon. That's Dr. Fernandez. So she's just letting you know who was the admitting surgeon for the procedure.

Q But then who's JM who signs off under --

A That would have been the resident. Every surgery has residents because the VA is a teaching hospital, so they have residents who come in. And, as I mentioned, they really are physicians, so they are allowed. And they're just -- he is working along that surgery, that surgeon in that -- what's the -- in that service.

Q Okay. So they're following the directives from the people

that are supervising them?
A Yes, ma'am.
Q Okay. And so who was supervising Patel that day?
A That would have been Dr. Jackson.
Q Okay. At the top of Government's 1 we have this date and time. We have 10/23/2015 and 13:34 -- wait. I'm sorry. This time stamp at the top.
A This here?
Q Uh-huh. What does that indicate?
A Pre-op note verification 1:34. I'm not sure and I don't want -- I don't know what that verification is.
MS. PARMER: Okay. Thank you. Nothing further.
THE COURT: Ms. Marie, you may step down. Thank you very much.
THE WITNESS: Thank you.
THE COURT: You may call your next witness.
MS. PROUT: The government calls Kinnari Patel.
COURTROOM DEPUTY: Please stand and raise your right hand.

KINNARI PATEL, M.D.,

herein, having been first duly sworn, was examined and testified as follows:
COURTROOM DEPUTY: Thank you. You may be seated. Please state and spell your name for the record.
THE WITNESS: My name is Kinnari Patel,

K-i-n-n-a-r-i, last name P-a-t-e-l.

COURTROOM DEPUTY: Thank you.

DIRECT EXAMINATION

BY MS. PROUT:

Q Good morning, Dr. Patel. Tell us where you currently work.

A I work at Kaiser Permanente in San Rafael, California.

Q What is your position there?

A I'm a staff anesthesiologist.

Q Did you previously work at the VA Hospital in Decatur, Georgia?

A Yes, I did.

Q In what capacity were you working there?

A I was a resident at the time, and I was doing a rotation for a month long at the VA Hospital.

Q How many years is your -- well, let me back up. You were a resident in what subject area?

A Anesthesiology.

Q How many years is an anesthesiology residency?

A It's three years plus one year of prelim program.

Q What's a prelim program?

A It's one year of doing internal medicine or a surgical intern year.

Q During your residency, about how much of that time was spent at the VA Hospital?

A I spent two months out of my time there.
Q What was the last -- well, what was the later of those two months? When was that, if you recall?
A I believe it was in October 2015.
Q Can you describe what your responsibilities were during that month-long rotation at the VA in October.
A I was responsible for providing anesthesia care for patients undergoing surgery, surgery pretty much every day at the hospital. I was responsible for meeting preoperatively, doing evaluation on them, getting consent from them, and then taking them to the operating room, and putting them under anesthesia, waking them up after surgery was done.
Q As a resident at the VA, are you a licensed physician at that point in time?
A I am not a licensed physician at that time, no. I'm a resident working under an attending anesthesiologist.
Q Okay. Do you have a medical degree at that time?
A Yes.
Q At the VA when a patient is given medication, how is that recorded?
A Typically, depending on who is administering the medication, it would be under a medical reconciliation form or an area documented on a medical chart or it would be under the anesthesia record.
Q Is the patient's medical record a paper record or is it

electronic?
A The medical record was electronic.
Q And who would typically record medication information once it's administered to a patient?
A It depends on who administered the medication. If it was the nurse, then the nurse would usually enter it into the system. If it was the anesthesia provider, it would be one of us doing it.
Q So the person who's administering it would typically record it?
A Typically, yes.
Q And would the dose administered be recorded?
A Yes, always.
Q And what about the time?
A Yes.
Q And would the time that's recorded be the time that the medication is being entered into the system or would it be the time that it's given to the patient?
A It's the time that's given to the patient.
Q And do you recall if under the VA system that time is something that automatically populates or if it's something that the user has to complete themselves?
A It depends. On the anesthesia record it was possible to backtrack and put the medication in at the time it was actually given if it wasn't given right away or you could just

automatically populate it if it was given right then.
Q Okay. And when you say it's possible that something is being recorded that was given earlier, what timeframe are we talking about? Hours? Minutes? How much time would typically pass between medication -- when a medication is given and when it's recorded?
A Typically minutes.
Q In your experience were the time entries fairly accurate or were they inaccurate?
A Fairly accurate.
Q I want to discuss with you the process for obtaining consent from the patient. Generally speaking, before a patient of yours can have surgery at the VA what sort of information -- well, what's your role in the consent process?
A So my role is to meet with the patient, introduce myself, talk about the plan for the anesthesia, make sure the patient understands what the plan is, and then obtain verbal consent to proceed with the plan.
Q And when you are explaining the anesthesia and the plan, would you typically describe for the patient how anesthesia medications would cause a patient to react?
A Typically, no. My general practice is to explain what I'll be doing, and if the patient has specific questions, I'll answer them. Otherwise, I usually just speak in generics.
Q Why is that?

A Most patients I come across are very anxious before surgery and don't want to hear details.
Q And if a patient requests details, are you willing to provide those?
A Absolutely.
Q Before you proceed with any anesthesia plan is the patient required to give informed consent?
A Yes. They are required to give verbal consent or sign documents saying they give consent, depending on what the policy is at that hospital.
Q Have you ever proceeded with anesthesia care on a patient who has not given their informed consent?
A Very rarely. And it's in a case where it's an emergency, and the patient is unconscious, unable to give consent.
Q Okay. Are you familiar with the drug Midazolam?
A Yes.
Q Is that sometimes given preoperatively to patients?
A Yes.
Q In your experience if a patient is getting Midazolam preoperatively -- and by that I mean in the pre-op area -- at what point in the pre-op process is that typically given? Is it given when they first enter pre-op or is it given later in the process?
A Typically given later in the process.
Q Do you recall providing care to a patient named [redacted]

[redacted] during your October 2015 rotation at the VA?
A Yes, I do.
Q Do you see him here today?
A I do.
Q And can you identify him by where he's sitting and what he's wearing.
A He's sitting behind you there.
MS. PROUT: Let the record reflect that the witness has identified the defendant.
Why was [redacted] admitted to the hospital in October?
THE WITNESS: He was having surgery because he had had a spontaneous pneumothorax and needed to have surgery on his lungs.
BY MS. PROUT:
Q Was that a planned surgery or was it an emergency procedure?
A It was an urgent procedure, not planned.
Q Well, was the surgery scheduled before that day or was it something that arose that day and had to take place that day?
A I don't recall.
Q Okay. At what point in the surgical process did you first see [redacted]
A I remember seeing him in the pre-operative area, talking to him, and doing my evaluation and then doing a procedure for

the anesthesia, yeah.

Q Okay. In the pre-operative area did you discuss the procedure and obtain informed consent from [redacted]

A Yes, I did.

Q And was he given the opportunity to ask any questions?

A Yes.

Q And did he ask any questions?

A I don't recall.

Q In general if a patient asks questions, what would your practice be?

A My practice would be to answer all the questions that they have to the best of my ability until they feel like they're satisfied with the response.

Q And did [redacted] provide his informed consent for the anesthesia plan?

A Yes.

Q Can you recall [redacted] demeanor when you were talking to him?

A Vaguely, yes.

Q Can you describe it?

A He seemed to be making a lot of comments that made me uncomfortable. I remember not wanting to be in his presence for any longer than I necessarily had to be.

Q Was there anyone with you at the time?

A There was a medical student with me.

Q Can you elaborate at all on the types of comments or what your reaction was.
A I don't recall the exact comments. I do remember feeling I had been very uncomfortable because of the suggestive nature of the comments that he was making.
MS. PARMER: Your Honor, I'm going to object to the -- calls for speculation. I don't really know where she's going here. She is testifying that something made her feel a certain way, but it seems very speculative as to what was said. And so I don't understand exactly where this is going, and I don't think that it provides anything of relevance to the government's case.
THE COURT: I'm going to overrule the objection.
THE WITNESS: I felt uncomfortable because I didn't feel, I would say, safe in that area. I had a female medical student with me, and I also wanted to kind of protect her.
BY MS. PROUT:
Q During the pre-op process, at what point in the process was it that you were having this interaction with [redacted]
A This was mainly while I was talking to him about the plan and then while I was doing the procedure that I had to do for his anesthesia care.
Q While you were talking to him about the plan was [redacted] on any sedation or mind altering medication?

A Not that I can recall.
Q And what procedure was it that you performed?
A I placed an arterial line to help measure his blood pressure during the surgery.
Q Does that feel like receiving an injection?
A It's -- it feels like receiving a shot.
Q Okay. And does that have any medication associated with it?
A Typically, no.
Q And in the case of [redacted] did it?
A I don't recall giving him medication.
Q Okay. Do you know how old [redacted] was on the date of surgery?
A I believe he was 33.
Q I'm going to show you Government's Exhibit 2. Do you recognize this?
A Yes, I do.
Q What is this?
A This is the anesthesia record that I filled out for his case during surgery.
MS. PROUT: Okay. I move to admit Government's Exhibit 2.
THE COURT: Any objection?
MS. PARMER: No objection.
THE COURT: It's admitted.

(Whereupon, Government's Exhibit 2 was marked for purposes of identification and admitted into evidence.)

BY MS. PROUT:

Q What was [redacted] height?

A His height was 6 foot 3.

Q And what about his weight?

A His weight is 117 kilograms.

Q Did [redacted] have any kidney or liver failure that you're aware of?

A Not that I'm aware of, no.

Q Would that typically be documented somewhere in his medical record?

A It would have been documented in the pre-operative evaluation of the anesthesia provider.

Q Okay. And what do you know about [redacted] alcohol use?

A I recall his pre-operative evaluation said he typically had one or two beers a night.

Q Okay. And does alcohol use tend to make a patient more susceptible to a drug or less susceptible?

A It makes them less susceptible to the drugs that we give, anesthesia.

Q So the same dose of drug for a patient who is an alcohol user, how would that affect the alcohol user compared to the same dose for a non-alcohol user?

A Typically it would affect the alcohol user less.
Q Okay. Do you know what time [redacted] arrived in the operating room?
A He arrived in the operating room at 11:27 in the morning.
Q And is that documented in the patient's record somewhere?
A Yes. It is on the anesthesia record.
Q Can you tell us where you're fining that?
A It's on the second page at the bottom in the left-hand box, line 5.
Q And what is -- can you read both the time and what that line says.
A It says 11:27 patient arrives in operating room.
Q Now, there are a lot of entries, time entries here. In some cases they're very close together separated by one minute. Why would that be the case?
A Once the patient enters the room we're working pretty quickly to get them set up, get all their monitors on, get them ready to induce anesthesia and put them to sleep.
Q And is the record similarly being updated with that type of speed?
A Typically with electronic records all you have to do is hit a button, auto populate activities and medications.
Q According to your memory or this medical record, when did [redacted] first receive Midazolam?
A He received Midazolam at 11:29, according to the

anesthesia record.
Q Now, do you have a memory of him receiving Midazolam prior to that?
A I do not.
Q Okay. Is it possible to tell from this record whether [redacted] received other medication -- well, according to this record, what is the first anesthesia medication that he received?
A The first one listed is Midazolam.
Q At what time?
A At 11:29.
Q And so that's when in relation to when he arrived in the operating room?
A That would be two minutes after he arrived in the operating room.
Q Okay. Now, is it possible -- are there other records that would show medication that he received before the anesthesia record?
A There is a medical reconciliation that would typically show medication administered by other staff, with nurses, if anything was given.
Q I'm going to show you Government's Exhibit 5. What is this document?
A This document shows medications and orders written for by the surgeons after surgery. And it also includes the

medications that were actually administered to the patient around the time of the surgery.

Q And is this the order summary for [redacted]

A Yes, it is.

MS. PROUT: I move to admit Government's Exhibit 5.

MS. PARMER: Your Honor, this does contain his social security number.

MS. PROUT: My apologies.

THE COURT: Okay. Well, I'll admit it but I guess before -- you can substitute in a redacted copy with a redacted social security number, but I'll admit it. I take it no other objections; is that right?

MS. PARMER: No. No other objections.

THE COURT: So I'll just admit it.

MS. PROUT: We will substitute a redacted copy of that.

(Whereupon, Government's Exhibit 5 was marked for purposes of identification and admitted into evidence.)

BY MS. PROUT:

Q Between Government's Exhibit 2, the anesthesia note, and Government's Exhibit 5, the order summary, do these documents contain all of the medications that the defendant would have received during his surgical admission?

A Yes, it would.

Q And according to these two documents, did the defendant

receive any medication before the 11:29 administration of two milligrams of Midazolam?

A No. He did not receive anything.

Q Okay. Backing up to before he was in the operating room, were you in the preoperative area with [redacted] immediately before he was taken to surgery?

A Yes.

Q Why were you there at that point?

A I was there to get him ready to wheel back to the operating room.

Q Okay. And was he conscious or unconscious?

A He was conscious.

Q Do you recall how he was acting at that time?

A I don't recall.

Q Was he acting drowsy?

A I don't remember.

Q Okay. Who was wheeling [redacted] from the pre-operative area to surgery?

A I was wheeling him from the head of the stretcher, and the nurse in the operating room was standing beside the stretcher pulling along.

Q So the nurse, was she -- at what position of [redacted] body was the nurse standing there?

A She was close to his head or chest area right to the side.

Q Okay. And who was steering the stretcher?

A I don't remember.
Q Okay. Were you standing in the rear or at the front?
A I was standing at the rear.
Q And does the person -- well, who typically steers? The person in back or in front or both?
A It depends. Some of the stretchers have the ability to self-steer, and the person in the back can steer. And sometimes the person on the side or front can steer.
Q Okay. Did [redacted] appear like he was nearly asleep at that point?
A No.
Q Do you recall if he was speaking or not speaking?
A I don't remember.
Q Okay. Did something happen as you took the stretcher out of the pre-operative area?
A Yes.
Q Describe what happened.
A We were in the hallway between the pre-operative area and the operating room, and [redacted] sat upright on the stretcher and reached around to the side in front and grabbed the nurse on the buttocks.
Q And were any comments made?
A Immediately, no, but once he laid back down there was another male employee walking in the opposite direction of us down the hallway, and I do remember him making a comment to

that employee about what he had just done.
Q Okay. Did he make a comment to the nurse after he reached forward and grabbed her?
A I don't remember.
Q Okay. What was the nurse's reaction?
A She appeared very shocked. I don't remember her saying anything to me, but I do remember her kind of looking around and looking at me to see if I had seen what happened.
Q Okay. What was your reaction?
A I was pretty shocked, but my main goal is to get the patient into the room and proceed with my anesthesia care and deal with everything that happened later.
Q Did the patient appear confused at that time?
A No, he did not.
Q Did he utter any nonsense words that you recall?
A Not that I remember.
Q Did he lose consciousness?
A No.
Q Did his motions appear to be involuntary to you?
A No.
Q Do you recall whether his speech was slurred?
A I don't recall that.
Q After the incident, you said that you pushed the stretcher on, and at that point you recall the defendant speaking to somebody?

A Yes.
Q Do you remember who he spoke to?
A I don't.
Q Okay. Do you remember what he said?
A I don't remember his exact words.
Q Do you remember the nature of what it was?
A It seemed like he was bragging about what he had just done.
Q Okay. And compared to how he was acting with you at the time that you said you were feeling uncomfortable as [redacted] was being taken on to surgery, would you describe his conduct or behavior as similar from that or different than that?
A I would say it was similar.
Q Over the course of your career, how many patients would you estimate you've wheeled from the pre-op area to the operating room?
A Over a thousand.
Q And how many patients have you either administered or seen administered the drug Midazolam?
A Hundreds.
Q Have you ever seen a patient in either of those circumstances assault you or anybody else?
A No.
Q Have you ever witnessed a patient act in a similar manner

to [redacted]

A No.

MS. PROUT: That's it.

THE COURT: Dr. Patel, I have a brief question before I turn it over to Ms. Parmer. I think you said that in cases where Midazolam is administered in the pre-op room, typically that's toward the end rather than the beginning. But I don't recall if you testified -- is it normal or is it typical for Midazolam to not be administered until the patient is in the OR? Is that normally done in the OR or in the pre-op room or is there any --

THE WITNESS: It depends on the anesthesia provider and what their discretion is. It can be given in the pre-operative area just before rolling the patient back or it can be, you know, waited. You can wait until getting into the operating room to give it.

THE COURT: So but when you were at the VA at that time, was there a standard procedure?

THE WITNESS: I don't remember.

THE COURT: Okay. All right. Fair. Ms. Parmer.

CROSS-EXAMINATION

BY MS. PARMER:

Q Good morning, Dr. Patel.

A Good morning.

Q So you are an anesthesiologist; right?

A Yes.
Q At the time when you were at the VA, you were a resident; right?
A Yes.
Q And so you were being supervised during that period of time by another anesthesiologist; right?
A Yes.
Q And that person was, I guess for lack of a better phrase, a full-fledged doctor with all the credentials who was making a lot of decisions as to the patient care; right?
A Yes.
Q Okay. But now you're a doctor, so you operate independently without that level of supervision; right?
A Yes.
Q But at this time what you did was being -- well, I guess, did you have kind of generally at this time as a resident the opportunity to make independent decisions free from these supervising anesthesiologists' purview or review?
A Yes, I did.
Q Okay. But, also, you would have with you at all times supervising anesthesiologists who, if they decided to do something, wouldn't have to get approval from you?
A That's true.
Q Okay. You were there -- you said it was a month-long rotation?

A Yes.
Q So it was a short rotation; right?
A Yes.
Q And you no longer work with the VA; correct?
A Correct.
Q Okay. When you were at the VA, you were dealing, in terms of the patients, with a population that was exclusively veterans; right?
A Yes.
Q And so you -- is it fair to say that you dealt with a lot of people that suffered from mental illness?
A Yes.
Q And PTSD?
A Yes.
Q And homelessness?
A Yes.
Q And so the population that you were dealing with was -- is it fair to say that it's a different population than you deal with today?
A Yeah. That's fair.
Q And is it fair to say that you didn't particularly enjoy the work at the VA for that month or did you?
A I enjoyed my work there.
Q Okay. Did you have -- did you have any instances with veterans where you felt that their conduct or their behavior

was difficult for you to handle?
A No.
Q Okay. But you were dealing on a regular basis with people with mental health issues; right?
A Yes.
Q And sometimes these people could conceivably be violent or reactionary?
A It's possible.
Q Okay. But there's a lot from this incident back over two years ago that you don't remember; right?
A That's correct.
Q And you can only testify to what you remember; correct?
A Correct.
Q Okay. So you don't remember the entirety of that day, October 23rd, 2015?
A No, I don't.
Q And you don't remember the entirety of, for example, what you said to [redacted] that day; correct?
A Correct.
Q Or what he said back to you; right?
A Correct.
Q Or who else he could have potentially interacted with that day; right?
A Correct.
Q Or kind of specifically what happened minute by minute in

the OR; right?
A Right.
Q This is over two years ago; right?
A Yes.
Q And so, for example, on direct examination you talked about what is typical; right? For example, that it would be typical in some cases to have an electronic record; right?
A Yes.
Q And you testified that it would be typical in some cases to give Midazolam as a pre-anesthetic; right?
A Yes.
Q But when it came down to the specific facts of this case, there were a lot of things that you just can't remember; right?
A No.
Q Okay. And that's fine. I mean, that's -- you know, you're under oath, so that's fine. So do you not remember whether you gave [redacted] Midazolam?
A I don't remember.
Q Okay. So you can't testify either way whether you gave him Midazolam; right?
A I can testify that on my documentation it appears that I did, but I can't remember giving it.
Q So your testimony is that it appears to you on your documentation that you gave Midazolam in the pre-op holding

area?
A No. That's not true.
Q Tell me what's true.
A What I see is that I gave Midazolam in the operating room after I had already wheeled him back into the operating room.
Q But do you remember specifically what you did involving [redacted] and this procedure that day?
A No, I don't.
Q Okay. And it's fair to say that there were a number of other people that interacted with [redacted] that day; right? Practitioners?
A Yes.
Q And, in fact, you were being supervised by an anesthesiologist who was really in charge of the show that day; right?
A Yes.
Q And that was Dr. Jackson; right?
A That's right.
Q And it's common for anesthesiologists like yourself to meet with the patient in the pre-op holding area; right?
A Yes.
Q And they might even walk around with some injections on them ready to give things like Midazolam in the pre-op setting; right?
A In some cases, yes.

Q Yeah. And what you're looking at, in terms of the record that you're referencing, the Midazolam on page 2 of the government's exhibit, comes from the intra-op notes; right?
A Yes.
Q And so this is a document that shows everything that happened in the OR; right?
A Yes.
Q This document does not show what happened in the pre-op holding area; right?
A Right.
Q Okay. So, in fact, if somebody, Dr. Jackson or you or a nurse, had given him Midazolam in the pre-op holding area, it wouldn't necessarily make its way to this document; right?
A It could actually make its way to the document. I could have been documented as being received before the patient entered the operating room.
Q And you say it could have. Does that also mean that maybe it would not have made its way into this document?
A Our practice is to put the medications at the time that we give them, so anything is possible but --
Q So your testimony is that the practice was to be as precise as possible; right?
A Yes.
Q Okay. Well, let me show you -- well, actually, let me ask this. Let's go to the first page of this document. What is

this first page, the pre-procedure status? What is that?

THE COURT: Just for the record, we're talking about No. 2; right?

MS. PARMER: This is -- yeah, Government 2, page 1.

THE WITNESS: This is just giving general information about the patient, what the diagnosis is, what the procedure is.

BY MS. PARMER:

Q That would happen in pre-procedure; right?

A This would not necessarily happen pre-procedure. This is just information about the procedure.

Q Okay. And what does this information right here say? What does it say about beta blockers?

A No beta blocker as outpatient not indicated.

Q What does that mean?

A Some patients take a medication called beta blockers for their heart, hypertension or just to slow their heart rate down. Typically if they are on that medication before surgery, we try to give it to them the day of or during surgery to continue the effect of the medication throughout their anesthesia care.

Q And so your understanding is that this indicates that he did not have that medication on that day; right?

A Yes.

Q Okay. I'm going to show you what's been previously

admitted and marked as Government Exhibit 1. Are you familiar with this VA pre-op verification sheet?

A Yeah. I remember it.

Q So this is a standard sheet that was used in the VA where you were working as a resident; right?

A Yes.

Q Okay. And I'm going to turn to the anesthesia section. You're familiar with the anesthesia section; right?

A Yes.

Q Okay. You didn't complete the section; right?

A No.

Q Okay. Tell me, what does it say about beta blockers as it relates to [redacted] in Government Exhibit 1?

A It says that he was on beta blockers.

Q Okay. So basically this looks as though it's inconsistent with Government Exhibit 2; right?

A Yes.

Q Okay. So despite perhaps our best efforts to be precise, it's conceivable and, in fact, we have evidence that records are not always accurately reflecting reality; right?

A Yes.

Q Okay. Now, as to Government Exhibit 5, you should have a copy of this; right?

A Yes, I do.

Q You describe this as listing all the medication that

[redacted] would have been given during the surgery; is that right?

A Around the time of surgery.

Q What do you mean by around the time? Before? After? During?

A Probably before and after.

Q Okay. And this also has a timestamp; right? A date and a time stamp to the far left side?

A Yes.

Q Okay. So you have before you this Government's Exhibit 5, and you also have before you this record that has the first page that we think has an error, Government's Exhibit 2. Let's turn to Government's Exhibit 2, the second page that lists the medications here. It appears -- correct me if I'm wrong -- that [redacted] upon entry into the OR was given, among other things, Fentanyl; correct?

A Correct.

Q And Lidocaine; correct?

A Correct.

Q Propofol; right?

A Yes.

Q I can't pronounce this one. Rocuronium; right?

A Yes.

Q All of these. And some of these are pretty heavy drugs; right?

A Yes.
Q Why don't you show me in Government's Exhibit 5 where those drugs that were alleged to have been administered at 11:29 or 11:27 are in this record. Just point them out for me, the Propofol, the Lidocaine, and everything in this Government Exhibit 5.
A They wouldn't be in this record.
Q Okay. Why would they not be in this record?
A Because these are the medications that were given before or after the surgery, not during surgery.
Q So this record does not show every medication that [redacted] was on during the surgery; right?
A I'm sorry. Which record are you talking about?
Q This Government's Exhibit 5 is not a complete picture of [redacted] medications; right?
A Not during surgery, no.
Q Okay. And this record over here is a record of what was given during surgery; right?
A Yes.
Q So even though it's important, like you said, to know kind of when something was given and what was given, this record doesn't include all of his medications --
MS. PROUT: Could you just specify which document you're holding up.
BY MS. PARMER:

Q This Government's Exhibit 5 doesn't have any indication of Midazolam whatsoever?
A From what I can see, no.
Q And no indication as well of Propofol; correct?
A No.
Q Lidocaine?
A No.
Q Okay. Fentanyl?
A Well, Fentanyl can be given. I haven't read through it.
Q Okay. You can go ahead and look through it. I'm going to have you turn to page 13 in Government's Exhibit 5. And we have here a resident, I believe, G. Kwayisi. Do you see that name?
A Yes.
Q Who's that?
A I'm not sure. I assume it's one of the surgical residents.
Q Okay. Now, in this pre-op holding area it's typical -- and, again, I understand that you don't remember a lot from that day. But it's typical to have a variety of different people in a position to be able to give [redacted] Midazolam; right?
A Yes.
Q Okay. So you would only be one of perhaps a handful of people that might have administered it to him; correct?

A Correct.
Q Now, in terms of this record, did you enter these drug quantities and amounts and times?
A Either I entered them or my attending anesthesiologist entered them.
Q Who would be the attending anesthesiologist?
A Dr. Jackson.
Q Okay. But you can't remember for sure whether you entered that or if Dr. Jackson entered them?
A I can't remember for sure.
Q Okay. And do you remember Dr. Jackson having any interaction with [redacted] in the pre-op holding area?
A No, I don't.
Q Okay. But it's conceivable that she could have; right?
A Yes.
Q Is there also like a nurse that does anesthesiology that could also have had interaction with [redacted] --
A Yes.
Q -- in the pre-op holding area? Who would that have been?
A I'm not sure, anybody who was working there at the time.
Q Okay. And you mentioned that this document, which is Government's Exhibit 2, has time that automatically populates, but also you can choose to enter the time as well; correct?
A Correct.
Q And so you can't say, in terms of your memory, whether you

just fill out the times automatically populate or whether you changed the time accordingly; right?

A Right.

Q Because you have no memory?

A No.

Q So there's a lot from this incident from two and a half years ago that you just can't testify to today because you have no recollection; correct?

A Correct.

Q You don't remember the entirety of your interaction with [redacted] in the pre-op holding area; right?

A Right.

Q You don't remember whether or not you gave him Midazolam in the pre-op holding area; right?

A Right.

Q But you do look at these notes, and you think that you gave it upon arrival in the OR?

A Yes.

Q You don't know if Dr. Jackson administered it in the pre-op holding area?

A No.

Q But that would have been typical for Dr. Jackson to do such a thing; correct?

A Not necessarily.

Q But it could be; right?

A It's possible. I don't think typical.
Q So you would say that it's typical to wheel somebody down the hallway to the OR without benzodiazepine sedatives to prepare them for the surgery?
A Yeah.
Q Is it also common to administer it in the pre-op holding area?
A Yes.
Q Okay. And it's also possible not just to Dr. Jackson, but a nurse could have administered it as well?
A It's possible. I don't recall what the policy was of the VA Hospital.
Q Okay. But you do seem to remember that he said he drank one to two beers a night?
A That was according to the medical record.
Q What record?
A That I was able to review.
Q What record is that?
A It was the pre-operative anesthesia evaluation.
Q Okay. Do you remember him saying that to you?
A No, I don't.
Q Okay. And it's possible that in any of these forms we have human error; correct?
A Correct.
Q We have people entering data into a system; right?

A Yes.
Q And so invariably sometimes some things are left out; right?
A Yes.
Q And sometimes some things are included that are incorrect; right?
A Yes.
Q In fact, as you look at this pre-op verification sheet, Government Exhibit 1, when compared to the first page of Government Exhibit 2, we have an error right here in this case; right?
A Yes.
Q Because he either was or wasn't on beta blockers, but these two directly contradict each other; right?
A Yes.

MS. PARMER: Okay. Nothing further.

THE COURT: Ms. Prout.

REDIRECT EXAMINATION

BY MS. PROUT:
Q Dr. Patel, let me ask you to look at Government's Exhibit 1. That's the pre-op verification form, the one that looks like this.
A I don't have a copy of that.
Q You didn't have a copy of Government's Exhibit 1 that --

MS. PARMER: I showed her my copy.

BY MS. PROUT:
Q Okay. First of all, the information that's being taken from this form, where is that information coming from? Who is recording that information?
A These are questions that are asked of the patient and being recorded.
Q Okay. So the question on page 2 on beta blockers, that would be a question that was asked of the patient?
A Yes.
Q And that response is based on his response?
A Yes.
Q And what does that mean, denies HTN?
A That means denies hypertension.
Q Okay. And would that be consistent with not receiving a beta blocker if you don't have hypertension?
A Not necessarily. People take beta blockers for various reasons.
Q Okay. So it's possible that the information on Exhibit 1, which states that the defendant was not receiving beta blockers -- I'm sorry -- that states that the defendant was receiving beta blockers, is different than the information on Government's Exhibit 2 that says no beta blocker as outpatient because Exhibit 1 is information that's being recorded by the patient; is that correct?
A The information recorded by the patient on Exhibit 1 would

typically be correlated with what's written on Exhibit 2.
Q Okay. When would beta blockers be indicated?
A If the patient had cardiac disease or a reason to be on beta blockers for a long period of time, that would be an indication they need to be on it.
Q Okay. And from your review of the medical record, was there any indication of heart disease or hypertension or other indications of beta blockers?
A No.
Q Okay. So the entry on Exhibit 2 would be consistent with the medical record?
A I would think so, yes.
Q Okay. If I could ask you to look at Government's Exhibit 2, which is the anesthesia notes -- and the page numbers are at the top -- please turn to page 8 of 10. On the box called Events, what is the first event that's recorded there?
A It's Start of Printed Intra-Op Record.
Q Okay. Now, the first event recorded, did that occur once the patient was in the operating room or did it occur before that?
A The first event was recorded after that.
Q Let me ask my question better. So what time is the event "Patient Arrives in Operating Room"?
A That is 11:27.
Q And does the record of events begin at 11:27, when the

patient arrives in the operating room, or does the record of events begin before that time?
A The record of events starts before that time.
Q Okay. So correct me if I'm wrong. It starts about 15 minutes before the patient arrives in the operating room?
A That's correct.
Q Okay. Now, you were asked some questions about what was recorded in Government's Exhibit 2, the anesthesia notes, and what was recorded in Government's Exhibit 5, the order summary. To make sure I understand, is there some other record that's not before you that could have additional medication that the patient was receiving before, during or after surgery? Or are these two the only records of the medications?
A These two would be the only record of the medications given.

MS. PROUT: Nothing further.

MS. PARMER: Just briefly, yeah, based on the redirect.

RECROSS-EXAMINATION

BY MS. PARMER:
Q But just because the medication is not in these records does not mean that somebody just failed to put it in after giving him Midazolam in the pre-operation holding area; correct?

A I think it would be very difficult not to record Midazolam, if that's what you're asking, because that's a controlled substance. And we have to account for every milligram given and return what's not used to the pharmacy.
Q But in terms of all the different people that could have possibly given him Midazolam, you can't say for certain whether all of those people entered every single drug onto this record; correct?
A Correct.
Q Let me show you -- you have a copy of Government's Exhibit 2 in front of you?
A Yes.
Q On this same page, page 8 of 10, do you see the second event, NPO status, Case Delayed or Cancelled? What does case delayed or cancelled mean?
A If the patient had had anything to eat or drink within the timeframe that's not appropriate for us to do anesthesia, they might delay the case for minutes, hours or cancel it outright.
Q Okay. So that's what that indicates right here?
A Yes.
Q So typically -- and, again, we're operating in this realm where you're just going to talk about what's generally -- what's typical at the VA. You would expect the patient to fast after midnight the night before the surgery; right?
A Not necessarily. Patients need to be fasting for eight

hours before surgery. So if their surgery is not until the afternoon, they may be allowed to eat and drink early in the morning.

THE COURT: Ms. Parmer, we're on recross, which is sort of the exception, not the rule. This is starting to feel like other ground that could have been plowed in cross and not specifically relating to new things that came up in redirect.

MS. PARMER: Well, my position is that on redirect she testified to kind of how this events portion of this document, specifically on page 8 out of 10, shows a timeline. And so what I'd like to show is that that timeline is again inconsistent with the previous government exhibit, and she testified to this specific timeline.

THE COURT: All right. I'll let you, but we've got to be brief in recross.

MS. PARMER: Okay. This is my last thing.

THE COURT: Okay.

BY MS. PARMER:

Q Okay. So I'm going to show you again Government's Exhibit 1, which is this pre-op verification. And we have right here from the nurse an indication that patient fasted appropriately; correct?

A Yes. That's correct.

Q But here we have the case delayed or canceled; right?

A Yes.

Q So we have again another inconsistency in the record; correct?
A Correct.
MS. PARMER: Okay. Nothing further.
MS. PROUT: Just on that subject.
THE COURT: Okay. Yes.
FURTHER DIRECT EXAMINATION
BY MS. PROUT:
Q Are these actually inconsistent with the -- I mean, it says case delayed, but then the case seems to have proceeded.
A It's possible the case was delayed. It may have been scheduled for an earlier time and just ended up being delayed until the patient was appropriate because they have anesthesia.
Q So there's nothing in this report where it says NPO status suggests that the NPO was not in place. Is that fair?
A That's fair.
MS. PROUT: Okay. Nothing further.
THE COURT: All right. Dr. Patel, thank you very much. You may step down.
THE WITNESS: Thank you.
THE COURT: May this witness be excused?
MS. PROUT: Yes. Thank you, your Honor.
THE COURT: Dr. Patel, you're excused. You may step down.

It's about ten of 12:00 now. I don't know if anyone needs a break or if you have a witness that we could get to the 12:00 o'clock hour or --

MS. PROUT: We do have a very -- we have at this point two remaining witnesses expected, and they're both very brief. We're happy to do them before or after lunch at your Honor's convenience.

THE COURT: When you say very brief, what's your estimate?

MS. PROUT: The next witness should be under ten minutes.

THE COURT: Okay. Anyone need a break before we get that one, at least that one done?

THE DEFENDANT: Can I just stand up for like two seconds? I won't leave the room. I just --

THE COURT: That's fine. Yes, that's fine. So all right. Looks like your agent is getting him anyway, so we'll at least get through this one. Then we'll talk about when we want to break for lunch at that point.

COURTROOM DEPUTY: To the witness stand. Please raise your right hand.

HARVEY CLARK,

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

COURTROOM DEPUTY: Thank you. Could you please state

and spell your name.

THE WITNESS: My name is Harvey Clark, H-a-r-v-e-y C-l-a-r-k.

COURTROOM DEPUTY: Thank you.

DIRECT EXAMINATION

BY MS. PROUT:

Q Good morning, Mr. Clark.

A Good morning.

Q Mr. Clark, where do you work?

A Atlanta VA Medical Center in Decatur.

Q Were you working at the Atlanta VA Medical Center on October 23rd, 2015?

A Yes, ma'am.

Q Do you recall an incident happening with a patient that day?

A I recall what a patient said when he was coming down the hall, what he said, raised up and said. The patient raised up in the bed and said, I got one up on you guys.

Q Did you see or hear anything that happened before that moment?

A No. No, ma'am, I didn't.

Q Okay. So at that moment you said the patient raised up out of the bed. He was going from what position into what position?

A He was on the way to have his operation.

Q Okay.
A Yes, ma'am.
Q And when he spoke those words to you, was he lying down or was he sitting up?
A He was lying down and kind of raised up.
Q Okay. Do you remember if his speech was slurred or if he sounded funny at the time?
A He didn't sound like it to me.
Q Okay. What did you understand his words to mean?
A I got -- later on got the interpretation he mean he copped a feel.

MS. PROUT: Okay. I have nothing further for this witness.

THE COURT: Ms. Parmer.

MS. PARMER: Judy very briefly.

CROSS-EXAMINATION

BY MS. PARMER:

Q Mr. Clark, you say later on you got an interpretation of that --
A That's the interpretation I got then.
Q Okay. So at the time you had no idea what he was talking about?
A No, I didn't.
Q You'd never seen this man before?
A No, I hadn't.

Q You didn't know what he was referencing? It didn't really make sense to you what he was saying; right?
A No, ma'am.
Q It was almost nonsensical kind of; right?
A Right.
Q It kind of sounded like he was, you know, kind of playing around with you as though he knew you, but he didn't; right?
A No, he didn't.
Q Okay. Was it strange to you?
A Yes, ma'am, it was.

MS. PARMER: Okay. Nothing further.

THE COURT: Any redirect?

MS. PROUT: No, thank you.

THE COURT: All right. Mr. Clark, thank you very much. You may step down.

And is the next witness is about the same timing or --

MS. PROUT: He may be two minutes longer.

THE COURT: Okay. Any objection to finishing that up at least before we break for lunch?

MS. PARMER: No.

THE COURT: Okay. Great. You may --

MS. PROUT: We'd call Sonya Cromwell, your Honor.

THE COURT: Okay.

COURTROOM DEPUTY: Please stand and raise your right

hand.

SONYA CROMWELL,

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

COURTROOM DEPUTY: Thank you. Would you please state and spell your name.

THE WITNESS: Sonya Cromwell, S-o-n-y-a.

COURTROOM DEPUTY: Cromwell?

THE WITNESS: C-r-o-m-w-e-l-l.

COURTROOM DEPUTY: Thank you.

DIRECT EXAMINATION

BY MS. PROUT:

Q Good morning, Ms. Cromwell.

A Good morning.

Q Can you tell us what your current position is.

A I am chief counsel for the VA over the continental district east. So that includes Louisiana, Arkansas, and Mississippi.

Q Where were you working back in November of 2000?

A I was working as staff attorney in the Atlanta regional counsel's office.

Q And were you working there in March of 2001 as well?

A Yes.

Q I'm going to show you Government's Exhibit 3. Tell us what Government's Exhibit 3 is.

A This is the -- there's a cover letter that is transmitting the cession of concurrent jurisdiction between the VA and the state of Georgia.
Q And can you tell us what the last page of the document is.
A The last page is a fax cover sheet that I sent on March 7th, 2001, to the VA post department at the medical center showing them that we had gotten all the papers executed for concurrent jurisdiction.
Q So were you in the legal department of the Atlanta VA at the time that the concurrent jurisdiction agreement between DeKalb County and the federal government was being negotiated?
A Yes.
Q And does Exhibit 3 contain a true and correct copy of the agreement of cession of concurrent jurisdiction?
A Yes.
Q And as far as you're aware, is the agreement still in effect today?
A Yes.

MS. PROUT: I'd move to admit Government's Exhibit 3.

MS. PARMER: No objection.

THE COURT: All right. It's admitted.

(Whereupon, Government's Exhibit 3 was marked for purposes of identification and admitted into evidence.)

BY MS. PROUT:
Q Last question. Is the VA Hospital located in the Northern

District of Georgia?

A Yes, it is.

MS. PROUT: Nothing further.

THE COURT: Very good.

MS. PARMER: I have no cross-examination for this witness.

THE COURT: Very good. You may step down. Thank you very much. You're excused.

THE WITNESS: Okay.

THE COURT: All right. Why don't we -- I take it you're likely to rest at this point; is that right?

MS. PROUT: Yes.

THE COURT: Okay. So why don't we take a break for lunch, let's say an hour. Let's return at 1:00. Then we'll take up any motions and then start with the defense's case in chief at that point. All right. So we'll be in adjournment until 1:00 o'clock.

(Whereupon, a recess was taken from 12:00 p.m. until 1:00 p.m.)

COURTROOM DEPUTY: All rise. Court is again in session, the Honorable Justin S. Anand presiding.

THE COURT: Thanks very much. You may be seated. When we broke, the government was about to rest, I guess. Does the government rest?

MS. PROUT: Your Honor, the government would just

offer a redacted version of Exhibit 5 and replace it with the one that was previously submitted, if I may.

THE COURT: Okay. Very good. You may hand that up.

MS. PROUT: And the government does rest.

THE COURT: Okay. Great. Any motions?

MS. PARMER: Yes, your Honor. We have a motion for directed acquittal at this time under Rule 29.

So what we have from the government's case is this evidence, that [redacted] was in a hospital setting about to undergo a very serious surgery. He was headed to the OR when the witnesses testified that on a gurney he sits up, and he makes physical contact with a nurse's behind with another resident anesthesiologist present, and then it sounds as though, from Harvey Clark's testimony, he then sits up again and says something like I got one up on you, guy.

Given those facts, we have to also consider the possibility of the affirmative defense under 18 U.S.C. 17, which is technically the insanity defense. But how we proceed is we use this test in cases where you present evidence, testimony, and a defense of involuntary intoxication. And I believe that what you've seen thus far is sufficient to get us here to this affirmative defense and find [redacted] not guilty.

So we have Etta Marie's testimony that she cannot give medication in that pre-op holding area setting. She does

not know whether he had been given Midazolam, but it's entirely possible. She also notes that on the pre-op verification sheet we may not have seen the Midazolam there, and Kinnari Patel also corroborates that. We know that his pain was a 10 out of 10, that he arrived there around 10:00 a.m., and was seen by a series of doctors and nurses, including a Nurse Zauphia who's on page 2 of the pre-op verification sheet under the anesthesia section. Etta Marie and Kinnari Patel have testified that this could have been somebody who could have administered Midazolam, and it would have been typical.

We also have testimony from Patel that Dr. Wykena Jackson was her supervisor, and therefore Dr. Jackson was making the decisions about the course of medication and treatment because Dr. Patel was a resident and not a full-fledged fully licensed medical doctor at that point.

There was also reference that another nurse anesthetist could have possibly given the medicine, and we know that in the record there's some reference to another resident who had some notes from the time before being wheeled out in the OR. And so we have evidence upon evidence that there are a lot of different practitioners interacting with [redacted] in a setting wherein it would be entirely typical to have given him a drug that we have evidence is intoxicating.

Consistent with that evidence we have evidence that [redacted] behavior, as reported by these witnesses, amounts to behavior that would be conceivably the kind of behavior we'd see with an intoxicated person. We have him holding a penny. I don't know why he has a penny while he's about to be going into the OR holding. He's holding a penny and saying he's a stripper. He says to the janitor, who himself testified that it seemed very strange, especially because he had never seen him before; he had never interacted with him before. He says to the janitor, I've got one up on you, guy.

And we have testimony that this was seen as bragging or bragging to brag about committing an offense that's a crime. I think it's also relevant because it goes to this convoluted intoxicated mental state. We don't brag about crimes after committing them.

So what 18 U.S.C. 17 says is that it's an affirmative defense to a prosecution under any federal statute, that at the time of the commission of the acts constituting the offense, the defendant was unable to appreciate the nature and quality or the wrongfulness of his acts.

We have a lot of evidence that [redacted] was alleged to have been acting like an intoxicated person. We have a lot evidence that it would have been typical that he was given an intoxicant right before being wheeled down the

hallway.

And we do have Patel. Now, Dr. Patel, again, is one of conceivably four people we've heard about who could have given him Midazolam in the pre-op holding room. However, she has no recollection. Her memory is so thin. That's all she was able to testify to today was her paperwork, but she could not rely on her own memory. She did not remember what exactly she had administered to him and when, so she used the document to refresh her recollection. And that's another issue that we have thus far, and that kind of goes to that it's the government's burden of proof.

We have these records that have been introduced as evidence that have glaring inconsistencies. We don't even know who JM is, no initials, no name, no signature. That's on the Government Exhibit 1, the pre-op verification. We have his NPO status being at some point 10:00 p.m. or 10:30 p.m., and before that it's 9:00 p.m. He is on beta blockers; he's not. And so as a result, we have inconsistent recordkeeping, and we also have Patel's testimony that even with that timeline sometimes it can self-populate. So if she walks into the OR and maybe had already given him Midazolam, she might just start her record there as opposed to entering the time in herself, just allow it to self-populate.

But given these inconsistencies and given the entire body of evidence as we have it right now before us, I think we

have beyond clear and convincing evidence that [redacted] was involuntarily intoxicated. He did not inject himself with anything, and therefore we need the standard under 18 U.S.C. Section 17.

And, further, I think the government's burden of proof as to the mens rea and the voluntariness is also not there. They have to prove beyond a reasonable doubt that there was volition, that he voluntarily did this. And given the totality of the facts and the evidence before the Court at this time, they haven't done that. So that's why at this point we are going to move under Rule 29 for a directed verdict of not guilty.

THE COURT: Ms. Prout.

MS. PROUT: Under the statute that's invoked by the defense, 18 U.S.C. 17, it is the defendant's burden to establish by clear and convincing evidence that the defendant was acting in a state of insanity. So there's a couple things to break that down.

First of all, it's the defendant's burden to put on affirmative evidence by clear and convincing evidence. Now, that evidence can come in through the government's witnesses, but there still has to be affirmative evidence rather than speculation and innuendo through the defense's own questioning. It has to be evidence, and it has to be clear and convincing and has to be put on by the defendant.

There has been no affirmative evidence whatsoever that the defendant was given any mind-altering medication before the events took place. The affirmative evidence was all to the contrary. The medical record confirms that the medication was given after the event. We heard Dr. Patel talk about the practices of creating medical records and that the time entries in her experience are accurate. We heard that there are medical stations, both in the pre-op area and in the surgical area, so that the medication, had it been given in pre-op, could easily have been entered in the pre-op area.

There are a few other legal problems with a defense under the Insanity Reform Act. First of all, no Rule 12.2 notice was ever given of an intent to rely on that defense, and if your Honor recalls, the defense objected to the government's ability to obtain medical records beyond those of this particular surgery in the event that such an argument or defense was raised. And so to the extent there's any other relevant medical facts in the defendant's history, we've been deprived the opportunity to review those, and we've been deprived notice of such a defense.

But the evidence itself here simply doesn't support their argument of involuntary intoxication, let alone insanity at the level required by 18 U.S.C. 17. What we have is evidence of inappropriate behavior, both inappropriate conduct in grabbing a woman's behind and inappropriate statements and

then bragging about that. There's nothing about that conduct or behavior that is remotely consistent with the type -- the standard of insanity set by the Insanity Reform Act of 1984. And the purpose of that act was specifically to disallow defenses of a lesser impaired mental state and to make clear that if mental state is going to be used as an affirmative defense to defeat a claim of criminal conduct, only a mental state that rises to that level of insanity may be relied upon.

The evidence of a defendant grabbing someone's behind, bragging about what they did, and generally having flirtatious and inappropriate behavior with nurses, if that were evidence of insanity, then we would be living in a very different world than we are.

As for the evidence of general intent, there are sort of two prongs, I take it, to defense argument. One is that there's an affirmative defense which requires their showing by clear and convincing evidence and which requires an establishment that defendant was acting temporarily insane.

The other argument, as I take it, is an argument that the government has not shown the requisite general intent to meet its burden under the elements of simple assault, and there again that is not the case. First of all, I have not identified any cases, whether cited by the defense or otherwise, of an instance where involuntary intoxication was accepted to negate general intent. And that's because the

standard for general intent is so basic, so much lower than specific intent, and is traditionally shown by the act itself.

There's, I think, an instructive third circuit case that talks about the standard for general intent. It's *U.S. v. Pohlot*, 827 F.2d 899, and it says that --

THE COURT: I'm sorry. 827 F.2d -- what was it?

MS. PROUT: 899. It says that mental abnormality can virtually never disprove the mens rea requirement for general intent crimes. And if I recall, that case is actually looking at some issues of involuntary intoxication. And the reason is because the requirement to establish general intent is so basic. It's simply a requirement that the defendant was acting intentionally involuntarily. He does not need to have had any higher mental state than that, and I would submit that the witnesses shown by the government easily establish that level of intent.

THE COURT: Let me ask you the question -- and really this relates more to a question that I think I might have down the road, but I don't know that it impacts the Rule 29 issue but since you brought up general intent. Focusing, as we are, only on Count 2, simple assault charge, the way I look at the elements of that offense and the way in which assault is typically formulated, there are really two species of assault. One is attempt to injure or engage in offensive touching, and the second is acts or conduct that serve as a threat, that put

the victim in reasonable apprehension of an imminent such touching.

And I gather we're not talking about the second prong here because this was not apprehended because Ms. Marie didn't see it coming. So it wasn't a threat of -- it wasn't conduct that would have put the victim in reasonable apprehension of an imminent touching. It happened before she knew it. So we're talking about the former, which is an attempt to engage in -- to inflict injury or offensive touching which is -- which includes the doing of it. Obviously attempt includes successful attempt but is not attempt.

I mean, I get the engaging in acts, the second prong, engaging in acts that would have threatened a touching would be general intent but is not attempt, the first prong of assault, inherently a specific intent crime, the attempt to engage in a crime. Attempt is typically quintessentially considered a crime of specific intent, is it not?

MS. PROUT: Respectfully I disagree, your Honor. If you look at Section 113, there are different types of assault identified in 113, and some of them are given express mental states in the statute and some are not. And the Eleventh Circuit -- and I don't have the case at my fingertips, but it is in our papers. The Eleventh Circuit has specifically analyzed 113(a)(5) and held that it in its entirety is a general intent crime.

And while I take the point of the Court between parsing the attempt from the act, it's a little bit artificial in this setting in that, to your point, the issue is not so much the witness seeing it coming and the moment before it occurs. The issue is the doing of. And I would say that attempt in that regard is actually very consistent with general intent because all that's excluding is somebody whose hand gets knocked accidentally into another or somebody who is involuntarily thrown into another and is not actually intending to do the act.

So I believe that this question has been answered by the Courts. I don't know that they've parsed it in the precise manner that your Honor has, but they have absolutely passed on the question of whether or not 113(a)(5) is a general intent crime, and they have found that it is.

THE COURT: Okay. All right. I didn't mean to cut you off.

MS. PROUT: I mean, there -- I think that's -- I'm going to rest at this point. I understand, your Honor. I hope I have the opportunity to present more at closing, but I will rest at this point.

THE COURT: Okay. Well, I'm going to deny the motion. We're here under Rule 29 at this juncture, which Rule 29 is the rule that provides that at the close of the government's case, if there are no facts in the record that

would justify looking at the facts in the light most favorable to the prosecution, upon which a fact finder could rely in entering -- in deciding on a verdict of guilty, then it's the Court's obligation to dismiss the case.

It's not at this juncture appropriate for me, even though I am the fact finder, to weigh evidence and decide what I think is the correct conclusions to be drawn from conflicting evidence. Rather, the conclusion is solely viewing the evidence in the light most favorable to the prosecution could a fact finder reach a verdict of guilty here in this case. And so the answer to that is yes.

There's conflicting evidence about the medical records, about whether the defendant was administered the Midazolam prior to the incident, the alleged assault. Maybe not conflicting evidence, maybe that's not the best way to put it, but there's the documentary evidence shows that he was not administered the drug before the incident, and we heard no testimonial evidence otherwise.

We heard from Dr. Patel that there's importance -- and generally it's considered very reliable -- to accurately note the administration of drugs such as Midazolam -- I don't know if I'm pronouncing that correctly -- in part because it's a controlled substance, and they have to account for every milligram. There is importance to accurately recording when it is administered and in what doses. I assume also it's

important for patient safety as well.

But we did hear evidence suggesting that in certain respects these medical records are not completely -- or a fact finder could find they are not completely accurate in certain ways. And so there is certainly evidence that a fact finder could question her or doubt the reliability of the records, but, again, I'm at this juncture looking at the evidence in the light most favorable to the prosecution, which is, again, that it shows that the drug was not administered until after the incident, the alleged assault.

Similarly, even if he had been administered the drug prior to the incident, there is evidence from which a fact finder could nevertheless find that the defendant had the requisite intent. Whether specific intent or general intent, I think viewing the testimony in the light most favorable to the prosecution, including Ms. Marie's statements where the defendant stated that I waited to get the medication so I could get away with it, supports a finding of intent, notwithstanding potentially being under the influence in some way of Midazolam or some other substance could be seen by a fact finder as basically an admission of pre-calculation and an intention to do the act as well as an understanding and knowledge that it was unlawful because it's talking about creating an excuse or waiting until there be an excuse to do it.

So even if -- and I'm making no findings on the legal issue of whether insanity defense applies, whether 12.2 is a problem or not. Even if it were to apply, there's evidence from which a fact finder could find in the government's favor on that question, certainly that particular issue given that it's a high burden on the defendant to show insanity. But even as to the existence of intent, whether it's general intent or specific intent, which is something we can get to -- I still have some questions about, which that would be the government's burden to show beyond a reasonable doubt -- there's evidence from which a fact finder could make that finding in the government's favor. So I'm going to deny the motion, the Rule 29 motion.

Are y'all ready with the defense case in chief?

MS. PARMER: We are.

THE COURT: Okay. You may call your first witness.

MS. PARMER: I'll call Dr. Joel Zivot. You can go right here. Have a seat on the witness stand.

COURTROOM DEPUTY: Please stand and raise your right hand.

JOEL ZIVOT, M.D.,

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

COURTROOM DEPUTY: Thank you. Would you please state and spell your name.

THE WITNESS: Joel Zivot, J-o-e-l Z-i- v like Victor -o-t.

COURTROOM DEPUTY: Thank you.

DIRECT EXAMINATION

BY MS. PARMER:

Q All right. Hi, Dr. Zivot.

A Hello.

Q Where are you currently employed?

A I'm employed at Emory University.

Q And what do you do at Emory University?

A I'm a physician. I work in the area of intensive care and a member of the Department of Anesthesiology.

Q Okay. How long have you worked in anesthesiology?

A Well, I graduated in 1995, so it's been 22, almost 23 years.

Q Okay. I'm going to show you what has been previously marked as Defense Exhibit 2, and let me know if you recognize this document.

A Yes, I do.

Q What is it?

A It's my CV.

Q Okay. And you mentioned that you graduated from medical school. Why don't you kind of walk us through the CV and tell us a little bit about some of your training and experience in the realm of anesthesiology.

A Sure. Well, I graduated from medical school actually in 1988. Then I went to the University of Toronto, and I spent five years there completing a first year what was called a PGY one year or internship and then four years of training as a specialist in anesthesiology. I completed my training there in 1993, and then I wrote specialist exams in Canada and was given a designate of a fellow of the Royal College of Physicians, which is what a specialist in anesthesiology and other medical specialties are referred to.

And then from there I went to the Cleveland Clinic in Cleveland, Ohio and did two additional years in anesthesiology and intensive care and then sat for the boards in -- that are offered by the American Board of Anesthesiology. And so I'm boarded as an anesthesiologist and an intensivist both in the United States and Canada, and all of that training finished in 1995.

Q Okay. And then when did you come to Emory?

A I came to Emory in 2010.

Q Okay. And so from 2005 to 2010, what other positions or appointments did you have?

A Well, I can -- I guess I can go through them from the, if you want, from when I finished my training?

Q Yes.

A So I finished my training in 1995, and then I went to the University of Michigan. And then I was on the faculty there

for three years. And then I was recruited to go to Case Western back in Cleveland. They were starting there a heart transplant and lung transplant program, and I had expertise in those things. So I was recruited there to Case, and then I was there for seven years.

And then I went -- took a position in the District of Columbia. I was again offered a position as a director physician, which I took, and then I was there just for two years because I was recruited for another position in the University of Manitoba back in Canada where I'm from, like a position with more responsibility. And so I took that too. And then after that -- I was there for a few years, and then I left there and came to Emory in 2010 again for a recruited position.

Q Now, in terms of the licensures and the boards that you've mentioned, is there some sort of process where you have to keep up on your education and your training to maintain current status with those?

A Well, because I graduated in 1995, I'm considered to be grandfathered, which is a term I do not like that much, but nevertheless that's what they call it. But as a consequence of being in academic medicine my whole career, I've been a teacher and in many capacities. And under the normal practice of an academic, I'm responsible for staying current, and so although there's no formal research education requirement, at

this point it's a necessary part of my job and my work to continue to be up to date.

Q Okay. And do you participate in publications or any writings in the field of anesthesiology?

A Yes. I have given lectures in a variety of subjects. I also have an area of interest in both, again, in anesthesiology and intensive care. So I've spoken on both of those subjects, and I've written some on those subjects. I also have an MA in bioethics, and so I've written and spoken about subjects whether it's bioethics. But I have many different subjects also that I've spoken about and written about.

Q Are you part of any -- are you part of the peer review process in that you review the work of other people in your field?

A Yeah. I've been involved in peer review in several different publications, been asked to review publications in chiefly critical care medicine, which is probably the most imminent critical care journal, and I'm an advisor on some publications in that journal. I've also worked in other journals as well and asked to review publications for peer review.

Q So, if you could, kind of look through what we've previously marked as Defense Exhibit 2 and make sure that it is up to date and current and that it looks to be in order as

you remember it.
A There's an additional publication that I've added since this has come out, but other than that, it looks right.
MS. PARMER: Okay. At this time we move to admit Defendant's Exhibit 2 into evidence.
MS. PROUT: I don't believe CVs are admissible here as hearsay. We have the witness to testify about his background.
MS. PARMER: I think that it's admissible.
THE COURT: Well, it would go to his qualifications as an expert. Is there any objection to the defendant --
MS. PARMER: I'd also move to admit him as an expert.
MS. PROUT: We don't object to qualifications.
THE COURT: All right. So I will accept Dr. Zivot as an expert. I do think, especially given that the CV is really unnecessary, but it is hearsay. I would agree with that. So I'll sustain the objection as to the CV. But his expert -- excuse me. His testimony is accepted as expert testimony.
BY MS. PARMER:
Q Okay. Dr. Zivot, why don't we start with how you got involved in this case.
A Sure. I think I was approached and asked by your firm to review these records and asked questions about specifically the effects of Midazolam and how Midazolam would alter a person's conduct with respect to their decision making and

comportment to demeanor. And that's how it began for me.
Q So it sounds as though you reviewed some documents. What did you review in preparation to provide your opinions in this case?
A I reviewed the medical records, and I reviewed a series of exhibits that were given to me that I think are numbered that you have.
Q Uh-huh. And did you also kind of rely on any knowledge or training or experience that you had beyond these specific records?
A Well, you know, as a long practicing anesthesiologist, when I was looking at these records, of course I put myself in the place and imagined -- considered how I would normally conduct such an anesthetic and what the normal practice is having, you know, conducted and observed it and taught it for a number of years. So those are the things that I considered while I was reviewing these documents.
Q Okay. And when we spoke and you had an opportunity to review the records, did you find anything in the records -- and let me know if you did or if you did not -- that would indicate whether [redacted] had received Midazolam in a pre-operative setting?
A I could not find any specific documentation that identified whether or not [redacted] had received pre-operative Midazolam.

Q Now, kind of along that same vein, did you feel as though the records that you reviewed, the discovery in this case, were in your opinion a complete picture and all of the records that should have been taken for this type of procedure?
A Well, I think that, you know, the records -- I think this is Exhibit --
Q Here. I'll give you a --
A -- 1.
Q Yeah, Government's 1. So we have Government's Exhibit 1, the pre-op verification sheet; Government's Exhibit 2, the intra-op notes; and then Government's Exhibit 5, which is an order summary with medication.
A So these documents are the -- in Exhibit No. 1 I think that each institution will lay out these sorts of documents in their own particular way. So there's not a kind of standard national document. In its format there are standard things that are required to be checked. Some of these things, again, are local decisions; some of them are national decisions. But these forms, of course, are designed to eliminate the need to free hand or to try to rely on memory to be certain that certain things are done.

So this form, again, has many things that an institution requires and for various groups of individuals who are to attest to the jobs that they're supposed to do to make sure that the patient is ready to go to the operating room.

Q So let's talk about, first, Government's Exhibit 1. So what really is this document to you having been an anesthesiologist as long as you have been one?
A So, again, it's a series of -- it's a checklist of various things by various people who, again, share the responsibility of providing a safe surgical procedure. The thing I would comment on is that in both pages here there are things that are scribbled -- well, I shouldn't say scribbled -- written in the margin free hand. And so I interpret those things to be things that the document either should have had and wasn't placed or a person decided that it needed to be included.
MS. PROUT: I'm going to object. This is speculation. The witness has testified he doesn't have personal knowledge of the VA's recordkeeping.
THE COURT: I'm going to sustain that, if you can rephrase it perhaps. I'm going to sustain the objection.
BY MS. PARMER:
Q Okay. So let's look at Government's Exhibit 1. And in Government's Exhibit 1 we have a number of kind of subsections here, and they appear to be signed off by different people. When you reviewed this document, would you have expected this particular document or is there any place on this particular document where if Midazolam was given in the pre-op setting, it would have been documented in this document?
A Well, this would certainly be a good place for it because

there is a section here that it says anesthesia on the second page.

MS. PROUT: Your Honor, the same objection. He is speculating about what should and should be on forms without talking about all the forms and without having any personal knowledge of how the VA maintains its medical forms.

THE COURT: Well, I think the question was slightly different. It wasn't going to the VA procedure specifically but, rather, Dr. Zivot's opinion as an expert in the field as to what he would expect from a pre-op verification document of this sort. And I think that he can testify about that, so I'm going to overrule the objection.

BY MS. PARMER:

Q Have you seen pre-op verification forms before?

A Yes, I have.

Q Okay. And is it fair to say you've seen them a number of times before?

A That would be fair.

Q Okay. And is this the type of form, the pre-op verification form, where you would see a pre-operative holding area delivery of Midazolam?

A Well, this would be a place -- it would either be on this place in this form or it would be in the anesthetic record. So anesthetic records actually have a location that would provide a space where one would document that a pre-operative

medication was given.
Q Now, on this form that you've reviewed, when you reviewed all the discovery, we have this section here on page 1, the pre-procedure medication given, if ordered, and it says no. What struck you about that, if anything?
A So sometimes medications -- I might order a medication to be given to a patient, and by placing an order, what I am now doing is instructing a nurse to go ahead and, say, give a medication. That would be one way of giving a medication to a patient prior to an anesthetic.

Another more common way is where I myself would administer the medication, and I don't need to give an order to myself in order to do that. That would not be documented there. That would just be part of what I would do, and I would include that in, you know, in my record in some fashion, depending on what the record specifies. And if there's a place to place a pre-operative medication, I would put it there, and if there isn't a place, then I would put it in another form.
Q Okay. Now, in terms of this form, did you see a place on this form to put, for example, the anesthesiologist themselves to put a record of giving Midazolam in the pre-op setting?
A No.
Q Okay. So when you looked at this, based on your experience and your training, not seeing Midazolam accounted

for on this form, did it make you think that it wasn't given necessarily?

MS. PROUT: I'm going to object to leading the witness, your Honor.

BY MS. PARMER:

Q Why don't you tell me a little bit about why -- well, let's shift gears, and we'll come back to this then. When you reviewed this case and you saw all of the documents and the discovery before you, were you able to make a conclusion about what typically would have been the procedure in the pre-op holding room for this type of surgery, this type of patient?

A Sure.

Q Okay. What do you think would be typical as it relates to a Midazolam administration?

A So under the normal common practice, I would -- if I was the anesthesiologist doing this exact case, I would, first of all, prepare the operating room and -- actually, let me back up. I would, first of all, of course review the case, decide what was going to be done, review the medical records, and then I would, based upon that, I would also, of course, go and examine the patient, talk to the patient. And then I would go get my operating room ready, and I would select the medications that I would use and so the operating room would be ready to provide a safe anesthetic.

And then I would go from the operating room to see

the patient pre-operatively. And in the typical conduct of anesthesia, it might be the first time I meet the patient would be right there in the pre-operative holding area. In our modern practice now patients don't come to the hospital often the night before. They come the day of. And so we're meant to meet them on that day, and we don't get to meet them too far in advance. And so you've kind of had to rely on a paper record up until that time.

So then I'll see the patient, and at that point either I or a nurse in the pre-operative holding area will generally start an intravenous. Intravenous is necessary to deliver all the medication that is going to be administered. So at that point again I'm talking to the patient and explaining to the patient what the plan is. And if there is a possibility of different ways that it might be done, I might offer a patient a choice, if I thought a choice was, you know, needing to be offered. Ultimately, of course a patient consent has to be able to be -- able to consent to what I'm doing, agrees on my plan.

And then after we've, you know, discussed it and we've agreed and intravenous has begun, the next thing that I would do is I would, again, very commonly administer some form of intravenous sedation. Usually Midazolam is used, and Midazolam is used here for some very specific reasons. It's used here because it is effective at creating relaxation. It

works -- its onset of action is quite rapid, and it creates the reduction of anxiety. It creates calmness, and it creates, you know, a state of, you know, of -- well, the word that I know I put in my report was intoxication. And that's fine because I don't really need the patient at that point to do anything other than to be calm, be relaxed, be cooperative, you know, to my direction. And that's really all they need to do.

Midazolam is also good because in the dosages that we classically give, it creates amnesia which, again, patients desire, and it creates the kind of calmness that doesn't render a patient unresponsive. And so what's peculiar about Midazolam is that when a person is administered Midazolam, they may chat and talk, and sometimes they can appear outwardly to be still fairly awake. And they speak in a way that seems like you might be talking to somebody who is in control of their faculties, but I've seen a variety of cases where people still again may say things that I recognize even though they're saying them with a clear voice, perhaps not what they would normally say.

And, also, afterwards, because of course I'll talk to my patients in the recovery room when it's done, they will never -- they won't recall the conversation at all. And it's quite striking how powerful the effect of Midazolam is. So outwardly a person may not appear to be falling over or

unconscious. They would still maintain their consciousness, but they're definitely altered cognitively as a consequence of the Midazolam. It's quite effective. And when I give it, of course what I'll also do is once I've given it, I'm staying with the patient, and now we're going to move out of the room into the operating room. And all the while I'm watching them.

If I give too much and the patient loses consciousness, then that's quite risky because now they're in kind of an uncontrolled environment. So Midazolam, again, is employed here in this -- in a smaller dosage that creates that balance of maintaining consciousness but still making them, you know, relaxed and somewhat intoxicated in a way that would be helpful in order for the conduct of the anesthetic. And that would be the normal way that we would do this.

Q And there's nothing in this pre-op verification sheet that made you think that this would not have -- this procedure in this pre-op holding area wouldn't have followed that same typical procedure prior to leading [redacted] down the hall?

MS. PROUT: I'm going to object again. I don't know that the witness is in a position to speculate about what was or wasn't done in the case of [redacted] He can talk about what the medical records say and don't say, but what was actually done is not simply what's captured on --

THE COURT: I'm going to sustain the objection. The

way it was worded was talking about the standard procedure, the normal procedure, and I think he acknowledges he's unable to say what the procedure was at the VA.

MS. PARMER: I was just asking him to testify to this document that he's reviewed and let us know if there was anything in here that led him to believe that they were not following the standard pre-op holding area procedure.

THE COURT: Sustain the objection. You can rephrase it. Again, I'm not sure I took his testimony to say there was a standard pre-op holding area procedure at the VA. I don't know that he's able to say that.

MS. PARMER: Well, he was able to say that typically Midazolam is given in the pre-op setting. And if this is the pre-op verification sheet, I'm just asking if there's anything in here that indicates either way, whether it was or was not given.

THE COURT: Well, why don't you reword it that way then without using --

BY MS. PARMER:

Q So in your review of this document, was there anything in here that either way gave you any indication that Midazolam was or was not administered?

A No.

Q Okay. Let's talk about what Midazolam does kind of chemically. So you said it renders somebody intoxicated, but

they're still able to speak. So you wouldn't necessarily see the same kind of outward sensory effects as alcohol; right?
A I think it's a function of dosage. So Midazolam, it creates in people, again, you know, relaxation. It takes anxiety away. They feel calm. They feel it's a pleasurable experience that people have. They feel loose. And I recognize that, you know, heading for surgery is a very anxiety provoking experience for people. I've had patients, you know, be tearful. And so if a patient is tearful, of course, that's not the kind of mental state that would be desired to begin an anesthetic.

And so I'm trying both with, you know, my words and with the medication to create this kind of state of calmness. And once we -- once Midazolam is administered, again, at that point the patient is not considered to be in a state where they would be able to consent. So the consent is done for the Midazolam. And after Midazolam, that's really the beginning of the anesthetic even before entering the room. That's normal practice.

And from looking at the anesthetic record at the VA, it looks like that's what they did. I mean, they practice in every other way that anesthetic looks like a very familiar well done anesthetic. There's nothing in there that makes me think they would deviate from that in any way in this case.
Q Who are the type of patients that you would not want to

give Midazolam to or in the pre-operative setting?
A So a patient that is critically ill, so a patient that is unstable with respect to blood pressure or breathing or something of that nature where even a small amount of sedation may further create risk of a loss of a normal breathing drive or a falling of blood pressure or something of that nature, a patient who is, frankly, you know, at baseline unresponsive or confused or something like that where in a sense they're already in a state that to certain degree I'm trying to achieve so there's no reason to add an additional dose of Midazolam.

It's really for a person and for younger people especially who generally have more anxiety. That would be the kind of person that I would, you know, specifically consider giving Midazolam.
Q Can you kind of explain the difference between being of sober mind versus being in the intoxicated state of Midazolam, and then also follow that up with certain things you as a physician would or would not do considering that mental state.
A So, again, under the -- under Midazolam -- Midazolam, let me say, also can be used as what's called an induction agent. So it can actually -- it's described to be able to be given in a larger dose to actually render a person unresponsive. Now, it's not used like that very often because there are, frankly, superior induction agents to Midazolam, but it really is

uniquely positioned, I think, as an induction agent and, rather, as a pre-operative sedation.

It's interesting to note that Midazolam is not available as an oral medication, not as a pill. It's only available to be injected. Now, people have taken the liquid form of it and have given it to patients, but it is meant to be only given in an operating room or in a controlled hospital setting under observation because of its going to -- powerful effects at interfering with people's capacity to make decisions. It's the kind of thing that if people took this medication at home, it would be very dangerous because they may -- outwardly others may observe them to think, well, they're okay, but clearly they would not be.

And so this drug is never prescribed, you know, as an outpatient's kind of medication. It's meant to be administered in a hospital setting at all times.

Q So in terms of thinking about it as a benzodiazepine, compare kind of the delivery and what you're saying about it to maybe something we can recognize as a more commonly known benzodiazepine.

A So as maybe a comparison, there are other kinds of benzodiazepines that are commercially available. A common one might be Xanax or Alprazolam. That's a drug that I think most people are familiar with, and that one is prescribed for a couple of reasons. It's prescribed for people who have sleep

disorders, but mostly it's really prescribed for people who have an anxiety disorder. And so in that circumstance you're giving a drug to someone who has the kind of anxiety where it is really a chronic condition.

And so in this case Alprazolam is intended to restore a person to kind of normal functioning from an anxiety producing state whereas Midazolam is not attempting to do that. Midazolam is taking a normal person or a person who's anxious in a circumstance where everyone would agree that that would be a reason to be anxious and then removing anxiety, frankly, to a person who under normal circumstances should be anxious.

So in that way I think the distinction is important that Alprazolam is for people who have anxiety in circumstances where perhaps they shouldn't, and Midazolam is for people who have, you know, to numb and remove anxiety and create a disinhibition and people who, frankly, should be a little bit inhibited and should be a little bit anxious. But it helps -- you know, understand that it helps. And, again, once I've given it to them, you know, I consider them to be incapacitated with respect to anything other, you know, than following my directions.

And, you know, sometimes even in a small dosage, again, people are not that cooperative. They don't mean to be, but I've seen patients who, you know, are, after

Midazolam, are not able to follow my directions. And that's, you know, that's just a finding with Midazolam.

Q So I'm going to show you what I've previously marked as Defense 1, and I'll give a copy to you. Do you recognize this document?

A Yes.

Q What is it?

A It's the FDA package insert for Midazolam.

Q And just take a second and look over it and let me know if it seems to be as you remember it to be in your daily life as an anesthesiologist for over 20 years.

A It has the wonderful small print that package inserts generally have, and it is a very long and exhaustive document. So, yes, it looks like the package insert for Midazolam.

Q So you're familiar with this packet insert?

A Yes.

MS. PARMER: This is one is blown up a bit to make the print a little larger. I'm going to move at this time to admit Defense 1 into evidence.

THE COURT: Any objection?

MS. PROUT: No objection.

THE COURT: All right. It's admitted.

(Whereupon, Defendant's Exhibit 1 was marked for purposes of identification and admitted into evidence.)

BY MS. PARMER:

Q Okay. And I'm going to have you kind of highlight a few things here. First, let's go to clinical pharmacology on the left hand side, first page. Roughly the third paragraph down, this talks a little bit about how quick it affects a patient, the sedation.

A Begins with when Midazolam?

Q No, the sedation.

A Oh. Sedation in adults and pediatric patients is achieved within three to five minutes after intravenous injection. The time of onset is affected by the total dose administered and the concurrent administration of narcotic pre-medication.

Q Okay. So is it fair to say it's very fast acting?

A I mean, honestly it's faster acting than three minutes.

Q Okay. And I know you've mentioned that in your experience people respond differently to Midazolam as they do with a lot of different drugs and narcotics; is that right?

A To an extent, yes.

Q Okay. Let's go to indications and usage on the right side in the third bullet point there.

A It says: Intravenously for induction of general anesthesia, before administration of other anesthetic agents. With the use of narcotic pre-medication, induction of anesthesia can be attained within a relatively narrow dose range and in a short period of time. Intravenous Midazolam can also be used as a component of intravenous supplementation

of nitrous oxide and oxygen.
Q Okay. So let's talk a little bit about dosage which is on the third page of this document. Under dosage and administration, kind of read the first few sentences and kind of let me know your experience in terms of dosage.
A Is this like the bold sentences?
Q Yeah, the first two bold sentences, and then I'll have you elaborate.
A Okay. I think it says Midazolam Hydrochloride injection is a potent sedative agent that requires slow administration and individualization of dosage. Clinical experience has shown Midazolam Hydrochloride four -- to be three to four times as potent per milligram as Diazepam, which would be commonly known as Valium. Because serious and life-threatening cardiorespiratory adverse events have been reported, provisions for monitoring, detection and correction of these reactions must be made for every patient to whom Midazolam Hydrochloride injection is administered, regardless of age or health status.
Q So what is a typical dose of Midazolam in this setting?
A So in an adult patient it can be anywhere from, you know, as little as 1 milligram to as much as 10 milligrams, but probably a working dose in an adult is around 2 milligrams.
Q Okay. And what would you see -- what have you seen with somebody in terms of their -- the effect it has on a patient

and kind of how their brain is acting or what you've observed when they've been given about 2 milligrams of Midazolam?
A So I've seen patients who really were tearful and quite anxious, and then I will tell them that I'm going to give them something, it's going to take that away, make them feel better. And, you know, within a moment of injecting it, a short period of time, you know, they feel better. They say to me, wow, I feel that quite well. And as a way of describing it, I'd say something like -- I might say something like this is like getting, you know, a stiff drink or something like that. I might use that language to give it -- so people have an expectation as to what exactly that they are supposed to feel.
Q Okay. And let's talk a little bit about kind of expectations as well. What is your experience in terms of kind of describing what a patient is going to expect and then their reaction based on what you've told them?
A So I tell them. I say I'm going to give you something. It's going to work quickly, and it's going to make you feel good.
MS. PROUT: I'm going to object again. I don't think what this physician describes through his patients, as far as how the drug works, is relevant to the issues here.
MS. PARMER: He's testifying as an expert to the effects of Midazolam as it relates --

MS. PROUT: He's testifying at this point to -- I'm sorry. He's testifying to his practice and what he tells his patients. I think it's perfectly acceptable for him to testify about how the drug operates, but as far as what he communicates to his patients, I don't see that as being relevant.

THE COURT: Sustain that objection. You can rephrase it.

BY MS. PARMER:

Q Why don't you describe in your experience other mental effects that you've seen in the course of giving medication like Midazolam, when you've given Midazolam to patients in this setting.

A I'm trying to be clear that what I'm describing is a common practice, so both what I was taught and what I teach. And so this is not something that, yes, individual physicians may have a little bit of a narrative that are unique. But generally speaking this is what anesthesiologists say, this is what anesthesiologists do and -- ask me your question again now.

Q Well, let's go -- why do you say it's a common practice?

A It's a common practice because patients are commonly anxious before surgery, and the anxiety that they experience becomes an impediment to the conducting of a safe anesthetic and agreeable anesthetic experience.

Q And when you talk to the patient about what you're going to administer and then follow-up with the administration of a drug, have you noticed any effects based on that interaction with the patient as well?

MS. PROUT: Again I'm going to object because the conversation between this doctor and his particular patients is not --

MS. PARMER: He's talking about the effect.

THE COURT: This question was not about conversation. It was about have you noticed the effect.

MS. PROUT: I understand.

THE COURT: I'm going to overrule that objection.

THE WITNESS: So can you ask me the question again?

BY MS. PARMER:

Q Yeah. So when you are going to give a patient Midazolam and you see them in the pre-op holding area and you describe what you're going to give them, what have you noticed about their reaction upon the administration of the drug, and what have you noticed in terms of their perception of what's happening?

A I think it's a -- you know, in my experience and my observation it's the first time that a patient may believe me, you know, that I can do what I say I'm going to do. So I say to them I'm going to do this to you, and then they wonder. You know, people are -- patients may think, well, it isn't

going to work in me. They wonder because it's kind of magical almost, and so I reassure them that it is going to work in them and that -- and it does. And people smile. They feel the pleasure of the relief of their anxiety. You know, they feel better.

Q And let's look back to Defense Exhibit 1, page 2, the left side, information for patients. Why don't you read what No. 4 under information for patients says.

A All right. This is the second --

Q I'm sorry. On our package insert.

A Oh.

Q Page 2 here.

A I really need a magnifying glass here for this. So where is it now?

Q On the left side. Information for Patients, No. 4.

A No. 4, patients should be informed of the pharmacological effects of Midazolam, such as sedation and amnesia, which in some patients may be profound. The decision as to when patients who have received injectable Midazolam Hydrochloride, particularly on an outpatient basis, may again engage in activities requiring complete mental alertness, operate hazardous machinery or drive a motor vehicle must be individualized.

Q So what is that referencing?

A So what that references is that if a patient is having a

procedure and an outpatient procedure, even when in the afterwards of the anesthetic and even after, you know, hours have gone by, we still have a policy, for example, that patients cannot drive themselves home, that patients have to be accompanied, that even if they themselves believe to be clear, we recognize that the pharmacological effects can be, you know, protracted even for a day.

And so I always make a comment to people before and subsequently in the recovery room. Whether or not they remember that one I don't know, but before I always say, you know, after this, I don't want you to sign any documents, you know, don't get married, don't operate fire machinery, don't do anything that requires any discretionary decision making until tomorrow.

Q And why do you say that?

A Because the effects of the Midazolam can be profound like that, and it can create a circumstance where the patient themselves doesn't recognize that they're impaired.

Q And, again, these effects that you're describing in your opinion are almost immediate?

A Yes.

Q Okay. They seem to last a while in some cases?

A They do.

MS. PROUT: Again object to leading.

THE COURT: I'll overrule.

BY MS. PARMER:
Q Okay. I'm going to return to some of these documents that you reviewed. And you reviewed this document that's been marked as Government Exhibit 2; correct?
A Yes.
Q Okay. Did you recognize what this document was?
A Yes.
Q What is it in your own words?
A It's a printed out copy of an anesthetic record.
Q Okay. So even though you aren't employed at the VA you still were able to recognize this for what it is?
A Yes.
Q Okay. Let's go to page 2.
A Is that page 17 in the bottom there?
Q Yeah, page 17 in the bottom.
A Okay.
Q One of the first things I'd like to talk about is in the top two boxes we have two names. We have the supervisor and we have the -- so the supervisor is Wykena Jackson, and we have Kinnari Patel. When you reviewed all of the discovery in this case, all of the statements and the evidence that I've provided, what were your thoughts about these providers and what their role might be?
A So Dr. Patel here is a resident, so she's a resident in the program of anesthesiology. She's training and, you know,

she at this point in her career, you know, would be able to, again, to be a, you know, a useful assistant in this case, will do many of the tasks. But all of the tasks -- and the plan, of course, would be dictated by Dr. Jackson. She's the attending physician here.

And so this is a typical circumstance, you know, with an attending physician and a resident who is training. So Dr. Jackson is really, you know, running this anesthetic and then would direct, you know, Dr. Patel to deliver it in a certain particular way.

Q Okay. So do you deal with residents at Emory?

A I do.

Q Okay. And in situations at Emory when you have residents there and you are the supervising anesthesiologist, is it typically your decision to do things like administer Midazolam in a pre-op setting?

A Every decision is my decision.

Q Why is that?

A Because I'm in charge of it, and so I'm responsible for it. Now, a conversation I may have with a resident, depending upon their nature of -- where their level of training is, we may speak broadly and say I want to give let's say Midazolam in a quantity that I think is sufficient to achieve a certain goal, but I won't say give 2 milligrams or give three 3 milligrams. I'll leave that to, you know, a senior resident

to discern if I'm not standing there watching.

The same thing in the operating room where, you know, we talk kind of broadly about goals of care. And depending upon the resident, where they're training and maybe even my views on the resident, it would be, you know, more or less particular on how I would direct them. But I recognize that everything that the resident does is my responsibility, and I'm in charge of it.

Q Okay. So let's look again on this with 17 but also page 2 of this particular exhibit. What is this section right here, this top half purporting to show, based on what you know, as --

A So this top half shows a few different things. It, first of all, has on the top a timing sequence. So it looks like, you know, there's a -- there are some times that are marked here, and then one I understand is to be a scale of time. Along the left hand there's a list of, first of all, medications that are given, and then lower in the list there's also a record of -- it says Cardiac Rhythm, which is the heart rhythm that's observed. Below that is something about intravenous fluids may be administered.

There's a column there for blood loss, something for urine output. TOF is Train Of Four. That's a marker of whether or not a person has received a drug that paralyzes their skeletal muscles and the degree of paralysis that takes

place. End title CO2 is a monitor for ventilation. And the fact that it says just at that point zero zero and then 43 means that in those first moments the anesthetic -- the induction had not yet occurred. So at somewhere between the second zero and 43, that's when a breathing tube would have been placed, and the patient would have been attached to a ventilator. It's now able to register the presence of carbon dioxide that's exhaled.

Below that is the percentage of oxygen that's being breathed again. This patient starts out actually with just room air, no extra oxygen when they first arrive it looks like.

And there's some other designations for various kinds of events here. I'd have to look at what those mean. I think it's actually down in the bottom here. It says 1 to 4. So if you go to the bottom, it says between 1, 2, 3, 4. It says, you know, the patient's NPO and the allergies reviewed and the ID band and the procedure verified it and so on.

And then I could go back up again to the medications given. The medications are the medications that are given in order to conduct the anesthetic, how much is given and the time roughly where they're administered.

Q Now, why do you say the time roughly when they're administered?

A Because so this is what's called an automated record, and

so a certain kind of things, once a patient is attached, then the machine will automatically extract data and put it onto the record. So, for example, things like heart rate will automatically be -- you don't have to enter that manually, but all of the medications are always manually entered. So I have to select the medication, give the medication, and then go into a computer and mark down, you know, how much I gave and at what time I gave it.

Now, the way that these things go is that the clock will kind of run. So if I just choose to enter it, whenever I enter it, it will either be at that moment, but I can also back up the time because it may be that it takes me ten minutes to get to the charting of something that I've already done. So it does allow me to kind of correct the time there and put it whenever I think I gave it.

Q Let's go to kind of along those lines. We have on No. 23 at the bottom or page 8 of 10, we have another timeline here.

A Uh-huh.

Q And we see that we have, for example, Propofol, Lidocaine, Fentanyl, Rocur --

A Rocuronium?

Q Yes. They're all given -- the time says 11:37, but kind of explain in practice what actually is going on.

A So it's -- you know, you can't obviously give -- it's difficult to give these medications precisely at the same

moment. So what's happening with this, all these 11:37s here -- so these are one followed by the other, followed by the other, followed by the other. There would be a little bit of time that would normally elapse between these two, you know, each of these medications.

Like, for example, Rocuronium is a paralyzing drug, so if that drug was given, you know, at the same time as Propofol, then the experience would be that a person would actually be paralyzed and awake, so it would never actually go like that. The Propofol would be given. You know, a minute or two would elapse. It would be determined that the patient was now unresponsive, and then the Rocuronium would then be given. So it would not be -- so, again, these times here are just to try to kind of get in the region when these things are given.

Q And so what's the most important in terms of documenting in this, the intra-op record? What's important in documenting the medication? What details do you want about the medication?

A Well, so I want to know, you know, when they were given, how much was given, and then of course the record also totals up all of the medications that are given. So it would be, again, up to the anesthesiologist to, you know, put times and dosages that are, you know, that one could then look upon and say, yeah, that makes sense to me, you know, that's

meaningful.
Q And this record, again, this record is just -- does this record in your opinion have any indication of what happened in the pre-operative setting?
A No, it doesn't.
Q Okay. Now, let me ask you, again staying on page 2 of 10, if there was anything that stood out to you --
A Actually, sorry. Can I --
Q Go ahead.
A I see there one, two, three, four has times there that are before -- I think maybe before the patient entered the room. But there's still nothing in there that marks, you know -- it just has NPO, allergies reviewed.
Q So that's 1 through 4?
A Yeah. And I don't know whether, again, these things are pretext, probably not. These things are going to be the kind of things that are going to be where you can select them. So it's not that you're having to type them in by hand, the sentence NPO status. It's just probably something that you have to just click on.
Q And in your experience do these events, 1 through 4, document the entirety of the pre-op procedures?
A Well, you know, it does.
Q Okay. And then as you look at this intra-op record and especially the drugs given, what, if anything, did you talk

with me about that stood out with you?
A So when I reviewed this record, I was puzzled by Midazolam here that's in present these. There's no other drug here that's in parentheses, and I don't know what the parentheses mean. Specifically it's -- what's interesting too is when I look on that one where it says three, when I then look again back to that page --
Q Page 8, page 8 with 23 at the bottom.
A 23, it actually says two and one, so as if there are two separate injections there. And so two plus one equals three, so I'm assuming that what they were trying to -- you know, it may be what this program does is that when you put medications where the time is very close, it just kind of averages them or sums them, rather, and indicates that by these brackets. They would have to be farther apart, and I don't know, again, how far apart they'd have to be before they would appear as separate designations. But it doesn't really make to me -- it's not clear that that would be -- it's not something that I understand why it would be done in that way.
Q And what do you mean by that?
A So I would -- it's common to give some Midazolam at the beginning of an anesthetic, but I wouldn't break it up in two dosages like that.
Q Back to back?
A I would just give the dose, and so there'd be no reason to

break it up like that, you know, a drug like Midazolam. So I find that, you know, that stands out to me, why it was done in that way.

Q And when you look at how it's been recorded in this document, we see on page 8 of 10 that at 11:29 there's two milligrams documented and then 11:36 again another milligram kind of documented around the same time as these other medications that we know were given in the OR. What did you think about what this document might be actually reflecting?

A Well, so the way that this would be done -- and I think I maybe have made this point before, is that I would -- and this is what I teach. This is what our residents do. So I'll go to the operating room, and I'll prepare the operation or, rather, my drugs and so on and the equipment. Then I'll take with me a syringe of Midazolam, and I'll bring it with me to the pre-operative holding area. I'll inject it there in the pre-operative holding area, and now I'm accompanying the patient. And then when I get to the operating room, I'll put it now in the record.

Now, because this record, again, doesn't have a place that says pre-operative medications, it would be fine and normal just to put it in like that because that just kind of gets the idea that it's been given. And, you know, it's not -- under normal circumstances it wouldn't -- the lack of specifying it in this way wouldn't affect, you know, the safe

conduct of an anesthetic. It would just be the way that it was documented here.

Q Because what's important would be like the total dosage?

A So you have to, you know -- so when I -- Midazolam is commonly dispensed in 2-milligram ampoules. It comes in a 2-milligram or a 5-milligram ampoule, so I might, again, take out two 2-milligram ampoules. And Midazolam is a controlled substance, and so I have to account for all of it. And so what I've taken -- you know, if there will be, you know, something that will show from pharmacy all the drugs I've taken, and I have to account for every one. And so in this case I've taken out 4 milligrams, and so I have to account for 4.

So if I have taken out 4 and I gave, you know, 1 or 2 before, I have to put it somewhere so it adds up to 4 because I can't just go to pharmacy afterwards and say, okay, I gave 4. I know that the record only documents 2, but just take my word for it that I gave 2 at another time and there was no place for me to document it.

Q So describe for me again, just so I'm clear, that in your role as an anesthesiologist it sounds as though -- you kind of elaborate on this -- you would travel with a dose to the pre-op holding area, and that would be typical?

A Yes. I would take a syringe with me to the pre-op holding area, and then I would inject it.

Q Okay. And in terms of this timeline from 11:29 getting 2 milligrams followed very quickly by the 11:36 1-milligram, did that strike you in any way? And if so, what way?
A I don't know -- there would be no reason to do that.
Q Why?
A Because the 1 milligram at that point adds nothing, you know, to what you're about to do and it's -- there's value in giving, you know, some Midazolam perhaps when the patient comes to the operating room. Some people would maybe give no more Midazolam. That may be enough. So the decision was made to give a little bit more, and so, again, you would give that.

In this circumstance, you know, before you would do -- you would wait a little bit before you gave the induction drugs. Just to add it to the four other drugs would not really get the full benefit of Midazolam here because the Propofol is going to take away anxiety. Absolutely it's going to take away consciousness. So there's no need to add that in this moment.
Q Right. Is there anything in this record that kind of documents somebody's -- I think you had referenced maybe BIS. Can you explain what BIS is and whether we see that on here or not.
A So there is a monitor that's commercially available called a BIS monitor, B-I-S, and it's a monitor that attaches to the forehead into one of the temples, three kind of adhesive

stickers, that then read brainwave activity. And it's marketed as a depths of anesthesia monitor, but we commonly refer to it as an awareness monitor. And not everyone uses it.

But what it does, what it purports to do is to determine whether or not a person is in this state where they would be anestic. So the number, for example, that the monitor generates is a number out of a hundred where a hundred is -- it would be seeing that person who is awake, and as long as that number is under 60, we'd consider that to be a person who would be in a place of anesthesia where awareness would be exceedingly unlikely.

Q And do you see anything on this record that would be helpful in that regard?

A No. There's no BIS monitor here.

Q Okay. So there's nothing on here that can really show brain activity --

A Oh, I'm sorry. Wait a minute. I do see it. BIS index. So this index -- so it actually does start to appear here at some point. So it appears, yeah, by 12:27, so an hour after they're into this I don't know what's applied, and the BIS monitor is low. And so at that point, you know, I think it's at a range where it should be.

Q Okay. And then in terms of -- I'm going to show you what's been previously introduced as Government's 5. I think

you have a copy of this here. When I gave this to you to review for this case, did you recognize what this is?

A I mean, this looks like, you know, a list of borders that were, you know, that are done. And I think that -- let me just get the times again. So these are, looks like, entered after the fact of the anesthetic on some of the times of these.

Q And then let's turn to page 13 of this document because we do have a few entries here that are before we have the intra-op record. So we have --

A These things here?

Q Yeah.

A These are just medications where, you know, the -- I think maybe this is on a surgical service. I don't know for sure. But it is requesting that something called a type & screen is performed, which is a blood test that puts -- takes the patient's blood and sets it up in case the patient needs a blood transfusion. So it's kind of a matching system so the patient's blood is matched to a unit of blood should it be required. And that would be pretty standard, you know, to do this before the procedure.

Q Now, when you in your typical capacity as an anesthesiologist, if you're giving somebody Midazolam in the pre-op setting, would it necessarily end up on this type of document?

A No.
Q Okay. And why would do say no?
A I mean, this is not my document. My document is the record.
Q Right. So what do you mean by that?
MS. PROUT: I'm going to object again. He's just testified this isn't his document. It's not in his record, and he's not in a position to say what's going to wind up on a VA record.
THE WITNESS: Well, I mean, you'll notice that there's --
THE COURT: I'm going to overrule the objection. I think he's -- the question is more general as to whether or not if -- as I understood the question, whether or not a drug administered in the pre-op setting in his experience would normally be or would necessarily be recorded in the pre-op versus the --
MS. PARMER: Intra-op.
THE COURT: Intra-op record. I think as an expert he can't testify to what the VA specifically does or does not do, but as an expert I think he can talk more generally about how -- is that necessarily the -- would he necessarily expect that to be the case on these records. So I'm going to overrule that objection.
MS. PARMER: And I think his response this is not my

record, if you can just continue on. What you're referencing is that --

THE WITNESS: I mean, I could say that none, actually none of the medications that are given, the anesthetic, none of them are here.

BY MS. PARMER:

Q Okay.

A So it's not that some of them are and some of them aren't. None of them are here.

Q Right. And in terms of this anesthetic record here, what were your thoughts on the timeline and the drugs that are documented here and only here? In your experience do you always have in recordkeeping things entered into the exact right minute every single time as you administer the drug?

A No. As I explained that the, you know, the precision down to the minute is not necessarily necessary depending on what's given. So, for example, this patient has received Fentanyl, which is a narcotic used for pain, and I see that the total given here is 250 mics. And so there's a hundred mics given at the beginning, and then there are three other times where Fentanyl is given.

And if I look down, sometimes, for example, a dose of Fentanyl might be given because the anesthesiologist thinks it's a patient that's experiencing some pain. So the pain might be indicated by a rise in blood pressure or a rise in

heart rate. And each time where these are given I don't actually see anything like that, and so it's probable they were just given at some point in that range.

So, again, the total added up to 250 mics, and, you know, whether the anesthesiologist again gave it, you know, ten past 12:00 and then documented at 12:15 or something like that, the precision is not necessary.

Q Okay. And so that's kind of why we see everything all in a row; right?

A Right. I mean, that's just the Fentanyl that's given in the few times.

Q So I guess after reviewing all of these documents and looking at discovery, let's also talk about some of the -- in the discovery you reviewed some statements, and some of the statements described [redacted] statements right after this alleged contact with the nurse's behind happened and some of the things he said. Do any of those statements sway you either way as to whether somebody in his position would have gotten Midazolam in a pre-op setting?

A Sure. Well, I mean, I don't know [redacted] I don't know his character. So, I mean, we're trying to imagine maybe, first of all, whether a person -- you know, what a person might normally say.

MS. PROUT: I'm going to object. It sounds like he's essentially preparing to speculate and answer, but he's not in

a position.

MS. PARMER: I just asked about somebody in [redacted] position, a hypothetical.

THE COURT: I'm going to sustain the objection. I think -- I mean, he can speak generally and has about the effects of the drug, but to comment specifically on whether specific actions of the defendant were or were not the result of a drug when he's just acknowledged he doesn't know -- he's not in a position to give an expert opinion as to [redacted] specifically, I just think that goes a little bit too far. So I'm going to sustain that objection.

BY MS. PARMER:

Q As you've testified in terms of a patient's ability to speak or move around --

A The one thing I would say that was striking to me was --

MS. PROUT: I'm going to object to --

MS. PARMER: You don't even know what he's saying. I'm talking about --

THE COURT: Well, there wasn't really a question that was put. Why don't we step back for a second. Why don't you put a question and then -- Dr. Zivot, your responsibility then will be to answer the question that's put.

THE WITNESS: I understand.

THE COURT: Not try to rephrase a prior answer but answer the question that's put.

BY MS. PARMER:

Q So in your experience a patient on a gurney who had been given Midazolam in a pre-operative setting would still on that gurney be able to speak and move around?

MS. PROUT: I'm going to also ask not to lead the witness.

BY MS. PARMER:

Q Tell me what behavior --

THE COURT: I'll sustain that.

BY MS. PARMER:

Q What behavior would not surprise you when it comes to somebody having pre-operatively received Midazolam and then is in transport to the OR?

A They may, you know, be conversant. They may be quiet. They may be jovial. You know, they may be any one of those things. Usually I tell people to keep your hands inside of the gurney because they may absentmindedly, you know, be positioning their body in a way on a moving stretcher where they don't realize that they're going to be moved.

And so I keep a close eye on them to make sure that they don't shift their body or, you know, to actually even fall out of the gurney, which is conceivable. That's why when patients are transported after Midazolam, there are side rails that are always put up as a guard against a person just rolling off the gurney as it's moving, which could happen.

Q And in your experience would you say that patients act consistently the same on this drug or have you seen a variety of reactions? Tell me in your own words kind of how patients respond and if they respond consistently or in varying ways.
A So patients respond, you know, in varying ways. So, again, they may say something; they may say nothing. They may move or they may be still.
Q And in terms of everything that you've reviewed in this case, the intra-op record and the other record and the pre-op record, was there anything -- tell me what, if anything, made you think that he was not given Midazolam or that he was. Tell me in your overall view of kind of the documents in this case.
A Well, one comment that he made that I found striking was he said that he had no memory of the experience. And that --
MS. PROUT: Judge.
THE COURT: There's an objection.
MS. PROUT: I'm sorry. That's not in evidence at this point, and that's a self-serving hearsay statement that we would seek to exclude. It's not being introduced by the government, and we're again getting very close to that area where the witness is opining on the defendant's actual mental state at the time.
BY MS. PARMER:
Q And I think if I'll just rephrase and ask, after you

reviewed these records, given what you know about a typical administration of Midazolam and a procedure like this, is it fair to say that it would have been typical for a patient in this setting to have received Midazolam in the pre-operative holding area?

A Yes.

Q Why do you say that?

A Because that would be the typical practice.

Q And there's nothing in any of these records that made you think it was an atypical day, practice for surgery?

A No, nothing.

Q And nothing about [redacted] that made you think he was atypical, non-standard or non-conventional as a patient?

A No.

MS. PARMER: Okay. I have nothing further at this time.

THE COURT: Ms. Prout.

CROSS-EXAMINATION

BY MS. PROUT:

Q Hi, Dr. Zivot.

A Hello.

Q Let me ask you first, you talked initially about Government's Exhibit 1 and that there were multiple providers involved in completing this form.

A Yes.

Q Is there anything unusual about having multiple providers involved in the pre-operative stage of a patient's surgery?
A I don't know if I understand what you're asking me, I mean, multiple -- like one person cannot do this, so it would be normal that there would be different people in each of these sections.
Q Okay. So that's typical in your experience?
A To have a different person responsible for each of these sections, yes.
Q And you were also asked a little bit about whether or not this form had a place to note the administration of Midazolam. Do you remember that?
A Yes.
Q Now, this is a paper form, and as you're aware, the VA also keeps electronic medical record; right?
A Yes.
Q And would it be better practice that the administration of a controlled substance be recorded in the electronic medical record than to rely on the handwritten record of a provider?
A I can't speak to that.
Q You don't have an opinion about whether electronic medical records are preferable to paper medical records?
A I think the electronic medical records and paper medical records each have their strengths and weaknesses.
Q And is it your experience that most hospitals are actually

moving away from paper and toward electronic medical records today?

A There's a -- you know, we're in a hybrid state I would say.

Q From all paper to partially paper and partially electronic?

A Yes.

Q Because it's moving toward electronic?

A Well, it's moving. I don't know. Some things are not moving; some things are.

Q You've never practiced medicine at the VA, have you?

A Correct.

Q And you're not familiar with Dr. Patel, are you?

A I might be familiar with her actually because she was a resident when I was an attending.

Q Well, are you or aren't you?

A I am familiar with her. I mean, I know of her.

Q Okay. Are you familiar with her medical care?

A No. I can't recall it.

Q Okay. What about the medical care of Dr. Jackson?

A No, never met Dr. Jackson.

Q You don't have an opinion about whether Dr. Patel or Dr. Jackson give appropriate medical care?

A I have no opinion about it.

Q Okay. And is there anything in the medical record that

suggests that they did not give appropriate medical care?
A No.
Q And you describe your practice of giving Midazolam pre-operatively, but that's not a medically necessary practice, is it?
A I'm not sure how you define necessary.
Q You don't know what the term "medically necessary" means?
A Well, if you're saying that it would be no difference of a life and death, is that what you're asking me when you say necessary? You're saying it's common or not common? I don't follow you.
Q I'm asking about whether it's medically necessary for the health of the patient.
A Well, can you define that for me, so I know what you're asking me?
Q So you don't have an opinion one way or the other? You don't have a common understanding of the term "medically necessary"?
A Well, I just want to be sure that we are having the same common understanding before I answer you.
Q Do you or do you not have an understanding of the term "medically necessary"?
A I don't know if I understand what you are asking me.
Q Okay. What's your understanding of the term "medically necessary"?

MS. PARMER: Judge, I'm going to object to relevance at this point. I don't understand how his understanding of her term of "medically necessary" goes to anything in this case.

MS. PROUT: I think "medically necessary" is a term of art, and I'd like us to get on the same page. But I'd like to hear what the witness's understanding is.

THE COURT: I'm going to overrule the objection.

THE WITNESS: I don't know -- I don't use that kind of language in the hospital. I don't say this is medically necessary. I might say this is required or this is not required, but necessary is, I think -- is different than, I think, what you're asking me. So there's no part in any form here that says this is the medical necessary parts and these are the unnecessary parts. So I don't know what you're asking me here.

BY MS. PROUT:

Q Okay. So that's a confusing term. Let me ask you about this: Your description of your personal procedure of providing a patient pre-operative Midazolam, that's not the only medically recognized procedure followed by an anesthesiologist pre-operatively, is it?

A I don't know what you're asking me. Could you --

Q Okay. Is it medically recognized that sometimes a patient could receive Midazolam for the first time in the operating

room?
A Yes. Yes, that's -- sure, yes.
Q And you don't know if the VA had a regular practice one way or the other?
A No.
Q And the only documentation of Midazolam being given to the patient in this case shows that it was given after the patient arrived in the operating room; isn't that right?
A Yes.
Q And Midazolam is a controlled substance; right?
A Yes.
Q And it's important to document the administration of all controlled substances; right?
A Yes.
Q You talked about one of your bases for giving Midazolam was when -- because patients tend to be nervous before surgery?
A Correct.
Q And in your case how do you decide what dose to administer to a patient?
A It's based on weight, age, my experience, the state of the patient's particular anxiety, what they're facing.
Q Okay. And so as far -- let's break those down as far as age goes. Would say an 80-year-old patient generally be given a larger or smaller dose than a 30-year-old patient?

A A smaller dose.
Q Okay. So a --
A I'm sorry. An older patient would be given a smaller dose than the younger patient.
Q Because it takes a little bit more to get the same effect for a younger patient than an older patient?
A Older patients don't require the same kind of sedation sometimes.
Q Okay. And what about for a patient who is overweight versus a patient who is an average weight? Who would require a bigger dose to get the same effect?
A Well, in the case of intravenous Midazolam, it doesn't have a lot to do with that. You know, it's a kind of lean body weight calculation, and because of the way the drug works it works pretty quickly and there's not a lot of variation honestly, you know, in weight.
Q So when you said that you would consider the weight of a patient, you didn't mean that you would really consider the weight of a patient?
A To a certain degree. I mean, there would be some of that, but it's not the only thing that I would factor.
Q So I'm asking sort of all other things being equal in these questions. So all other things being equal, you said that you would consider whether or not a patient seemed nervous; is that right?

A Yes.
Q And so you'd be more inclined to give a dose or a higher dose for a patient who was acting nervous?
A I think that the range of dosages that I give between someone who was say between 50 kilograms and a hundred kilograms and someone who's 20 to 60 might actually all be the same dose because the drug is pretty safe, and so it doesn't require that kind of precise adjusting.
Q But this was a question about the state of anxiety of the patient.
A Yes. To the best of my ability I would gauge it on that.
Q Okay. And Midazolam is fast acting, as you've said?
A It is.
Q And so would it be your practice to typically give it right before the patient is taken to the operating room?
A Yes.
Q Okay. Even though the patient spends a long time in the pre-operative area, it's not your practice to give it early in that pre-operative process. It's your practice to give it right beforehand?
A It's given -- I mean, my practice would be to, you know, under again talking about a normal -- if we can think of other possible strange scenarios where it might be slightly different. But if we're talking about kind of the general kind of thing I would do, I would, again, go see the patient,

introduce myself, do what I need to do, and then give them the Midazolam. And then we would -- I would accompany the patient, so I wouldn't give Midazolam and walk out of the room. I'd give the Midazolam and then stay with the patient and then take them to the operating room.

Q So midazolam, straight on to the operating --

A Well, Midazolam moment, you know, be sure that it's working, give everybody a chance to say good-bye, and then start to move toward the operating room.

Q Now, to be sure that the Midazolam is working, is the patient hooked up to monitors at that point to identify whether it's working?

A Monitors, no. There's no monitor in that circumstance there, really wouldn't be necessary there.

Q So you're going to determine whether the Midazolam is working based on your clinical observations?

A And what the patient says.

Q Okay. So how the patient is acting?

A Yes.

Q You testified that the side rails are up when transporting a patient who's been given Midazolam to the operating room. Remember that?

A Yes.

Q The side rails are typically up when someone is transporting a patient from pre-op to surgery whether or not

they've been given Midazolam; right?
A Yes.
Q You're not testifying today that [redacted] received Midazolam before he arrived in the operating room, are you? You don't have a basis to conclude that, do you?
A Well, I think I do, actually.
Q So you're testifying today that the VA medical record is not accurate?
A Incomplete perhaps or -- but that's my opinion.
Q Okay.
A That Midazolam was given.
Q And is it your opinion then that an additional dose of Midazolam that's not reflected anywhere in the record was given to the patient pre-operatively?
A No. My opinion is that it's reflected in the record.
Q Okay. And so why don't you show us where in the record it's reflected.
A Exhibit 2? Yeah. I think it shows that in where the -- it says 3 in parentheses. This would be on page 17 of Exhibit 2.
Q Okay. And you testified about that a little bit and is that -- where it shows 3 in parentheses, does that line up with the notations for Midazolam on page 8 of 10?
A This is the one that begins page 23? Did it line up? Is that what you're asking me?

Q The 3 on page 2, is that the same as the --
A There is no 3, actually. There's a 2 and a 1.
Q Okay. You identified where it said 3.
A Well, it says 3 on page 2 of 10.
Q Right.
A And then later on in that page it says 2 and 1.
Q Okay. And you testified that it was your belief that the 3 was the addition of that 2 and 1; right?
A Yes.
Q Okay. And so it's that 2 and 1. That's your testimony about the Midazolam the patient received here?
A One of those quantities, I believe, was injected to the patient in a pre-op.
Q Okay. So you believe that one of the time stamps here is inaccurate?
A Correct.
Q And what's your basis for that?
A Common practice.
Q Okay. But you just testified that your practice wasn't necessarily the same as the practice at the VA?
A I don't think I said that.
Q Okay.
A You asked me if I'd worked there. I don't.
Q That's right.
A But the common practice is common practice.

Q Okay. But you don't -- well, okay. I'll move on. Let's see, you never examined the defendant in this case; right?
A No.
Q And you never reviewed his medical or mental health records other than the records you received pertaining to his surgery; right?
A No.
Q And you have no idea how the defendant normally behaves in his unmedicated state, do you?
A I don't.
Q And other than perhaps the police report that you may have reviewed, you don't know how the defendant was behaving in the pre-operative area before he received any medication?
A I don't.
Q And you're not offering an opinion about the defendant's mental state at the time of the incident, are you?
A I'm not.
Q Okay. How often do you do expert work, Dr. Zivot?
A I don't know, periodically. I mean, probably maybe two times a year, maybe three times a year. It depends.
Q How much do you get paid for that work?
A Paid $400 an hour.
Q That's what you're getting paid in this case?
A Yes.
Q How does that compare? So at $400 an hour, are you

getting paid for your entire time today or just for the time that you're testifying?
A Well, it's the normal time of doing work and the testifying. It's all separate.
Q Okay. So you're getting paid for both?
A Yes.
Q And how does that compare to a day's wage for you at your job at Emory?
A Depends. I mean, different places make different amounts of money. It's not -- you're asking me is this a big part of my annual salary? Is that what you're asking me?
Q No. I'm asking you how much a day's wage that you're making for your testimony compares to a day's wage that you personally make at Emory.
A I'd have to calculate that. I think this -- you know, this work pays more than that work.
Q Okay. You don't practice general anesthesia anymore, do you?
A I don't know what you mean when you say that. You mean practicing as an anesthesiologist?
Q You don't know what general anesthesia means?
A I know what that means, but I don't know what you are asking me. Am I practicing -- do I provide anesthetics?
Q You just practice in critical care at this point; right?
A I've practiced in critical care exclusively for the last

four months, but I'm also doing a little bit of anesthesia as well that's actually coming up.

Q Isn't it true that while this case was pending you accepted an appointment at the VA?

A That's true.

Q The Atlanta VA that we're talking about today?

A Yes.

Q Okay. So you have a contract with the VA currently, same place where this incident occurred, but you haven't started working there; right?

A True.

Q When you accepted this engagement, were you aware that this case was about inappropriate touching of a sexual nature?

A Yes.

Q You yourself have been the recipient of allegations of inappropriate sexual misconduct, haven't you?

MS. PARMER: Objection. I think this is entirely improper. It's -- I don't think he should -- it has no relevance whatsoever to this case, and it's also incredibly prejudicial. And I have no idea what she's referencing, and we object.

MS. PROUT: Because of the nature of the case, your Honor, we believe it goes to the bias of the witness.

THE COURT: I'm going to overrule the objection. We don't have a jury here, so issues of prejudice are somewhat

different. I don't know that -- I'll have to assess relevance as we go through it but 403 doesn't -- I mean, you know, I'd have to hear what this is all about, whether by way of a proffer or by just hearing the testimony. I then can assess the relevance at that point, and if it's to be excluded as not relevant, then I'm not going to consider it. So I'm going to overrule it at this point and hear a little bit more, and you can renew your objection. But I want to hear a little bit more to make that decision.

THE WITNESS: I don't know what you're referring to, actually.

BY MS. PROUT:

Q I'm referring to the time when you were at the University of Michigan, and you were accused of inappropriate conduct of a sexual nature toward undergraduate or multiple undergraduates trying to gain admission into the medical school.

A I think I know what you're referring to, and I can tell you something about that if you would like me to.

Q I'm just asking whether you've been the recipient of those allegations. Can you just answer that question.

A Well, I think it's necessary to explain that the person that came forward turned out to be a -- the wife or, rather, a woman who was a friend of my ex-wife. And so that claim was made -- that was entirely unsubstantiated and shown to be. So

I haven't thought about that in years because there was no truth to it.

MS. PARMER: So, your Honor, I would renew my objection. I think it's prejudicial. It's also completely irrelevant to this case and his opinion as an expert.

THE COURT: Is there anymore from that or --

MS. PROUT: There are some additional questions of a similar nature.

THE COURT: So what's your questions relating to?

MS. PROUT: The questions are related to other allegations of separate misconduct.

THE COURT: That are pending or that are more time relevant or --

MS. PROUT: More current allegations that occurred during his current employment at Emory, your Honor, regarding sexual misconduct.

MS. PARMER: And if there's nothing substantiated here and she's going off of just something she's heard, there's no documentation, there's no one here to testify to this, I think it's entirely speculative, irrelevant, and highly prejudicial.

MS. PROUT: Your Honor, we do have facts that we can put forward, if necessary. But I believe this witness is capable of admitting or denying the questions that are put to him.

THE COURT: As far as the government's understanding, anything pending or these are just past?

MS. PROUT: These are past in the government's understanding.

THE COURT: I think I'm going to sustain the objection. I just don't see how historical allegations of miscon -- they don't in and of themselves constitute instances of dishonesty, so it doesn't go to that prong of the impeachment Rule 608, if I'm not mistaken. But, I mean, as to whether it goes to a current bias --

MS. PROUT: Your Honor, it would be the government's position that a witness who's been the recipient of sexual allegations that he regards as unfair or unjust is prone to be biased toward a defendant right now who's the recipient of sexual allegations. And I would add that while my understanding is that the latter allegation is no longer pending, it is my understanding that the witness has received a written warning letter under his current employment, which is still in effect for his employment.

MS. PARMER: And I would say if there's nothing that substantiates these claims, then she's saying that this bias stems from something that never happened. And even then if it's a false accusation and it's not pending, I don't think that it's proper impeachment of the witness. I think it's highly irrelevant and prejudicial.

THE COURT: I just think we have a specific situation here where there's an incident for which the defense is principally not -- the defense that this defense witness is here to support relates to an excuse generated by intoxication, which I just can't see or I just think past allegations as to the witness are -- don't really -- I don't see it being probative to a bias that would lead to false testimony on the question of the effect of medication on an individual's conduct, which unless that was somehow at issue or involved in -- which I'm not hearing --

MS. PROUT: No, your Honor.

THE COURT: -- anything to do with the persons involved, I just see it as being a little bit too far afield to really be probative on the question of the witness's bias. And if it did have some probativeness, you know, I do think it would be substantially outweighed by the prejudicial value. And I know we don't have a jury here, and I've made that point.

And I do feel that if I'd make a decision something is irrelevant, not consider it, but Rule 403 does still apply to some extent and I think if there's some probativeness to it -- and I'm not sure there is given the specificity of the issue to which this witness is testifying, not that something didn't happen or that something is not serious or shouldn't be pursued but, rather, that there's a medication issue and what

its effects are, which I'm hearing this has nothing to do probably with the allegations against the witness, I just think it's -- the probative value is, if any, is just not enough to justify going forward, so I'm going to sustain the objection.

BY MS. PROUT:

Q Now I'll go forward on different questions. In your testimony on direct you talked about Midazolam having an effect of making a patient feel disinhibited. I wanted to get on the same page as you about definitions. Disinhibited, is it fair to say that that makes somebody more likely to act on impulse and less likely to consider the consequences of their action?

A Yes.

Q And in your written opinion you list the effects of Midazolam as antiretrograde amnesia, reduction of anxiety, somnolence, and stupor; right?

MS. PARMER: I have a copy.

THE WITNESS: Let me be just be sure that that's how I put it.

MS. PARMER: Yeah.

THE WITNESS: It would be anterograde not antigrade.

MS. PARMER: She's referencing this, which we did not introduce. We just relied on your testimony.

THE WITNESS: Can you, just so I'm on the same page

as you --
BY MS. PROUT:
Q Sure. If you'd look at page 2 of your opinion, the paragraph that starts the most common widely used --
A Yes.
Q And the second sentence there, do you see where you list the effects of Midazolam?
A Yes.
Q Okay. So would it be correct that the effects commonly produce anterograde amnesia, reduction of anxiety, somnolence, and stupor?
A To varying degrees.
Q Okay. And to the extent that there may be some other effects that occur, sometimes those would be more frequently outliers?
A I think you need to ask me specifically what you're asking me. Then I'll be able to answer your question.
Q My question is, other than those four effects that you've identified, are there any other effects that you've failed to identify?
A Sometimes patients who receive benzodiazepines like Midazolam can have paradoxical effects where they're actually more agitated, but usually in a low dose that's not -- that's really kind of uncommon. I guess people could be allergic, so they could have a rash or other kinds of things.

Q Those would be what I would call outlier effects. Is that fair?
A Outlier, you mean less common or what do you mean?
Q Less common.
A Under what? In terms of everybody or in terms of this patient?
Q In terms of your experience as a provider who has administered Midazolam.
A Those are less common.
Q Okay. And you said that the effects occur to varying degrees; correct?
A Yes.
Q Okay. Now, at the high end someone who has received a very large dose of Midazolam, they could be induced into full anesthesia; right?
A Correct.
Q And at the low end, very low end for a patient who's less susceptible to the drug, those effects might be barely perceptible; (sic) right?
A Now, when you say less -- you said less susceptible?
Q Correct.
A What do you mean by -- what would you mean by that?
Q So do you have an understanding of when a patient would be more or less susceptible to Midazolam?
A I have an understanding.

Q Okay. So under your understanding of an occasion where a patient would be less susceptible to Midazolam and in that occasion where a patient receives a low dose, the effects in some cases could be barely perceptible?

A I think that those are two separate things. There are patients who might be less susceptible, and there are some patients where, you know, they would have normal susceptibleness, I suppose. And the effects of Midazolam would be, you know -- I mean, if a very, very small amount was given, then it seems reasonable to assume that's not as strong and a reaction might be present of all of these things, for example, stupor. But amnesia is present in my experience to occur even with small dosages.

Q Okay. Now, as a practitioner have you ever given a dose of Midazolam and then subsequently given a second dose?

A Yes.

Q And can you -- at the times where you've given a second dose, has that ever been a result of your medical opinion that the first dose was not sufficient to achieve the desired result for the patient?

A Yes.

Q Okay. And when you've reached that conclusion, has that typically been based on your clinical observation of the patient?

A Yes.

Q So I want to talk about somnolence and stupor, which you identified as effects of the drug. Now, pardon me because I've looked up the definition of somnolence in an online medical dictionary. There it says that somnolence is defined as drowsiness or sleepiness. Is that reasonably accurate?
A That's fair.
Q Okay. And it's in large part one of the main objectives of the drug to induce that relaxed state in a patient; right?
A The patient doesn't have to be sleep. They just have to be relaxed.
Q Okay.
A I guess I would add that benzodiazepines don't really put people to sleep in maybe the way that that might be commonly understood.
Q But as you were saying, a high end of dose would induce anesthesia in a patient?
A A high enough dose, you know, can cause a, you know, a state of unresponsiveness.
Q Okay. And where a patient is no longer conscious?
A Conscious is a term of art, and it's somewhat in dispute in the medical literature.
Q Okay. So you're not sure whether there is an objective definition of consciousness?
A Well, I think that there are people that may claim what consciousness is but I think it's -- under the circumstances

here, it's not clear that it produces what I think might be commonly understood that is unconsciousness. It produces a state of unresponsiveness, but the interior experience, you know, cannot be known.

Q Absolutely. That's exactly right. The state of stupor, again my layperson's googling of it, arrived at a definition of partial or nearly complete unconsciousness. I recognize you don't like that term, but is there a substitute there? Partial or nearly complete unresponsiveness, is that fair?

A Well, I guess, and it's a range. So stupor, you know, can be anything from mild to moderate, you know, to more than moderate.

Q How would you identify whether a patient is experiencing moderate or extreme stupor?

A By talking to them, by looking at them.

Q Okay. And what sort of responses would you receive to lead you to conclude that the patient was experiencing moderate or severe stupor?

A Well, if a person became unresponsive, you know, their eyes closed or, you know, their breathing changed, so something in the -- under normal circumstance of when I would call their name or interact with them and they would not, then I would -- I could -- I mean, would imagine that under those circumstances, that would be a severe case of stupor.

Q Would a person who's experiencing moderate to severe

stupor generally become less aware of their surroundings?
A Yes.
Q We talked earlier about how the guardrails are typically up on the stretcher whether or not a patient has received Midazolam. Remember?
A Well, if nothing is being done to the patient. If something is being done to the patient, then the guardrail would have to be lowered.
Q I should have specified. When a patient is being transported, the guardrails are typically up?
A Yes.
Q And that's generally a policy; right?
A I can't speak to a policy or not, but that's generally a practice.
Q Okay. So maybe it's optional, but it's considered a good practice?
A It's considered a good practice.
Q One of the things that you talked about as a regular practice in anesthesia was obtaining the patient's consent before going forward with the procedure; is that right?
A Yes.
Q In your experience that's a common practice?
A Yes.
Q And I think what you said is there are some cases where there may be choices involved, and it's your practice to make

sure that the patient is aware of the choices in the election in order to decide the course of action?
A Yes.
Q And you're not aware of any basis to conclude that the patient here, [redacted] did not provide his informed consent or refuse medical treatment, are you?
A I don't understand your question.
Q It was a bad question. Is there any indication in the patient's medical record that he did not provide informed consent for the procedure?
A For the surgical procedure or for the anesthetic?
Q Well, let's take them one by one. For the surgical procedure?
A I believe that he signed. There was some at least attestation that he signed with provided consent.
Q Okay. And is there any indication that he did not provide consent for the anesthesia?
A Not that I can see.
MS. PROUT: If I could just have a minute, your Honor?
THE COURT: Uh-huh.
(Brief Pause.)
BY MS. PROUT:
Q I did want to ask you a few questions about Defense Exhibit 1.

A Sure.
Q I take it this is a package insert for Midazolam?
A Right.
Q On the first page on the left hand column, clinical pharmacology, the insert says that the effects of Midazolam on the CNS -- that's the central nervous system -- are dependent on the dose administered; right?
A Yes.
Q Okay. And it says that onset time of sedative effects after IM administration -- what is IM administration?
A Intramuscular.
Q Okay. In adults 15 minutes. Okay. We didn't have intramuscular administration here, did we?
A I don't know.
Q Okay. You don't know. Okay. And on page 2, the section that you discussed with Ms. Parmer on the left hand side, Information for Patients, Number 4, patients should be informed of the pharmacological effects of Midazolam, such as sedation and amnesia, which in some patients may be profound. Is it your experience that when obtaining informed consent, patients are informed of that information?
A Well, you mean when -- you mean obviously before, not afterwards?
Q Yes, before. But when they are providing their informed consent.

A For what? For the anesthetic or what are you asking me? Informed consent for --
Q Informed consent for receiving their anesthesia care.
A Are you asking me if I tell patients that if they get Midazolam, that they should be knowledgeable of these possible effects? Is that what you're asking me?
Q Well, it says here that patients should be informed of the pharmacological effects of Midazolam; in some patients it may be profound. Do you inform your patients of that?
A Yes, I do, yeah.
Q Okay. And then on the last or on the third page, Dosage and Administration, if you could turn to that page where it says Monitoring on the left hand column.
A Yes.
Q Do you see where it says, Patient response to sedative agents and resultant respiratory status is variable? You see that?
A Yes.
Q And that's consistent with your experience; right?
A Yes.
Q And sedative doses should be individually titrated. Do you see that two lines down?
A Yes.
Q And that's your practice; right? To individually titrate a dose; right?

A Yes.
Q Based on patient characteristics?
A Yes.
Q And in your experience does regular alcohol use make a patient more susceptible to Midazolam or less susceptible?
A I don't know when you say regular alcohol. What do you mean?
Q One to two drinks per day say?
A I haven't -- what are we talking about? Beer or something else?
Q One to two alcoholic beverages.
A I don't know. I think it's very variable. I don't know.

MS. PROUT: Okay. That's it. Thank you.

MS. PARMER: I have two very brief follow-ups, and I think we would ask for a quick break.

THE COURT: Uh-huh.

REDIRECT EXAMINATION

BY MS. PARMER:
Q Dr. Zivot, you were asked on cross-examination whether you had any familiarity with the regular practice of the VA, and you said no; right?
A Yes.
Q So when it comes to deciding as an anesthesiologist whether or not to give Midazolam pre-operatively, is that in your experience just a blanket policy of a hospital or is it

more practitioner by practitioner, patient by patient?
A I think that every anesthesiologist -- the common practice is what I'm speaking to, that the common practice is to give some pre-operative Midazolam under these circumstances.
Q And in terms of Emory, where you are now, do they have anything in writing that would say, you know, we give this much Midazolam in this setting followed by this much in that setting? Is it that kind of scripted out?
A No.
Q And is that what you would consider a regular practice of all the hospitals and medical institutions that you've worked at, to allow it to be kind of a physician by physician situation?
A Yes.
Q Okay. Another thing that you testified to was that typically you give the Midazolam, and then you escort the patient to the room. In this case, you know, we talked about a resident versus the supervising anesthesiologist. You also deal with residents. In your experience would it be okay to allow the resident or somebody else to monitor the patients that are escorted?
A Yes.
Q So there have been situations -- and you can elaborate on this -- where you might give the dose and then leave and go to the OR and wait for the patient to come accompanied by

somebody else?
A Well, once I give the dose either I or the resident would stay with the patient.
Q So either you or a resident could stay with the patient after you, as a supervising anesthesiologist, gave the dose?
A Yes.
Q So long as either you or the resident anesthesiologist is there to accompany them?
A Correct.
Q Okay. And you also testified on cross about you would know kind of the effects -- you would know if it was working on a patient based on how they were acting and -- just correct me if I'm wrong. But what you would look for is whether they seemed intoxicated. Is that fair?
A Yes.
MS. PARMER: Okay. I have nothing further.
THE COURT: Dr. Zivot, thank you very much. You may step down. Why don't we take a break at this point. Let's say 3:30 let's be back. It's now about 3:17, according to that clock, so about 13 minutes.
(Brief recess.)
COURTROOM DEPUTY: All rise. Court is again in session, the Honorable Justin S. Anand presiding.
THE COURT: Thanks very much. You may be seated. Ms. Parmer.

MS. PARMER: Defense calls Mr. [redacted]

[redacted]

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

COURTROOM DEPUTY: Thank you. Could you please just state your name for the record.

THE WITNESS: [redacted]

COURTROOM DEPUTY: Thank you.

DIRECT EXAMINATION

BY MS. PARMER:

Q All right, [redacted] let's talk a little bit about you. What's your most recent employment?

A United Talent and Fairmont Brine Processing.

Q Okay. What's that?

A Turning tracking water in the salt. I accept the trucks, look over the contracts, look at how many barrels each truck is bringing, basically taking track water and making it clean again.

Q Okay. What did you do for employment before that job?

A MDBS Creative, which I still own and try to operate when finances are available.

Q Okay.

A I purchase retail overstock at 3 to 20 percent of retail value, sell it on Amazon, sell at yard sales, stuff like that, and do remodeling with some of it as well.

Q Take me back a few years. Tell me about what employment you had, if any, with the VA.
A I had ten years with the VA.
Q And what year did you start working at the VA?
A In 2004.
Q Until roughly?
A 2012. In fact, they're sending me back pay finally, took them long enough.
Q And my understanding is that you had a bunch of different jobs at the VA. What were they?
A I started in the laundry as a temporary, became a Schedule A disabled veteran, was given the opportunity to go permanent in housekeeping, went into housekeeping, became a housekeeping safety officer, did the heritage month every month -- well every May. I was in charge of May and was on several boards and committees, ended up starting school and getting a promotion, I guess you could say, applied for a different position, became a medical support assistant, which is what I was at when I resigned from the VA.
Q What does a medical support assistant do?
A It's like a secretary. In fact, I was one of the secretaries that would record patients as they came in. In fact, I remember the lady that sat at the desk by where my pre-op was as the same position I have.
Q Okay. So you're referencing that you worked at a

different location?
A I worked, yes, Pittsburgh and Charleston VA.
Q Okay. Let's talk a little bit about you referenced going back to school. Tell me about your education.
A Right now I'm pursuing a masters in project management at Walden, pursued my MBA with Strayer, had two weeks to finalization before my lung issue and all this.
Q Okay. Now, you've referenced being a Schedule A disabled veteran. Why don't you start by telling me when -- I'm presuming you joined the military -- when you joined the military and what branch.
A United States Army when I was 18, 11/7 of 2000.
Q Okay. And why don't you just tell me various locations and jobs or divisions that you were in while serving in the military.
A Let's see, I started my training at Fort Sill, Oklahoma for basic combat training, advance training AIT, was in Fort Jackson, Columbia, South Carolina, went into Airborne School in Fort Benning, Georgia, was transferred from Fort Benning, Georgia to Fort Bragg under Third Group Special Forces. Before entering Third Group Special Forces was replaced in the 82nd Airborne Division where I was injured and took a general discharge.
Q Okay. What kind of injury did you get?
A My wrist does not turn.

Q Okay. You're indicating your right wrist?
A Right wrist.
Q Tell me what happened that resulted in that injury.
A I was working -- I was a mechanic, a special operations mechanic, and we were doing training in Fort Mojave -- well, Mojave Desert in Fort Irwin, California. I was underneath a Humvee when we had a gas attack, private jumped in and the Humvee took off. I was underneath. My wrist got snapped.
Q Okay. What year was that?
A I believe that was 2001 or 2002. I mean, it's been a long time.
Q Okay. Did you ever sustain any other injuries while serving?
A My right knee during the drop in September of 2011 or -- I'm sorry, 2001, because I was in the hospital for 2011.
Q Okay. So you've had a couple injuries and --
A Several more than that but yes.
Q Okay.
A Back, several others.
Q Okay. Your back as well. In terms of receiving medical care, where do you receive your medical care?
A Unfortunately, the VA.
Q Why do you say unfortunately?
A After this, I'm scared to go to the VA. Let's put it that way.

Q Why are you scared to go?
A I don't know if I did what I'm accused of, and the way they painted me as a monster, that's not me. I've been drunk. I've been intoxicated many times when I was in the Army, in my youth. I never acted like that no matter how bad I was, no matter who I was around. That's not who I am.
Q Let me ask you this: You referenced -- when did you ultimately leave the Army? What year?
A 2002.
Q Okay. Now, you've referenced drinking in your youth and in the Army. At the time of this alleged incident and now and, you know, kind of leading up to this, what are your habits in terms of intoxicants?
A I can't drink.
Q What do you mean by that?
A Maybe one beverage and I have a headache the next day for two to three days. I'm no good.
Q So at the time of this alleged incident in 2015, did you ever report drinking one to two drinks a night?
A No.
Q When is the last time that you remember drinking heavily to the point of intoxication?
A After this incident I did.
Q Okay.
A I was quite depressed, and I lost a job, a very good job

that I worked very hard to obtain, yeah.
Q So leading up to this incident, would you consider yourself somebody that drank regularly?
A No, and I had ample opportunity. I did marketing for Darius Rucker for years. There was free alcohol all the time.
Q And you abstained?
A Why? I mean, who wants to hurt.
Q So in your -- it's -- you've seemed to discover in yourself that you have a bad reaction to alcohol, so you don't drink alcohol?
A Yes.
Q Let's talk a little bit more about your job history, and you don't have to get into all of it. Have you ever been a stripper?
A No. I'm sorry, but I wouldn't make much money I'm sure. I've done medical research, one of which a publication received first place in lupus and cardiovascular in the African American Seattle woman from Charleston, South Carolina to Washington, D.C. I've done, I mean, numerous, numerous facilitations, health fairs. I've worked with a lot of non-profits out of several board members, been a board member of one of the largest churches in Charleston, South Carolina. So, yeah, I've done a few things.
Q But never stripping?
A No. I don't have no rhythm, so I doubt I'd be good.

Q Let's go back to part of the days leading up to this incident. You experienced what they've termed a spontaneous pneumothorax; right?
A Collapsed lung.
Q Collapsed lung. Okay.
A It happened the week prior. They weren't able to treat me properly, so they discharged me and told me to come back.
Q Okay. So you went to the VA. Do you remember the date that you first went to the VA to get serviced for this, treatment?
A You know, because of the paperwork and the case, I'm thinking the 19th, but I'm not a hundred percent. But it was the 19th.
Q But you do remember going and not going straight into surgery?
A Yes, because I got very irritable, as a matter of fact, with a gentleman I just seen in the hallway. So, yeah, I remember that.
Q Okay. What -- and we may get into that. When you went to the VA on the 19th, describe your condition. How were you feeling?
A Pain.
Q Okay.
A Severe pain to the point where, yeah, I went to the VA. So that should tell you how much pain I was in.

Q Okay. And you were ultimately discharged; right? What were the terms of the discharge? Did they tell you what to do? Did they schedule surgery? Kind of let me know what happened there.

A Basically there was either a resident or a surgeon that they wanted to do the operation. I'm not a hundred percent in recollection, so I don't want to mislead. So basically I was told by an older gentleman who came in, set beside of me. He said, we want to discharge you. We can't keep you here or we can keep you here, but you can't have surgery until next week.

I was finishing my masters. This was the second attempt after the first collapsed lung. I wanted to get back and get my school work done, couldn't get it done from there. So I went home on a discharge.

Q Did they give you any medication?

A I was on Dilaudid and/or Demerol, something with a D, and Oxycodone.

Q To deal with the pain that you reported?

A Yes.

Q And you were given a prescription to last until the 23rd of one or was it both substances?

A I think even longer than that because there was still pills left when I got home from surgery in the pill bottle.

Q Okay. And they told you to just take it as prescribed for pain?

A Per needed or per PRN, I think, is written on there, but it's every two to four hours as needed.
Q So you returned to the VA on the 23rd; right?
A Yes.
Q And tell me -- just kind of tell me extemporaneously what you remember on the 23rd.
A I remember getting there with my fiancee at the time, Tiffany. We walked up to either the second or third floor. We were there early, so my fiancee wanted to go get breakfast. It was quite painful for me to walk, but I chose to walk with her. And we walked down to, I think, the first floor, walked back up, sat in the waiting room. I was on my laptop typing.

Somewhere in that timeframe a middle aged woman came out and called my name, took my vital signs, asked me where my pain level was, asked me if I needed anything for pain, then directed me with another similarly middle aged young lady that took me back into a room with a bunch of curtains, which was kind of at the corner of where I was at getting my vitals.
Q And what do you remember from that room with the curtains?
A I remember being nauseous. I remember being asked to place all my belongings that I hadn't left with my fiancee in a bag. I remember putting a gown on. I remember laying down and two student nurses coming up with a young lady that handed me the gown, neither of which was present today.
Q Okay.

A And then after that, I don't remember much. They told me something -- they gave me a -- it was a hollow needle, but they specified that -- I mean, it was as big around as this cord. They specified it would hurt, and they placed that right here on my left wrist. I had an IV right here in my left arm. I remember them taking an inventory, but other than that that was -- I mean, that's literally all I can remember. I remember waking up briefly in ICU. After that, I don't remember even being discharged.

Q Okay. So how did you find out about this allegation?

A My fiancee and my father, and then afterwards, the ticket. I got a -- I think it was a call or a letter or something. Something came to my house in February of 2016. Maybe it was Michael that came. Somehow I was contacted in February of 2016. That's when I found out about --

Q Do you remember any interaction with the police while you were in the hospital?

A Briefly. I remember being upset, and I remember a nurse coming in. And I remember my dad -- now, this is what my dad told me, so I don't know if it's what I remember or what he told me.

MS. PROUT: I'm going to object if there's hearsay.

BY MS. PARMER:

Q You can just talk about what you remember. If you don't remember, you don't remember. Do you remember any interaction

with police?
A I do, but I don't remember what. I remember being upset, very, very upset.
Q When you woke up after the surgery?
A Some point in time. I can't tell you literally from the time I put that gown on and had my arm full and my inventory taken to the time I was discharged. I've got photographs with my fiancee in the hospital. I don't remember taking them.
Q Do you remember -- you know, you've seen a number of people testify today against you. Do you remember specifically any interactions with Dr. Patel?
A Unless she was one of the students, which I don't think she was because of her skin color. And I hate to say that, but I remember specifically the two students were African American females, and I remember because of one of them's hairdo and my previous child's hairdo. I used to do the same two-strand twist with her, and that's how I remember. I don't remember her.
Q Do you remember Nurse Etta Marie?
A No.
Q So the last thing you remember is an IV and also an injection?
A And being coded with her and an inventory.
Q An inventory, okay. Do you remember making any references to being a stripper or having a penny?

A Sorry.
Q Do you remember being moved down the hallway?
A No.
Q Did you touch Nurse Etta Marie on her behind?
A I sure hope not. If I did, I want to apologize, but it doesn't sound like me in any fashion.
Q When you say it doesn't sound like you, why do you say that?
A After seeing her today, several reasons.
Q What do you mean by that?
A Not my style.
Q When you say not your --
A Not my taste in women. Not only that, we're in a professional environment. My fiancee was there. I was quite happily engaged till an illness took her, so I don't understand. I just don't see that being possible, and I honestly doubt that it happened.
Q And you have no recollection of it whatsoever?
A No.
Q How did you feel when various people, your family, your fiancee, myself, kind of started telling you about the allegations against you?
A Same way I feel now, so angry I can barely sit still.
Q How do you feel in terms of -- what would you say to Nurse Etta Marie if you could say --

A I really honestly hope that she understands that that's not me, if that happened. I've been in situations where -- I have a very good friend who was raped, and just being eyed in public makes her uncomfortable. And so, I mean, I could have caused those feelings in that nurse had I known. I've got nurses that I've worked with for over eight years who every day are subjected to that, one of which I talked to last night, had a patient that continuously rips off the catheter. And, you know, there's that type of stuff happening. So on one side of me I feel, you know what, put me as an example, make me guilty. The other side knows that's not me.

Q When you say put me as an example, make me guilty, why are you saying that?

A These patients shouldn't get away with it.

Q What do you mean by these patients? Are you referencing yourself?

A There are veterans. I've seen veterans in the hospital. I was a housekeeper on the floor. I was a secretary on the floor. I've seen it happen daily, day in, day out. Most of the nurses shrug it off. Some it does bother. Either way it shouldn't be happening, and the thought that I could have been pun of those patients, just a man like that in general, it's not me.

Q You referenced being familiar kind of with the layout of the VA because you worked at a VA for --

A I worked at five VAs. Pittsburgh has three plus a CBOC, and Charleston has one plus several CBOCs.
Q What do you remember? You said you kind of remember a few things as to the intake area and the pre-op area. What do you remember about recordkeeping?
A In the VA?
Q You know, we can talk generally, but why don't you tell me specifically with October 23rd kind of what you remember, if anything, about people entering notes nearby you or do you have any recollection of that?
A I remember there was the lady that took my vitals had a COW.
Q What's a cow?
A A computer on wheels. The VA's term is COW. I think they even changed the terms for them now. I've been out for almost seven -- five years. So there was one with the lady who was taking my vitals and who gave me my medicine. Now, there was another lady three curtains in with another patient. She was sitting on a COW. The lady that was with me when she took my inventory did not have the COW, before she took my inventory had the cow. And another nurse took that COW to the end of the room. I don't know with another patient, what.
There were two computers at the desk with the secretaries and that was -- like the curtain was here. The secretary desk was here. I came in here to the vitals. So,

in other words, you check in with the secretary here. You go over to the waiting room. They come out in the hallway and grab you. That's pretty much what I remember.

Q Okay. In your experience generally -- like you said, you kind of served as a secretary -- what's your experience generally with the recordkeeping at the VA?

A You want to know the truth? I've had patients come in and check in with an appointment, and it shows that they're deceased. What better records could be than that? I've had wives call me and tell me that they, you know, received a call that their husbands or loved ones have passed, and they're healthy and fine sitting in Bed 4 or Bed 3.

You've got to have a computer access card to gain computer access. A lot of times the residents will sit in stations on the floor and leave their card, go make the rounds, and come back or take their card with them. Either way they're not going to use the computer along the hall. They've got all their information on this computer. It's easy to pop up. Just put the card in. They've got it locked. I did it for years.

Q Fair to say it's sloppy?

A I can make a call now and have the nurse go into anybody's records if I knew their last name and last four and change anything in the record. Anybody could. If you know somebody that has access to the CPR or Vista, you can change anything

in the record.
Q Have you ever been accused of sexual assault before?
A No.
Q Have you ever sexually assaulted anybody before?
A No.
Q How has the experience of being accused of this and going through two and a half years of prosecution made you feel?
A Two different ways. One, I'm just tired, and I want it to be over. Two, I want to know did I do it or not, and I don't know. In my heart I know I didn't, but after hearing what I heard today, it's -- it hurts.
Q When you say in your heart I know I didn't, what do you mean?
A There's no way it's me, intoxicated, sober, otherwise. My wrist doesn't turn to open a can of tuna. How -- I've got holes in my lung. How am I getting up out of the bed doing this? It's almost impossible physically.
Q And so you have no recollection of anything that's been described today?
A Some of the things that's been described today.
Q Such as --
A Nothing after the pre-op. You know, as far as was I voluntarily there for a surgery, no. If I could have went anywhere else, I would have. In fact, if they would have fixed it the first time in June, I wouldn't have had to be

there in October.
Q So you first had a collapsed lung in June?
A My first one that was realized.
Q Okay.
A They documented that as being thrown by a jet, which has happened to me, but it was not the reason for my lung collapsing.
Q Okay. You mentioned that you are Schedule A disabled veteran. What does that mean technically?
A A little higher service connection, I believe. And Schedule A is more -- I don't know a hundred percent. I know half of the Schedule A can be mental. The other half could be physical. Basically I'm one degree short of being paralyzed with my right wrist.
Q Okay. So yours is physical?
A Physical.
Q And what percentage disabled are you?
A 40 percent right now.
Q And have you been back to the VA since this experience?
A Not in Atlanta. I wouldn't.
Q Why not?
A You know I called you the whole time. There's no way I'm going for my medicine so that some cop who wants to go after me because I made some people mad when they discharged me with a collapsed lung could write me another ticket for doing

something else. Next time I might have groped a man. I might have groped two women. There's no way I was going to do that.
Q You referenced this discharge October 19th as kind of happening under difficult circumstances. What are you referencing?
A When I was in the hospital during the 19th, one of the nurses stole my medications.
Q How do you know?
A Because every time they'd give me the medication there was two syringes. As soon as they'd give me the first one they'd put the second in the IV to flush it. After I got the second one, it would be less than ten minutes I was asleep, I was out.
Q It was a heavy medication?
A Big time.
Q Okay.
A When he gave it to me, he had one syringe. I didn't go to sleep. My pain level was through the roof. I had to continuously call to the point where they brought the -- I forget the -- AOD is what it is, administrator on duty or something. Basically she's the charge nurse for all the floors while no one else is there from the business side.
They gave me something called Tylox, which immediately I was, again, a pleasant patient. I'm not in pain. I'm laying down. The next day or the day of discharge,

whenever it was -- I don't remember the consecutives there -- I went to the director's office furious and wanted to make a complaint, wanted the nurse investigated. I'm a fairly young guy. I was able to remember this. What about these patients that are laying here with bed sores that are there day in and day out? And this was a SICU floor.

Q So you made a complaint to somebody in charge about the fact that you thought a nurse had stolen your narcotic pain medication --

A I know for a fact he did. I was sent from the director's office to a resident or a doctor's office across -- I believe it was either across the hall or down in HR. In fact, I seen the guy here today. And I went off on him because he wanted me to sign a release of liability for the hospital, for the facility.

Q For the theft of the medication?

A For the theft of the medication and that they would have the charge nurse investigate him. I worked ten years on the floor. I know charge nurses. I know how they are. I know what they do. They're not going to investigate nothing. They're going to say, hey, if you're doing something, stop it. It's starting to get noticed. You know, they get audits when that stuff happens. That's the biggest thing that's going to be in an investigation, an audit.

Q So you were upset?

A I was furious. I went off on the guy. I mean, I wasn't a pleasant guy like right now.
Q And so then you were discharged that day; you came back on the 23rd?
A Yeah.
Q Okay. Is there anything else that you remember about the 23rd?
A I remember waking up that morning. I remember taking my medication. I remember getting in the car, taking my medication again. I remember getting to the hospital. My fiancee carried my book and my laptop to the floor. I remember I couldn't do the work I was attempting to do.
Q Why not?
A Think about it. I was on more pain meds than a little bit.
Q What pain meds were you on that you had been prescribed?
A Oxycodone.
Q Did you take anything that wasn't prescribed?
A No. I don't like to take what is prescribed. I've got a whole trunk full. Do you guys want them?
Q No. Do you know the janitor, Harvey Clark?
A Never met him before in my life.
Q Did you at all recognize him either when he testified today?
A No.

Q Is there anything else you'd like to say?
A If it did happen, I'm sorry. I'm sorry for wasting everybody's time, and just remember I wouldn't have intentionally did it if I did.
Q So you're saying that it just sounds to you it's just completely contrary --
A To me it sounds impossible, number one, and it sounds like what do they call a conspiracy, because I went off on the VA. That's what it sounds like to me. This isn't the first time I've been in court with the VA, and it's not the first time -- I beat the VA in court without a lawyer the first time.
Q But as to kind of the testimony today about the medication and what happened, you don't remember any of it?
A I wish I did.

MS. PARMER: That's all for now.

THE COURT: Okay.

CROSS-EXAMINATION

BY MS. PROUT:

Q Hi, [redacted]
A How are you?
Q You testified that you served in the military back in, was it around 2000 to 2002?
A Uh-huh.
Q Was it about 18 months that you were in the service?
A A little longer than that.

Q How long?
A I believe it was two years, two months.
Q Two years, two months.
A It may have been 18 months. I don't keep track of that stuff.
Q Okay. But the reason you were discharged was because --
A I took a general discharge.
Q And general discharge, is that different than an honorable discharge?
A It can be.
Q In your case --
A I didn't want to sit in a medical unit for a year. I was a young kid. My wrist was completely separated, which still hasn't fixed.
Q Was there any other reason for the general discharge?
A My first sergeant told me the only way I could get out without a med hold was to get caught under age consumption of alcohol, so I did consume alcohol and went to PT formation, had to do it twice.
Q So I'm going to --
A And my captain still didn't want to let me out.
Q Government's Exhibit 4.
A Separation misconduct, underage consumption of alcohol.
Q What is this we're looking at? Is this your discharge document?

A 28, Number 4, copy of DD-214 for me, myself, [redacted] It was a narrative reason for separation, was actually misconduct because of the fact that, again, instead of sitting in a med hold unit, my first sergeant advised me to show up to PT formation. Consuming alcohol as an underage member, that would get me put out. The first time I did it my captain would not put me out. He said I know why you're here. I know what you're doing. He argued with me.

I went back to formation the next day drunk, and that is how I got it. And even then he fought me for two weeks before he would give me a dragon stamp because he said, B.J., you're a good soldier, do you know what this means --

Q I'm going to stop you because --

A Well, if you want to bring it in, you've got to bring it all in.

MS. PARMER: I think that, you know, a lot if this is irrelevant, and we want to keep it, you know, just to the relevant evidence.

THE COURT: Well, is there an objection?

MS. PARMER: Yeah. I'm going to object to this being irrelevant and beyond the scope of direct, also prejudicial, improper impeachment.

THE COURT: So what's your response?

MS. PROUT: First of all, I would move to strike the hearsay from the statement. But as far as relevance goes, I

think the defendant clearly testified about the grounds for his discharge on direct, and so I'm examining those grounds and that's all.

THE WITNESS: I was a 19-year-old kid who wanted out and didn't want to sit in the hospital with a cast.

THE COURT: Well, I'm going to overrule the objection because I do think it is within the scope of the direct testimony as to discussing the discharge, so I'm going to overrule it on that ground.

MS. PROUT: And I will move on at this point.

You never provided medical care at the VA, did you?

THE WITNESS: Provide?

BY MS. PROUT:

Q Correct. You weren't --

A I'm not licensed to provide any care.

Q And you never were responsible for entering medications that were administered to patients in --

A I was responsible for scanning the records, making sure that all those records were in.

Q Okay. So --

A So I know the exact procedures for them.

Q So Exhibit, I believe it's 2 that you may have in front of you.

A Government or defendant's?

Q Government Exhibit 2, the anesthesia records.

A Okay. I found them.
Q Were you responsible for entering that type of information into the anesthesia record of patients?
A That has been over five years. If I did any ambulatory care, it was as a temp. If I would have entered any information or even scanned in the records or any of that, it would have been something I don't remember, highly unlikely that I would put in anything about medication because I didn't administer medication.
Q And so --
A Now, if you would have wrote down on here, I would have scanned it into the system.
THE COURT: [redacted] you've got to wait for the question and answer the question.
THE WITNESS: I'm sorry.
BY MS. PROUT:
Q Okay. So being a person who was not responsible for entering those medication records into the anesthesia, no, you don't have personal knowledge of how those medications or when those medications were entered, do you?
A Yeah. I can look on there and find out, and I can look on there and change it. Anybody can who has access to the CPRS.
Q So your testimony is that you're able to change the records at the VA?
A Anyone who has access can change a patient's record. Now,

they can't change everything about it, they can't remove everything, but they can change the records in the system.
Q And is that a standard practice --
A It was testified by your own witness here earlier that it can be backtracked and back stamped.
Q Is it a standard practice in your experience --
A I would hope not.
Q Let me finish my question, sir. Is it a standard practice that you're personally aware of that after a medical procedure was completed, someone would go back in and change the records?
A It was very standard, very standard for a nurse to remember something, very standard for a patient to arrive on a floor when you have five patients coming to the floor at one time and the nurses go back in the notes and change the notes. One nurse would actually put something in a patient's file because she was typing so much that she was putting the wrong information in the wrong patient's records, so she'd have to go back and remove it, put it back in.
Q How much time did you spend in the operating room in your job at the VA?
A As a housekeeper or as a secretary?
Q How much time overall?
A Three years.
Q How much time per day would you spend in the operating

room?
A Eight to twelve hours. If it was a heart transplant, I could be there up to 18 hours.
Q And so you'd be in the operating room during the surgery?
A If I was the janitor, I'd be on the outside. They would hand out bags sometimes. But as far as being in the operating room, no. No sterile environment should be.
Q Okay. And the computer for entering information in the operating room, that's located inside the operating room; right?
A I get what you're saying.
Q I'm just asking you. Is it located inside the operating room?
A She could have gave me the meds in pre-op and went in the operating room and entered it because she is locked on that computer. But, yes, what you're saying is true.
Q Okay. So your involvement with the operating room was on the outside, but the computer was on the inside; is that correct?
A There's a computer all over the operating room. Two is in the hallway in the stations. There's some at the secretary desk. There's some in the pre-op. There's some right after -- before you scrub, and there's some after you scrub.
Q Okay. And so if the provider is administering medication in the OR, would they ever come out of the OR in the middle of

surgery to enter medication in the medical record?
A Highly unlikely. But what if the computers are full? I've seen them dance in the OR with Jay-Z. So, I mean, there's a lot of things that happen in the OR that's a little different.
Q So anything is possible?
A Very much.
Q Okay. You testified that it wasn't your choice to go to the VA for surgery?
A No.
Q Did you shop around to find other options?
A With what healthcare that I can afford?
Q Okay. So when you said it wasn't your choice, what you meant is you couldn't afford to go to another provider; is that right?
A Yeah, because every time I get --
Q Sir, could you just --
A -- insurance the VA tries to charge me for service connected conditions. So why would I pay a private insurance company to pay the government for something that had they done right the first time and not practiced and actually done something the way it was supposed to be done or be licensed, I would have never been in that situation.
Q Okay. And if money were no object, it sounds like you would have absolutely preferred to go to another hospital?

A I would go to a community clinic versus that hospital if they had the sufficient means of fixing me.
Q And other than money, there was no reason preventing you from doing that? Is that a yes?
A Yes.
Q Okay. You testified on direct that you were not much of a drinker?
A In my youth I was. I was a heavy drinker in the Army.
Q Back in 2015.
A Very rarely.
Q Okay. It was not your practice to drink one to two beers per night?
A No. It gets me sick. I mean, I drank so much when I was in the military, that it makes me sick to this day to drink.
MS. PROUT: Okay. I've got no further questions.
THE COURT: Any redirect?
MS. PARMER: No redirect.
THE COURT: [redacted] you may have a seat.
THE WITNESS: I'm sorry for the attitude.
THE COURT: That's all right. You may step down. Anything further from the defense?
MS. PARMER: Nothing at this time, no.
THE COURT: Okay.
MS. PROUT: Your Honor, we do have very brief rebuttal to call if you want to proceed.

THE COURT: Okay. Let's see. Yeah, let's go ahead and begin with the government's rebuttal case.

MS. PROUT: Okay. The government calls Dr. Patel.

THE COURT: Okay.

COURTROOM DEPUTY: Please raise your right hand.

KINNARI PATEL, M.D.,

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

COURTROOM DEPUTY: Thank you. Would you please state your name again for the record.

THE WITNESS: My name is Kinnari Patel.

COURTROOM DEPUTY: Thank you.

DIRECT EXAMINATION

BY MS. PROUT:

Q Hi, Dr. Patel. Just to remind you, you're still under oath. I'm going to show you Government's Exhibit 7. I apologize that this has not yet been redacted. We'll replace it with a redacted version, and we do not have copies of this unfortunately. What is Government's Exhibit 7?

A This appears to be some imaging that was done and part of the anesthesia pre-operative record.

Q For what patient?

A For [redacted]

Q And is that record familiar to you as the type of progress note and record that the VA typically kept for pre-operative

patients?

A Yes, it is.

MS. PROUT: I move to admit Exhibit 7. If you need to --

MS. PARMER: We object for a number of reasons. I don't think she's authenticated it. I don't think that she can authenticate it unless she's familiar enough with it. I know this would specifically be what it purports to be, and I don't think we've established that yet. I also think that it's hearsay, and again we renew our objection for it not being redacted protected medical information that we have not agreed pursuant to our standing order to allow in.

THE COURT: Yes.

MS. PROUT: Your Honor, with regard to hearsay, it's a medical record which falls under one of the hearsay exceptions I believe is 8034. And with regard to authentication, she just stated that it's the type of medical record that she has seen at the VA, and this appears to be [redacted] medical record from that period. And if you would like, we can pass it up to your Honor for review. I apologize for only having the one copy.

MS. PARMER: I don't think that she can testify as to its contents being in the same or similar state that they were at the time that they were made. I don't think she has familiarity to the level to authenticate this record, which is

a different record from the types we've already seen here before.

THE COURT: Let me let you have an opportunity to voir dire. I mean, the testimony as it was was that the record was imaging and part of the pre-op records for [redacted] If you believe that -- let me give you an opportunity to voir dire on the authenticity on the foundation.

VOIR DIRE EXAMINATION

BY MS. PARMER:

Q Now, this record, you don't specifically remember entering this record yourself into a system?

A No, I don't.

Q Okay. And so you don't know if this, in fact, is an accurate record because you don't know whether or not you entered it or who did?

A Well, I can see who entered it.

Q Who entered it?

A Zauphia Daffin --

Q Do you know who that is?

A -- who was the CRNA.

Q Okay. That's not you, though; right?

A No, it's not me.

Q So you can't say that everything that she entered is, in fact, true?

A If she interviewed the patient appropriately and whatever she wrote in the note was what she had discussed with the patient, then our practice is to usually accept that.
Q But that's your practice. You can't say for sure that, you know, this was actually what the patient said. You can't say that?
A Well, no, I don't remember what he actually said.
Q And, also, you were not the one who entered this to know or interpret what was said?
A No, I did not --
Q This is not your note?
A It's not my note.
Q Okay. So you can't say whether or not this note is even in the same kind of format and with the same information as it was at the time it was actually entered in 2015?
A No, I can't.
MS. PARMER: Okay. So that's why we don't think this is an authentic document, and we object.
MS. PROUT: And, your Honor, I apologize. This seems to have left my immediate fingertips, but if I have a moment, I can produce a certificate of authenticity that was produced together with this document when we received the medical records earlier today.
THE COURT: Why don't we do this: Why don't we go ahead and I'll provisionally admit it. First of all, I don't

think it's a hearsay issue for the reasons that Ms. Prout indicated. It being a business record and/or medical record would fall under the exception to the hearsay rule. I do tend to think there needs to be evidence authenticating it, meaning demonstrating that it is what it purports to be. As a business record, that could be satisfied by a certificate. On the representation that you have one, I think we could go forward.

I'm not sure that the witness's testimony so far in and of itself would satisfy that rule, but if there's a certificate, then I don't need to make that finding one way or the other. I mean, you know, the witness knowing whether or not the entries are correct would not be the issue because it would be more to explain that the document is what it purports to be, not -- you don't necessarily need a witness to -- who has personal knowledge of the entries.

So I'll reserve on whether the testimony so far is sufficient because it sounds like you have a certificate. Let's provisionally admit it, and then I'll let you present the certificate. We can talk about the timing of that, but I'll provisionally enter it and why don't we go on.

MS. PROUT: Thank you, your Honor.

So reviewing Government's Exhibit 7, is there a reference anywhere in that document to the defendant's alcohol consumption?

THE WITNESS: Yes. I see a review of his alcohol history.

BY MS. PROUT:

Q What does the record say as far as his alcohol history is concerned?

A It says in quotes, I drink one to two beers most nights. I had a half can of beer last night.

Q Can you see what date that record was created?

A It was signed on October 23rd, 2015.

Q And was this record the basis for your testimony earlier regarding the defendant's alcohol consumption?

A Yes.

MS. PROUT: No further questions.

THE COURT: Ms. Parmer.

CROSS-EXAMINATION

BY MS. PARMER:

Q You referenced in your testimony earlier that you said that you assumed [redacted] drank one to two beers a night based on your review of the record; correct?

A That's correct.

Q But you have no personal recollection of anything he said to that effect; correct?

A Correct.

Q And, in fact, the record that you're looking at right now is not a record that you authored; correct?

A Correct.
Q And so what this is is that something that somebody else allegedly heard [redacted] say; correct?
A I wouldn't say it's something somebody allegedly heard. It's something that one of our anesthesia colleagues wrote and documented in the medical record. I would say it's something that she definitely had a discussion with the patient about --
Q But you can't say that a hundred percent; right? Because you weren't there.
A Well, no, I didn't sign the record.
Q And your testimony that you gave regarding this alleged alcohol consumption stems from you looking at that exact document; right?
A That's correct.
Q There's nothing else that jarred your memory about his alcohol consumption; right?
A No.
Q You didn't even, as far as you remember, ask him about that or discuss anything like that with him?
A I don't specifically recall discussing it, but it is my general practice to do that.
Q Okay. But you have no recollection of if you asked it or what he said in response; right?
A No, I don't.
Q And the only reason this was brought up was based on you

looking at that document and then saying that document makes me believe this; right?

A Yes.

Q Okay. So there's nothing that you remember whatsoever regarding [redacted] -- personally regarding [redacted] alcohol consumption as it was reported to you?

A No.

Q Okay. And it's conceivable that sometimes when you're entering data into this kind of system, there's room for human error. Is that fair?

A That's a fair statement.

MS. PARMER: Okay. Nothing further.

THE COURT: Any redirect?

MS. PROUT: No, thank you.

THE COURT: Dr. Patel, you may step down again. Thank you very much. Anything else for the government's rebuttal case?

MS. PROUT: No. Thank you, your Honor. And if the Court is willing, if we can take a five or ten minute recess, I can obtain that authentication document.

THE COURT: Okay. So I guess subject to that, the government rests? Is that --

MS. PROUT: Yes, your Honor.

THE COURT: Any renewed motions then?

MS. PARMER: Your Honor, we're going to renew our motion at this time for directed acquittal based on everything that we stated before. Certainly we can close, but I think at this point we have, again as I think we were before, ample evidence that somebody was under the influence involuntarily and intoxicated. And I think some things that Ms. Prout said, based on my previous motion, kind of missed the mark. And my reason for saying that is that she keeps referencing they must be insane.

And that word is used in a lot of contexts, but as it relates to the law, the test is written out in this statute, 18 U.S.C. 17. And so even though it's labeled the insanity defense, it lays out specifically what we mean by that test. And there's been a lot of filings in this case that basically say, well, he wasn't insane. Well, it's not about insanity. This is an involuntary intoxication defense. It's an affirmative defense that uses the test set out in this statute.

But it's not the same as putting on an insanity defense. For example, you know, the repercussions that follow a finding of insanity are totally different than what would follow a finding on an affirmative defense of involuntary intoxication. The test here in 18 U.S.C. 17 is whether --

THE COURT: The cases I've seen have described it as a case of temporary insanity. Would that be a fair way to --

MS. PARMER: And that's fair, but I think even then we also can say that that could be a mental defect, which is slightly different, or diminished capacity, which is slightly different, some of which the Insanity Defense Reform Act have ruled are no longer viable defenses. And so I think for this what my reading of involuntary intoxication cases show is that we use this test here so we determine whether the intoxication was voluntary or involuntary. And then we determine as to the intoxication whether the intoxication rendered the defendant unable to appreciate the nature and quality or the wrongfulness of his acts. So it's not, you know, turning and saying, hey, do we have some psychiatric or psychological evidence as to his insanity. We use this language and apply it in the involuntary intoxication framework.

First, it's clear that he was not voluntarily intoxicated. I think we have ample evidence that he was given Midazolam in a pre-operative setting not only because it's standard and typical but also because we don't have everybody here who can testify as to the many numerous opportunities they would have had to administer the Midazolam in a pre-operative setting.

The only person who testified who would have been somebody to administer it is Kinnari Patel, and she can't say for certain. What she was going off of is the record that Dr. Zivot had looked at and said, yes, there's 4 milligrams

total. But the fact that it's in a parenthetical and if you look at the actual break down of time, what it seems like is as though in the OR we're creating this record and we're entering a lot of drugs at once, but this conceivably was 2 milligrams that were administered in a pre-op setting.

All of that is consistent. Kinnari Patel is the only person who would have been in a position to administer it who testified. However, we know that Zauphia, I believe is the one who completed the anesthesia portion of the pre-operative form, she was not here, so I don't think we can say what she would have done. And beyond that, we're missing Dr. Jackson who would have been the actual person administering the drug and making those decisions.

And so without Dr. Jackson here, we can only speculate based on Kinnari Patel's complete lack of memory about what the actual facts are. But we can conclude from the records and we can conclude from the testimony of Dr. Zivot and we can conclude from [redacted] testimony that it seems consistent that this was given in a pre-op setting, based on [redacted] testimony that he remembers nothing, but he remembered getting both the drip and an injection. But a lot of different people interacted with him.

And I think lastly we have to look at the conduct that's been described by the government witnesses that seems consistent with an intoxicated person. And so I think that,

you know, I stand by the motion that I made on the government's case, and I understand that standard is different.

But another thing I'll note is that involuntary intoxication is looked at with -- unlike the Rule 29 motion, with involuntary intoxication there's deference to the defendant who's putting on that defense. And I think given everything before us and I think everything before us at the juncture before we put on our case, it seems clear that the facts fit an affirmative defense of involuntary intoxication by clear and convincing evidence, and, therefore, there's no crime. Whether or not there was even a touching, there's no crime. There's no mens rea. There's no affirmative defense, and that's why we renew our motion.

I do have a closing argument prepared as well, but I do want to renew the motion at this time.

THE COURT: Okay. I'm going to deny the motion, the renewed motion, for the reasons that I've stated before, although I know that there is more evidence now in the record. The basic rationale remains the same, which is first that, again, viewing the evidence in the light most favorable to the prosecution there's evidence to support a finding. I'm not saying I ultimately will make the finding, but there's evidence to support a finding viewing the evidence most favorable to the prosecution that the Midazolam was

administered after the alleged assault. That is, literally speaking, what the medical records state, and based on that alone, viewing that in the light most favorable to the prosecution, would support that finding.

I know that there's contrary inferences that the defense would urge me to draw based in part on Dr. Zivot's testimony to explain perhaps reasons to believe that those time entries were not accurate, and that ultimately -- again, deciding what I think the evidence shows beyond a reasonable doubt and trying to weigh conflicting inferences from evidence or conflicting evidence in the record, is not what I'm doing right now.

What I'm doing right now is simply analyzing whether we go forward to a verdict or whether the evidence even viewed in the light most favorable to the government would not support a conviction. I can't find that for all the reasons I've just said and said before. And to repeat, it's still relevant that the evidence from the testimony of Ms. Marie and the others would support a finding, again, viewed in the light most favorable to the government that there was intent, notwithstanding whether or not there was -- the Midazolam was administered prior to the assault.

The statement alone, if made, which again for the purposes of resolving this motion I assume was made along the lines of I was waiting to do this, to get the medicine, so

that I could have an excuse is sufficient to support -- and, [redacted] let me explain I'm not rendering a verdict right now. I'm not saying -- no, sir, you cannot -- I'm not deciding the question. I'm trying to -- all I'm deciding right now is do I dismiss the case, as your lawyer has argued, because there's no evidence sufficient to support a verdict.

In other words, viewing everything in the light most favorable to the government, believing every witness and taking every inference in the light most favorable that they presented, could there not be a verdict supported by the evidence. That is not so. The verdict of guilty would be supported by the evidence. I'm not saying that's where I'm going. I don't know yet. I need to hear closing argument and think more on some things, but I'm going to deny the motion to dismiss at this ground -- I mean at this juncture.

I should say, you know, technically the evidence is not complete because you need to submit that certification, but the comments that I've just made are not dependent on the admission of that document or the testimony, the rebuttal testimony, on the relatively small issue of the drinking. But we do need to complete -- submit that certificate to complete the record.

It's 4:30 anyway so even irrespective of that, I was going to propose that we reconvene in the morning for closing argument, which closing argument in a bench trial is, you

know, at least as much oral argument as it is summation of facts. It's relatively straightforward chronology instead of facts. I do have some probably more in the way of legal questions, as I've already previewed, about the intent level that applies and how that impacts the, you know, issue of how we address the intoxication.

Let me just -- this is in the end not a directly pertinent case in terms of any holding because it didn't make a holding on the question, and it's also unpublished anyway. But it frames the issue in the way that sort of frames the uncertainty that I just explained earlier on. This is *United States v. Fleming*, 902 F.2d 1580. It's a Ninth Circuit case, and it's unpublished. So it's not binding on any number of levels but -- and, again, it makes no holding on the question.

What it says is -- but, again, it frames it the way that I was struggling with. This is on page 2. Simple -- it's quoting. I'm going to drop the internal quotes and citations. But simple assault is committed by either a willful attempt to inflict injury upon the person of another or by a threat to inflict injury upon the person of another, which when coupled with an apparent present ability causes a reasonable apprehension of immediate bodily harm.

So there's two prongs essentially of what assault, simple assault, is. And this is a case applying Section 113, although it's, I think, applying a slightly previous version

of 113 because 113(e), which doesn't exist anymore, so I'm not sure what 113(e) was. But, in any event, the general notion of what a simple assault is is, I think, consistent with what I just said. It's committed either by a willful attempt to inflict injury upon the person of another or by a threat to inflict injury, which when coupled with apparent present ability, causes a reasonable apprehension of immediate bodily harm.

So I may be wrong but I don't think -- and I'll need to be convinced otherwise -- the facts here support the second prong, in other words, the reasonable apprehension prong because that requires, I think -- but I'm open to being told otherwise -- evidence that there was apprehension, in other words, that there was fear in advance of the harm. That's the difference between assault and battery; right? Battery is harm. Assault is classically the threat, attempt or apprehension of the harm. But I think the first prong the evidence would support or again I'm not saying -- viewed in the light most favorable to the government would support, which is that there was a willful attempt to inflict injury upon the person of another.

Attempt doesn't require apprehension. That first part does not require apprehension. But the way I read that and the way that the *Fleming* case states the issue raises the question whether that's a different intent level. What

Fleming goes on to say is there is some confusion over which of two definitions of willful applies. The first definition is a specific bad purpose, specifically bad purpose on the part of the actor. The second definition of willful would simply require that the actor know what he is doing.

I don't know, and you can tell me if I'm wrong, Ms. Prout, obviously tomorrow. And you both can address this issue, whether that question has been answered. I've not been able to find an answer to it in my quick research. I've seen some general statements in cases that don't apply 113 specifically but talk generally about in different state jurisprudence what simple assault means. And I've seen some suggestions that the attempt prong is specific intent because attempt classically, quintessentially, is a specific intent crime, attempt. You have to attempt to -- the attempt to do something presupposes an intention to do something illegal, but I don't know.

Maybe there's something specific to 113 that says otherwise. In this case it openly says we need not decide whether the crime of simple assault requires general or specific intent in all respects because the evidence in that case -- and it may be here too. But the evidence in that case was sufficient to convince the trier of fact of guilt even under the more demanding specific intent standard. So the appellate court punted, if you will, on that, what it saw as

an unresolved question in the law. But that's the conundrum that I was -- and it affects whether or not the extent to which the intoxication is a defense or not.

But, anyway, in any event, there is other authority that -- for example, I think the *F.D.L.* case, I think you guys both cited, and there's the *Faucett* case, Seventh Circuit, which discusses how even a general intent case at least involuntary intoxication may be appropriate, although that would be at the level of essentially at least temporary insanity. But, you know, at least one fundamental or threshold legal question is what I just posed, if we're talking about assault by willful attempt to inflict injury, is that a specific or general intent crime?

So I'll leave you with that question, and otherwise your closing arguments can be whatever you deem appropriate. But that's a question that I have that would be helpful if y'all have guidance on that.

So why don't we reconvene tomorrow morning. I mean, thinking this was a jury trial I'd blocked off several days, so I'm fairly wide open. But 10:00 a.m., you tell me if you want more time, less time.

MS. PARMER: 10:00 a.m. is fine.

MS. PROUT: (Nods head.)

THE COURT: All right. Let's reconvene at 10:00 a.m. tomorrow. And I don't specifically feel I need to give y'all

time limits, but I think it probably doesn't need to be a whole lot more than 20 minutes, 20, 30 minutes. But if I'm finding it helpful, I'll let you keep going, but I'd say try to keep it at 20, 30 minutes.

MS. PARMER: That's fine.

THE COURT: All right. Anything else we need to take up tonight before we adjourn?

MS. PROUT: No, your Honor.

MS. PARMER: Nothing on behalf of [redacted]

THE COURT: All right. And I'll let you introduce the certification as well tomorrow. First thing in the morning we'll take that up. Remind me we need to take that up first thing in the morning. All right. We'll be in adjournment.

(Whereupon, the proceedings were adjourned at 4:40 p.m.)

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REPORTERS CERTIFICATE

I, Wynette C. Blathers, Official Court Reporter for the United States District Court for the Northern District of Georgia, with offices at Atlanta, do hereby certify:

That I reported on the Stenograph machine the proceedings held in open court on December 4, 2017, in the matter of UNITED STATES OF AMERICA v. [redacted] Case No. [redacted]; that said proceedings in connection with the hearing were reduced to typewritten form by me; and that the foregoing transcript (Volume I of II, Pages 1 through 243) is a true and accurate record of the proceedings.

This the 19th day of January, 2018.

/s/ Wynette C. Blathers, RMR, CRR
Official Court Reporter

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA

UNITED STATES OF AMERICA,
Plaintiff(s)

V.

[redacted],
Defendant(s)

Case No. [redacted]

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January 21, 2018 — Date
Wynette C. Blathers — Court Reporter

VERIFICATION OF FINANCIAL ARRANGEMENTS

Proceeding Type: Bench Trial

Proceeding Date: December 4, 2017

Volume Number: Volume I of II

Notice is hereby given that financial arrangements for a copy of the transcript have been made with the following individual(s): Molly Parmer

as counsel/party in this case. He/She is to be provided with remote access to the transcript via CM/ECF and PACER.

January 21, 2018 — Date
Wynette C. Blathers — Court Reporter