V I R G I N I A:
IN THE CIRCUIT COURT OF FAIRFAX COUNTY

DENNIS MARK JEWETT, Personal Representative of the Estate of ERIC JUSTIN JEWETT, deceased,
Plaintiff,
Case No. 2020-0002561
v.
INOVA HEALTHCARE SERVICES, INC., d/b/a INOVA FAIRFAX HOSPITAL, et al.,

Defendants.

Thursday, November 10, 2022
REMOTE DEPOSITION OF:
MARK R. CARYL, D.O.,
the witness herein, was called for examination by counsel on behalf of the defendants pursuant to Notice of Videoconference Deposition, Rule 4:5 of the Rules of the Supreme Court of Virginia, and agreement as to time and date, scheduled to begin at 10:00 a.m., before Donna L. Linton, RDR-CCR-CLR, and Electronic Notary Public in and for the Commonwealth of Virginia.

APPEARANCES

ON BEHALF OF THE PLAINTIFF:
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ALSO PRESENT:
Judy Kerby, Inova Representative

I-N-D-E-X

E-X-H-I-B-I-T-S
(Included with transcript.)

P-R-O-C-E-E-D-I-N-G-S
(9:58 a.m.)

WHEREUPON,
MARK R. CARYL, D.O.,
the witness herein, was called for examination by counsel on behalf of the defendants, and after having been duly sworn by the notary public was examined and testified as follows:

EXAMINATION BY COUNSEL ON BEHALF OF THE DEFENDANTS

BY MS. NIKOLIC:

Q. Good morning, Doctor. My name is Aneta Nikolic. I am the attorney for INOVA and Dr. Amatya in this matter.

A. Good morning.

Q. Could you please state your full name and business address?

A. It's Mark Robert Caryl, and my business address is 736 Irving Avenue, Syracuse, New York 13210.

Q. And have you been deposed before, Doctor?

A. I have not.

Q. Okay. So I'll just go over some brief

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ground rules.
I'm going to be asking you a series of questions. If you do not understand a question, please let me know. If you just want me to repeat it, also please let me know. If the Zoom cuts out and you just can't hear something, please do let me know -- that does happen from time to time -- and I would be happy to repeat or rephrase a question for you. Okay?
A. Yup.
Q. If at any time you get paged or you need to take a break or anything like that, just let me know, and as long as there is no question pending, we can go off the record and take a break. Okay?
A. Yup.
Q. So let me just start with some questions about your background.
I received a copy of your CV, which is -- I don't know if you have it in front of you, but the version I received is just a one-page Word document version, and it has your name on top, and then the very bottom of it ends with your

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certification.
Is that the most correct and up-to-date version of your CV?
A. Yes.
Q. No changes need to be made to that?
A. No.
MR. BLAZER: Aneta, I wrote Cindy earlier today to advise that I had to retype that CV to correct a formatting error and inadvertently omitted the dates of his licensure and certification. So the complete CV would have 2011, I believe, as licensure and original certification and recertification in 2021.
MS. NIKOLIC: Okay. Thank you. I can ask the Doctor about that very briefly.
BY MS. NIKOLIC:
Q. What I wanted to check with you, Doctor, is is this the only version of a CV that you have, or do you have any type of longer version?
A. That's the only one.
Q. Okay. No problem. So I'm not going to make you repeat everything verbatim to me, but can

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you just give me a brief overview of your educational background starting with medical school?
A. Sure. So I went to medical school at the New York College of Osteopathic Medicine. That's in Old Westbury, New York, on Long Island, and that was 2004 to 2008.
And then I went to residency in internal medicine at the University of Connecticut. That's in Farmington, Connecticut. It's about 15 miles east of Hartford, Connecticut. And that was 2008 to 2011. And then -- that was for internal medicine residency training. And then I started working after that.
Q. Did you complete any fellowships or any other additional training following your residency?
A. No.
Q. And I understand you are board certified in internal medicine?
A. Yeah. I first got board certified in 2011 when I completed residency, then I recertified last year.

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Q. Okay. Perfect. I think those were the dates that counsel was referring to, so thank you.
And you are currently licensed in the state of New York?
A. Yes.
Q. Are you licensed in any other state?
A. No.
Q. Have you ever been licensed in Virginia?
A. No.
Q. And, as I understand it, after you finished your residency in 2011, you began working at Crouse Hospital, which is still where you are today; is that right?
A. That's correct.
Q. And you are a hospitalist at Crouse Hospital?
A. Correct.
Q. Can you just briefly explain or describe what it means to be a hospitalist?
A. Sure. So a hospitalist -- we take care of admitted patients in the hospital. So, you know, primary care doctors mostly don't go over to the

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hospital now to admit their patients, so when they get sick enough to require hospitalization, we go down into the ER; after talking to the ER doctor, we evaluate them, we deem if they need admission or not, and then if they do, we put in admission orders.

We follow them throughout their hospitalization, and then we arrange for discharge medication prescription, you know, follow-up appointments, and then we coordinate with specialists in the hospital if they need that level of, you know, care.

I'm an internist, so I only follow adult patients, so I don't follow pediatric patients. And that's basically what hospitalists do.

Q. Okay. So is it fair to say when you admit a patient, you are the primary attending of record for that patient during that admission?

A. Yes.

Q. Other than Crouse Hospital, do you presently hold any other clinical positions or practice anywhere else?

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A. No.

Q. Do you hold any academic positions?

A. No.

Q. Do you hold any administrative positions at the hospital?

A. I do not.

Q. Have you authored any peer-reviewed publications?

A. No.

Q. Any other type of publication?

A. I've done, like, poster presentations in residency at certain American College of Physicians, like, local meetings, but nothing else other than that.

Q. So nothing following residency?

A. Correct.

Q. Okay. Any of those poster presentations happen to be relevant to the specific issues in this case?

A. No.

Q. Have you ever had your medical license revoked, suspended, or acted upon adversely?

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A. No.

Q. Have you ever had any hospital privileges revoked, suspended, or acted upon adversely?

A. No.

Q. Have you ever been named a defendant in a medical malpractice lawsuit?

A. No.

Q. Prior to this case, have you ever served as an expert witness in a medical malpractice case before?

A. I have not.

Q. So this is your first time?

A. Correct.

Q. I know you testified earlier this is your first deposition, so I take it you've never testified at trial before as an expert?

A. I have not.

Q. Have you ever been deposed or testified at trial as a treating physician?

A. No.

Q. How much do you charge for record reviews?

A. This is my first time, so I kind of go

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back and forth with, you know, Mr. Blazer about what seems appropriate, you know.

Q. So let me ask it this way. How much are you charging for this case for a record review?

A. So I believe I received 250 an hour for the review of the chart and giving my opinion in just written form, and then this deposition, I believe $500 an hour.

Q. Do you have a fee that you would charge for a trial appearance?

A. No. This is my first trip to the rodeo, so I'm not sure. I'll probably be back and forth again about what seems appropriate.

Q. Okay. Are you able to estimate approximately how many hours you've spent working on this case?

A. Probably five or so. Four or five.

Q. Do you know how Mr. Blazer came to contact you or how he found your name?

A. My wife knows his children.

Q. Is that socially or professionally?

A. Socially.

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Q. When were you first contacted by Mr. Blazer for this case?
A. I think late summer of this year.
Q. So late summer of 2022?
A. Correct.
Q. Had you met Mr. Blazer before, prior to this case?
A. I had not, no.
Q. Do you recall how you were initially contacted, whether it was by telephone, e-mail, letter?
A. I think it was -- I believe it was through e-mail.
Q. And do you recall when you were initially contacted just generally what you were asked to do or what your role would be?
A. I was asked to give a medical opinion on the case.
Q. Can you list for me all of the materials that you have reviewed in conjunction with this case?
A. Yeah. I got a copy of the medical record

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from Mr. Jewett's hospitalization in late August of 2016, and then I got a copy of the death certificate, the toxicology report, and the police report, and the declaration of expert witnesses and some questions with them. I reviewed the deposition of Dr. Amatya.
Q. Anything else you can think of?
A. And then I also got a list of the prescription drug monitoring program for previous prescribed medications, I think it was of the last year or so, in Virginia for this gentleman, the deceased.
Q. Anything else?
A. That's all I can think of off the top of my head.
Q. Other than Dr. Amatya, did you review any other deposition transcripts?
A. I got a copy of Dr. Dombrowski's deposition as well.
Q. And did you review that?
A. Yes.
Q. I just want to make sure, you said you

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received a medical record from August of 2016; just to confirm, that's from INOVA Fairfax Hospital?
A. Correct.
Q. Other than that particular medical chart, did you receive any other medical records that you reviewed?
A. I don't believe so. I don't believe so, no.
Q. And are you relying on all of the documents that you just told me that you've reviewed in formulating your opinions today?
A. Yes.
Q. Did you receive, at any point prior to your review, any type of factual summary or description from Mr. Blazer?
A. I received, you know, the Complaint that was filed initially in the case with -- I think it was Dennis Jewett, the patient-who-passed-away's father. And then -- I don't believe so, no. We might have sent, like, one or two e-mails about roughly what the case, you know, was and the timeframe, but nothing else substantial, I don't

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think so.
Q. Did you create any notes in conjunction with your review of this case?
A. I have, you know, one page of just scribble basically just summarizing the medical chart, pretty much.
Q. Okay. And are those notes only regarding the medical chart, or are they referencing any of the other documents that you mentioned for me?
A. I think just the medical chart.
Q. And I think you said they were sort of summarizing the things that you read in the medical chart?
A. Yeah.
Q. Did you review any medical literature in order to formulate your opinions in this case?
A. No. It was past experiences and conferences.
Q. Do you intend to rely on any medical literature at trial in support of your opinions?
A. There was one short, brief article on pain management, and there was one summary of an Opiate

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Withdrawal Scale that I sent to Mr. Blazer. We're not sure it's going to be relevant to this case or not, but I did look through those briefly.

Q. And those are two separate publications?

A. Yeah. One of them is called a Clinical Opiate Withdrawal Scale, or a COWS scale. The other one was just a pain management review article from New England Journal. But, again, Mr. Blazer and I were going to decide if it's relevant to this case or not.

Q. Do you recall what the second article was called or who the author was?

A. It was an article on opiate use disorder. It was put out -- there's a training module called "Knowledge Plus" from the New England Journal of Medicine. It's just on pain management and opioids. It was an article.

Q. Do you happen to have that in front of you?

A. Yeah.

Q. Okay. I can see you looking down, so I just wanted to see. Okay.

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And what year was that from?

A. That's from this year.

Q. Published in 2022?

A. Correct.

Q. What about the clinical withdrawal scale? What year is that from?

A. I think it's from 2013, but let me just double-check.

Oh, that's from 2003, actually.

Q. 2003?

A. Yeah.

Q. Do you intend to rely on either of those publications at trial in support of your opinions?

MR. BLAZER: Well, Aneta, that's a decision that will be made jointly by me and Dr. Caryl, and if the articles are deemed relevant and reliable by us, we will so designate them consistent with the statutory timetable and provide you with a copy.

But as he has explained, I have not yet reviewed them, and we have not discussed them, so I think realistically that's as far as you're

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entitled to go today. He's identified them for you; you're free to find them yourself.

MS. NIKOLIC: Sure. Okay.

BY MS. NIKOLIC:

Q. Let me ask you this, Doctor. For purposes of the opinions that you've been designated to testify about that I'll be asking you about today, are you going to be relying on those two publications?

A. No. I expressed my opinion on this, before I read those articles, to Mr. Blazer, and those kind of support my stand on it.

Q. Understood. Thank you.

Have you been told of the trial date in this case?

A. I've given -- I've been given the month and the year. I believe January of 2023 is what I was told.

Q. Are you holding a particular day for trial?

A. I'm going to defer that to Mr. Blazer and Mrs. Santoni. No.

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Q. I was just wondering whether you had, for example, something blocked off on your calendar in order to travel for trial?

A. No.

Q. Let me ask you -- I'm going to move now to your expert designation, which is a document filed by counsel. It's entitled "Plaintiff's Designation of Expert Witnesses."

Do you by any chance have that in front of you or able to access it?

A. I don't have it in front of me. I did copy off a blurb from Kevin Schneider about the toxicology interpretation. The rest of it I think I didn't print off. I can pull it up on my computer.

Q. You're free to do so. I'm going to ask you -- my questions are going to be based off of the designation. I'm going to try to do my best to sort of go in order.

A. Okay.

Q. If at any time you want to look at something, at a specific page, please feel free to

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pull it up on your computer.
A. Sure.
Q. And that document, do you recall that that document contains sort of a factual summary of the beginning and then it's followed by the designation of multiple health care providers?
A. Yes.
Q. So at the very beginning, it's entitled "Summary of Events for Eric Justin Jewett" regarding the INOVA Fairfax August 2016 admission at the very beginning of the "Plaintiff's Designation of Expert Witnesses" that is about 10, 11 pages long.
Do you recall reviewing that as a part of the document?
A. I believe so, yes.
Q. Did you have any part in writing or revising any of that factual summary in the document?
A. I don't believe I did.
Q. And then just for the record and for your information, in case you decide to pull it up, your

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designation starts on page 17 of that document, and it goes through page 20, so it's a little bit over three pages long.
Does that comport with your recollection?
A. Yeah, that sounds right.
Q. And in terms of the designation for you and your opinions, is that something that you wrote or participated in revising?
A. Yes.
Q. Can you just briefly explain to me, did you personally write portions of this, or did you receive written information and then you reviewed it and you made revisions or suggestions?
A. I believe I wrote just about all of it, and I think Mr. Blazer might have edited a word or two here or there.
Q. Does this designation accurately and completely describe your opinions in this case?
A. It does.
Q. Is there anything else you believe you need to review in order to finalize your opinions in this case?

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A. I don't believe so.
Q. So as I mentioned, I'm going to work my way through this designation. I'm going to do my best to kind of go in order as the way that it's written, but I might jump around a little bit.
Again, if at any time you want me to point out exactly what page I'm on or what part I'm on, please let me know; I'm happy to do so. Okay?
A. Yup.
Q. Okay. So as I understand from your written designation, you will be testifying as to standard of care and causation in this case; is that correct?
A. Yes.
Q. And you will be testifying as to the standard of care for Dr. Amatya?
A. Yes.
Q. How do you define standard of care?
A. Standard of care is acceptable clinical practice for a physician for -- it can be applied to other fields, I guess, but for me it would be the medical field.

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Q. So I'm on page 17 right now. The designation states -- one part of it states that the history of depression with previous suicidal ideation with pain complaints out of proportion to exam and imaging findings should have prompted the consideration of a psychiatric consultation while hospitalized.
Is that an opinion that you hold?
A. Yes.
Q. And what is the basis for that opinion?
A. So some patients have complaints where they appear to have some kind of secondary gain for them, so occasionally patients will come to the hospital and say they have pain because they like the euphoria they get from certain substances. It could be a narcotic. It could be sometimes IV Benadryl.
But this patient appeared to have complaints that didn't have any obvious organic cause, and so if there's no organic cause that can be found, you should give some due diligence to look for some kind of mental disorder.

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Q. In terms of your opinion that there were pain complaints out of proportion to exam, what were those pain complaints that were out of proportion?

A. So the patient came in saying he had severe low back pain, and throughout the hospitalization he said he had severe leg pain. And they did an MRI of his lumbar spine and it said he had stable postoperative changes.

He didn't have any recent surgery; at least his most recent surgery was in February of 2016. He didn't have any recent trauma to explain his pain, and so his complaints of pain and his requirement of higher than previous given narcotic doses in the outpatient didn't seem to add up to his imaging findings while in the hospital, and his physical exam findings.

Q. Are there always imaging findings when someone is complaining of pain? Is that something you would always expect to see?

A. Not always. If someone had a history of sickle cell disease, they can get sickling of blood

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in their blood vessels and that can be painful. This patient didn't have that history. So it is possible to have, you know, pain complaints that can't be seen on imaging.

Though in that situation, sickle cell, you can get labs that would demonstrate an acute sickle crisis, such as elevated liver function tests or elevated reticulocyte count. So usually an astute clinician can find some reason, while in the hospital, to explain an increase in pain. If they can't, usually a provider would look for secondary gain.

Q. Did you believe that Mr. Jewett was a patient that was looking for secondary gain when he arrived to the hospital?

A. I think it's likely, yes. He said he ran out of his pain medication, I believe, six days prior to being admitted, and, you know, no one seemed to contact his primary care provider to go over, you know, why this patient would require pain medication, and he had a history of being in substance abuse and going to rehab for substance

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abuse, I believe involving narcotic abuse, and so those are kind of red flags to say this is a patient who might complain of certain symptoms to get higher doses of pain medications than are actually clinically appropriate.

Q. Do you recall whether upon arrival or admission to the hospital on August 28, 2016, Mr. Jewett presented with any other complaints or presenting symptoms apart from the low back pain that you had mentioned?

A. I believe he said he had urinary retention; I believe there was some mention of stool incontinence; and I believe he said he had some decreased sensation, I believe, in the groin area or the proximal thigh.

I mean, throughout his hospitalization he complained of being anxious, you know. He requested, I believe, benzodiazepines and received Ativan. He also received Valium before his MRI to try to relax him to tolerate the test.

Q. So in terms of what you've been referring to as, quote/unquote, secondary gain, as I

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understand it, so is it your opinion that when a patient presents to a hospital and it appears that they have complaints for the secondary gain, is it your opinion that a psychiatric examination or consultation is always required for that patient?

A. A majority of the time, yes, especially when someone is requesting controlled substances such as high doses of Oxycodone or Ativan, you know, that have pretty serious side effects, and especially someone who has a history of depression and anxiety like this gentleman, as well as alcohol abuse and narcotic dependence like this gentleman, who's a high-risk patient.

Some of those are risk factors for opiate overdose, so you would want to get a psychiatrist involved to help lower the risk and perhaps prescribe him medication that has less serious side effects than a benzodiazapine to help control his anxiety and other mental health acute issues.

Q. As you've just mentioned benzodiazepines, you state that -- or the designation -- I'm back to that -- states that the Ativan and Oxycodone are

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both respiratory depressants, and this patient's history of sleep apnea further increases the risk of opioid and benzodiazepine-induced respiratory depression.

Is that your opinion?

A. Yes.

Q. And what is the basis for that opinion?

A. 11 years of clinical experience and, you know, textbooks state this. It's a known side effect that narcotics and benzodiazepines both can cause respiratory depression, and they have additive effects when given together.

Sleep apnea, this gentleman was diagnosed with that. He was prescribed a CPAP machine to treat it. Usually you're not given a CPAP machine unless you have at least moderate sleep apnea, and Dr. Amatya had stated that the patient was noncompliant with his CPAP while in the hospital.

When you're noncompliant with a CPAP machine with sleep apnea, you can get drowsy in the daytime. If you're already drowsy, on top of that, taking a narcotic and a benzodiazepine, those all

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increase your risk of slowing down your respirations to the point where it can be fatal.

Q. Can we agree that Mr. Jewett did not have any signs of sleep apnea at the hospital?

A. The signs can be subtle. You know, if someone is drowsy but they're a very anxious person to begin with, it can mask some of that, but, you know, I don't know if anyone witnessed him snoring or would document that in the chart, but, you know, that can be a sign of that.

So, yeah, the signs aren't always incredibly easy to see, but it still can be there.

Q. In your review of this medical chart, did you see any signs of sleep apnea in this patient?

A. Again, he was prescribed a CPAP machine, and he had been diagnosed with it in the past, so it's already an established diagnosis of this patient. So, you know, it's hard to put into a clinical summary for a nurse or a clinician signs of sleep apnea unless someone was, you know, frequently dozing off in the daytime, and they're not going to document that kind of thing in the

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hospital chart. It's more of a subtle thing that a primary care doctor would look into for, you know, a month's long history of poor attention at work or with others, you know, social settings, someone taking daytime naps.

This person could have napped, you know, three or four times in the hospital every day and they wouldn't document it because it's not really clinically relevant, you know.

Q. Sure. And I understand that, Doctor.

What I'm asking you is whether you saw any documentations in the medical chart of signs or symptoms or concerns of sleep apnea in this patient?

A. I didn't see anything mentioned in the chart about his sleep apnea other than the diagnosis in the history and physical when he got admitted to the hospital.

Q. And he had not been using a CPAP machine at home, right?

A. It was stated that he wasn't using it in the hospital. I don't know if he was compliant at

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home or not. The machines usually have a way of recording if someone is complying or not. Usually if you're not compliant for a certain period of time, they would eventually take the machine away, so he might have had, you know, occasional compliance with it.

Q. So is it fair to say you don't know one way or the other whether or not he was using a CPAP machine at home?

A. Not with a high level of certainty, no.

Q. And, to your knowledge, he did not request one at the hospital?

A. I don't know the policies and procedures at INOVA Fairfax. I haven't worked there before. Where I work, if someone has that history, usually you just order the machine, and they have the right to refuse.

Q. And you plan to testify that the combination of Ativan and Oxycodone is what can increase the risk of respiratory depression?

A. Correct.

Q. I think you touched on this at the

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beginning when you were giving me an overview of what it means to be a hospitalist, but as the attending hospitalist, do you obtain consultations from other providers in other areas of medicine or other subspecialties?

A. We're consulted for, like, preoperative evaluations to say what someone's risk is for, you know, either a hip surgery or something like that, or a bowel surgery, so we do a preoperative assessment, and we might be consulted by a surgical service for diabetes management or other medical problems they want us to assist with managing; so we do do those kind of inpatient consults, yes.

Q. Sorry. That' my fault. I probably asked the question poorly. I was actually asking the inverse. So when you're the attending of record, when you're the hospitalist of record, can you order consultations from other subspecialties --

A. Yeah.

Q. -- and other areas of medicine if you deem it's necessary or appropriate?

A. Yeah, of course. Sorry if I misunderstood

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that.

Q. No. That's okay. I probably worded it poorly.

And as the attending of record for the patient, as a hospitalist, that's something that you can place an order for, as I understand it; is that right?

A. Yeah. Certain -- there's fields you just put an order in the system, a computer order; and some of them you call and give information; some of them have answering services, but yes.

Q. And is that something that you do in your practice on a day-to-day or a regular basis?

A. Yes.

Q. Okay. And even though these other medical providers from other specialties may come to consult on a patient, that patient would still remain your patient, and you would be that main attending still regardless of any consultations; is that fair?

A. Correct.

Q. In other words, you're not handing off

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care when a consultant comes in, right?

A. Not ordinarily. If you consult a surgeon and they have a large surgery, then they might transfer their service, but that's pretty rare.

Q. So just by a consultation or even several consultations, you would still be the primary decision maker for that patient because you're the main attending of record, right?

A. Correct.

Q. From your designation, you will testify -- here it's written "prudent to consult with Dr. Andrew," so -- "with Dr. Andros," excuse me. So are you planning to testify that it was appropriate for Dr. Amatya to consult a pain management doctor in this case?

A. It was appropriate. He didn't follow his recommendations, but it was appropriate to consult him to begin with, yes.

Q. And you plan to testify that Dr. Amatya disregarded the advice of Dr. Andros?

A. Yes. To some degree, he did.

Q. Okay. Can we agree that an attending

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hospitalist does not have to follow each and every recommendation made by a consultant?

A. That is true, but with the understanding that if you're consulting someone that has an expertise in the field that you don't, usually you would want to give some credence to their input.

Q. In your practice, when you have a consultant, do you engage in a type of conversation with them or look at what they've written in the chart for your patient to determine what, if any, recommendations they have?

A. Usually you discuss with them around the time of discharge. That kind of solidifies the discharge plan. You might not be called on the exact same day, but usually you go over things with them before the patient leaves the hospital.

Q. So after a consultant has either spoken with you or put a note in the chart regarding a patient in terms of a care plan or next steps or, as you mentioned, you know, what may happen upon discharge, would it still fall on the clinical judgment of the attending of record to sort of

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solidify the plan and to make a decision as to what's best for their patient?

A. It does. Usually if you're not going to follow the specialist's recommendations, you would call them and try to, you know, express your concerns for why -- you know, or try to get their thought process of why they made a certain recommendation or call them and see if they agree with the change that you made, if there's maybe something differently -- change things a little differently.

But, yes, ultimately it's up to the hospitalist, the attending of record, to either follow the consultant's recommendations or not to.

Q. Okay. And in terms of this specific consultation that Dr. Andros provided to Mr. Jewett, you will testify that -- so after the consultation, you will testify that Dr. Amatya prescribing 30 milligrams of Oxycodone instead of Dr. Andros's recommended MS Contin 30 milligrams plus Oxycodone 20 milligram was ill-advised because of the Ativan; is that your opinion?

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A. Yes.

Q. And what is the basis for that opinion?

A. So, as you mentioned earlier, Ativan is a strong respiratory depressant. When you combine it with the Oxycodone, the effects are additive increasing the risk of someone having a respiratory arrest and dying from that combination.

When you're using high doses of any medication like that, it should be taken into consideration what other medications they're on that can be sedative.

Q. And then you plan to testify that the increase of Oxycodone from 20 milligrams to 30 milligrams as immediate release plus Ativan produced this unfortunate outcome; is that your opinion?

A. Correct.

Q. And what is the basis for that opinion?

A. So the patient had been given doses of narcotics by his primary care provider, and it seems like he was on 15 milligrams of long-acting morphine, or MS Contin, three times a day and

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15 milligrams of Oxycodone every four hours as needed. That's what his primary care provider, who knew him very well and knew what his risk profile was, thought he would be safe on.

The hospitalist, who did not know him very well -- I think Dr. Amatya started rounding on him a day or two into his hospitalization -- decided to make an increase of those narcotic doses without any clear-cut reason to increase them, and it resulted in a much higher dose the patient could get of narcotics in a 24-hour period, and so the patient had an increased risk of having unwanted effects from that medication.

And the Ativan had not been readily prescribed by his primary care provider, and, again, it's dangerous to take that with high doses of narcotics. I think he should have had a conversation with his primary care provider to see if they agreed with that approach or not.

Q. Just a few follow-up questions to unpack what you just said.

You testified a few times about his

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primary care provider, and I think you said something like "knew him well" or "knew him better" than Dr. Amatya, and knew his risks.

What physician are you referring to when you say his primary care provider?

A. So he had a primary care doctor's office. I think it was Gary Davidson was the primary care provider. I think there was a Dr. Harry Holt, I believe, who also, I believe, was in that same practice.

You know, they had face-to-face interactions with this patient, and they would have had more interactions documented in their office charts than were in the hospital charts, and so that, I think, would have provided a better understanding of this patient's needs.

Q. Did you review any medical records from Dr. Davidson?

A. I did not.

Q. Did you review any medical records from Dr. Holt?

A. I did not. I believe the police report

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mentioned that they called Dr. Holt and discussed that he prescribed some narcotics back in May of that year. The prescription drug monitoring program says it was a two-week supply. Usually when you give someone a short supply, less than 30 days, you have some concerns about either they're abusing their meds, or they're someone who doesn't need to be on these medications long term. So that's telling, I think.

Q. And are you aware where Dr. Davidson or Dr. Holt practiced?

A. I think it was Falls Church, which was somewhere in Virginia.

Q. In terms of your testimony that the PCP provider with which you mentioned was Dr. Davidson and knew him very well and knew his risks, do you know how long he had been following Mr. Jewett?

A. I believe several years. I don't know exactly how long, no. I think the drug monitoring report goes back, I think, at least two years. So at least two years.

Q. You also testified that Dr. Amatya

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increased the narcotics without a clear reason. I think that's what you said. Am I saying that correctly?

A. That sounds right.

Q. So in terms of the discharge medications, while Dr. Amatya did increase the Oxycodone to 30 milligrams, we can agree that he completely omitted the MS Contin, right?

A. Yeah, I guess August 30th he had him on MS Contin. I believe he was going to prescribe that in case he went to a rehab facility, and then the following day he omitted the MS Contin and increased the Oxycodone.

Q. And that following day, August 31st, that was the day of discharge, right?

A. Yes. I think they initially were trying to discharge him on the 30th to a rehab, if he had a bed available; he didn't, so he stayed one more day.

Q. So on that day of discharge, August 31st, when he did increase the Oxycodone to 30 milligrams, he did not prescribe MS Contin,

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right?

A. That's my understanding, yes.

Q. And I think you already mentioned this. MS Contin is morphine or a type of morphine, which is another narcotic; is that right?

A. Yeah. MS Contin just stands for Morphine Sulfate, and then Contin just means extended release of that drug.

Q. Are you aware as to what the equivalency is between Dr. Andros's recommendation of the MS Contin plus Oxycodone and then Dr. Amatya's ultimate prescription of just the Oxycodone?

A. Yeah. So there's calculators that calculate this, but if you put in 30 milligrams of Oxycodone, 10 milligrams of Oxycodone is equivalent to 15 milligrams of morphine. So if you do 30 milligrams, you can get six doses in a day; it's every four hours. So 180 milligrams in a 24-hour period of Oxycodone is equivalent to 270 milligrams of morphine. So that's a morphine milligram equivalent of 270.

If he was going to give him 15 milligrams

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of morphine three times a day, that's 45 morphine milligram equivalents, and then if you add that to the 20 milligrams of Oxycodone every four hours, that would be 120 plus 45, I believe 165, so it would be much less.

Q. What would be much less?

A. The amount of morphine milligram equivalents would be less of what Dr. Andros recommended to what Dr. Amatya prescribed.

Q. So your testimony is, from that calculation, you believe that what the equivalency of what Dr. Andros prescribed was still less?

A. Yes. Or he didn't prescribe it; he recommended it.

Q. Excuse me, yes, you're right; recommended. Thank you.

The designation states that the -- let me see if I can find it. It writes that the MME, which I understand is the morphine equivalency, between the two was probably the same. Is that no longer your opinion?

A. Let me calculate it out quick.

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Q. I was impressed that you were doing it all without a calculator.
A. So 45 plus...
So I think it would be 225 to 270. So Dr. Andros's would have been 225, and it would have been 270 with Dr. Amatya's.
Q. I'm sorry. Would you mind just stating for me, slowly if you could, what the actual equation is that you're using?
A. Sure. So the Oxycodone -- if you do 30 milligrams every four hours -- or, I'm sorry, if you do 20 milligrams, you can get every four hours. That would be six doses in a day. So 20 times 6 is 120. You multiply that by 1.5 to get the equivalence of morphine; so that's 180.
(Whereupon, the court reporter interrupted for clarification and read back the record as follows: You multiply that by 1.5 to get the equivalence of morphine; so that's 180.)
A. You take the -- you add that to the morphine extended release. So you take 15 milligrams of morphine extended release. You

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can get it three times a day. So that's 15 times 3; that's 45. So you do 45 plus 180; that's 225 milligrams or morphine milligram equivalents.
For the pure Oxycodone, you do 30 times 6; so you can get 180 milligrams of Oxycodone in a day. So to convert that to morphine, you do it times 1.5, and you get 270.
Q. I'm sorry. So you said the Oxycodone 30 times 6 is 180, which I follow, and then you said you add the morphine?
A. No. Dr. Amatya didn't prescribe any morphine finally. So you do 30 milligrams times 6; you get 180 milligrams of Oxycodone. Oxycodone is roughly one-and-a-half times as potent as morphine. So you do 180 times 1.5 to get 270 daily morphine milligram equivalents.
Q. And in terms of what you put in your expert designation, the MME between the two was probably the same, is that still your testimony with these numbers, or is that no longer your opinion?
A. Well, no. I think --

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MR. BLAZER: Aneta, that may have been a typo on my part. But go ahead.
A. I think I was referring to the dosing he was getting with the Dilaudid. He was getting, in the hospital, IV Dilaudid, 1 milligram, as needed, and he was getting -- I think it was every four hours as needed, and he was getting 20 milligrams of Oxycodone on top of that every four hours as needed. And in the hospital, he was on the IV pain medication. He was not on all oral pain medication.
So to convert the IV Dilaudid to oral Oxycodone, 1 milligram of IV Dilaudid is equivalent to about 13 milligrams of oral Oxycodone. So if you convert that over, that's roughly the same as 30 milligrams of Oxycodone every four hours PRN.
BY MS. NIKOLIC:
Q. Okay.
A. Did that make sense?
Q. No, it does make sense, and just for the record and for you, I'm looking at the top of page 18, and I'll just read verbatim.

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It says, "The change from Dr. Andros's recommendation to what Dr. Amatya eventually prescribed was not well thought out. Yes, the MME between the two was probably the same, but that still ignored three significant factors..." and then it goes on.
So that's where my question was coming from because it appeared to be related to Dr. Andros versus Dr. Amatya.
A. Dr. Andros made recommendation both for inpatient pain medication dosing and for outpatient. So I guess I was referring to what he was getting in the inpatient.
Q. Okay. So putting for a moment aside the Ativan, which we've already talked about a little bit, do you believe that it was a breach in the standard of care for Dr. Amatya to prescribe the 30 milligrams of Oxycodone for discharge and no MS Contin?
MR. BLAZER: Are you talking in isolation, Aneta?
BY MS. NIKOLIC:

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Q. Doctor, did you understand my question, or would you like for me to rephrase it?
A. Could you rephrase it, I suppose?
Q. Sure. So I understand earlier your testimony was about the combination of Ativan and Oxycodone being prescribed, and I understand what your testimony is. So just -- and we can say that this is a hypothetical.
So hypothetically had there been no Ativan prescribed -- so everything else is the same for this type of patient, upon discharge, Dr. Amatya prescribed 30 milligrams of Oxycodone and did not prescribe any MS Contin. So my question is just the 30 milligrams of Oxycodone, that amount of Oxycodone alone, do you believe it was a breach in the standard of care for Dr. Amatya to prescribe that amount of Oxycodone for this patient upon discharge?
A. I think that factored into the, you know, addition of Ativan as well -- those combined was a breach of the standard of care, yes.
Q. Okay. And I understand that.

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And just, again, as a hypothetical, Doctor, which I can ask you about here, putting the Ativan aside, if there was no Ativan, was it a breach in the standard of care to prescribe 30 milligrams of Oxycodone, in your opinion?
A. I think that was too high of a dose, yes. I don't think there was a clinical indication to give him a higher dose than he previously had been on.
Q. Okay. And when you say "than he previously had been on," do you mean during this admission? Do you mean in recent time? Do you mean ever? Can you clarify that?
A. I mean in recent times before the admission; in other words, what his primary care doctor had prescribed to him.
Q. And when you say his primary care doctor, you're referring to Dr. Davidson?
A. Davidson's practice, yes.
Q. I'm just scrolling through your designation.
What is the basis for your opinion that

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Dr. Amatya ignored the patient's history of sleep apnea?
A. I don't think he took it into strong consideration. I can't get inside Dr. Amatya's full thought process that day, but I don't think he gave enough weight to the patient's sleep apnea being a large risk factor for giving someone two medications that can strongly suppress someone's respiratory drive.
Q. If someone has a history of sleep apnea, does that mean they can never be prescribed a narcotic and a benzodiazepine because of that history?
A. Not necessarily.
Q. What, if any, are the instances where that would not be inappropriate to do?
A. I think you would want to watch someone titrate those kind of medications up very slowly, especially for any increases in those kind of medications to make sure they tolerate them. I guess on the day of -- yeah.
Q. So if I understand your testimony, it

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would be important to have an opportunity to be able to watch a patient on that combination just to ensure that they're doing okay or they're not having any adverse effects?
A. Correct.
Q. You will testify as to an increased risk of immediate-release opioids?
A. Yes. I mean, there's a faster peak of the medication in your system for rapid release.
Q. Okay. My follow-up question was just going to be what is that increased risk of immediate-release opioids?
A. So an immediate-release opioid is released immediately into your bloodstream, so when the medication gets its peak effect on your body is going to be quicker than something like a long-acting Morphine Sulfate, or MS Contin, so also the adverse effects from it, like respiratory depression, will also occur more quickly.
Q. In terms of the immediate release and then the extended release, when you testify that it will act quicker or affect you more quickly, is there a

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specific formula or a time that by which can be measured when that effect would be, or how much quicker it would be, in other words?

A. Yes. I mean, you should get positive action for immediate-release oral Oxycodone within about a half an hour.

If you had an extended release, like MS -- Morphine Sulfate Contin, it will take several hours or just over an hour to start seeing effect. And then when you get a peak effect, the maximal effect, it will take a longer time with extended-release medication.

That's kind of the benefit of why you want to give some extended-release, especially in someone who's opioid tolerant, is that you always have some level that's stuck in their system so they're not going to get spikes in their pain levels; they'll always have some pain control. That's why pain specialists I've seen like acting extended-release formulations for someone on high doses of pain meds, narcotics.

Q. I think you briefly mentioned this before,

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but we can agree that at the hospital in August of 2016, Mr. Jewett was also receiving the Dilaudid, right?

A. Yeah, he received, I know -- he had 2 milligrams in the emergency room trying to get his pain controlled through the MRI, and that wasn't enough, but then he maintained on it throughout his hospitalization.

I know on the day of the 30th, the rehab wanted him to get off of IV pain medicine for him to be a candidate to go there, so I think on the 30th they started converting the IV Dilaudid to more of the -- to pretty much solely oral pain medications.

Q. And Dilaudid is another narcotic medication?

A. Yes. It's a very potent narcotic. It comes in IV form and oral form.

Q. So throughout that admission, Mr. Jewett had been receiving the Dilaudid, and he'd also been receiving Oxycodone; is that right?

A. Yes. I believe he was getting them

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overlapping at times.

Q. Okay. And during that admission, Mr. Jewett was also given Ativan; is that right?

A. Yes. And Valium, I believe, also.

Q. And all of the drugs that Mr. Jewett was given during this admission were administered to him at the hospital, which would be considered a controlled setting that's being monitored by numerous health care providers; is that fair?

A. That's my understanding, yes.

Q. And Mr. Jewett did not have any signs of intoxication at the hospital, right?

A. From review of the record, there's no clear-cut signs. I guess he had urinary retention at one point, which can be from narcotic intoxication, but other than that, I didn't see any clear-cut signs of it.

Q. Many things can cause urinary retention, right?

A. Yes.

Q. So you would agree that there was no documentation in that medical chart of signs and

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symptoms specifically of intoxication of Mr. Jewett, right?

A. Other than, again, urinary retention, which you stated can have other causes, no.

Q. And in the documentation from this hospital admission, there weren't any documented concerning signs or symptoms that Mr. Jewett was experiencing as related to being given the combination of narcotics and Ativan at the hospital, right?

A. I guess the concerning signs or symptoms were that he was saying the Oxycodone was minimally effective, and that means someone might want to take extra doses of it to try to get better effects from it.

He seemed to think that the Dilaudid was more effective than the Oxycodone. And the Dilaudid does come orally, so they could have tried him on oral Dilaudid instead of Oxycodone but -- yeah.

Q. Well, as I understood your earlier testimony, concerning signs or symptoms in a

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patient related to narcotics and a benzodiazepine would be something related to respiratory suppression or respiratory depression, right?
A. Correct.
Q. So we can agree that he didn't have any of those concerning signs or symptoms at the hospital, right?
A. I don't think he had signs of respiratory depression in the hospital. Usually if someone's respiratory rate is less than 10, you would be concerned that their respiratory rate is depressed. I didn't see documentation of that.
Q. Okay.
A. But, again, it was given in the controlled setting to make sure he wasn't getting it more often than he should have been or taking it inappropriately.
Q. And as you mentioned this controlled setting, Mr. Jewett was being monitored by health care providers and, I think as you mentioned, taking the amounts, the appropriate amounts that he was given in that controlled setting while he was

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being monitored, right?
A. Yeah. I guess on the 30th he did ask for an extra dose of Oxycodone, so I guess he required a little extra that day. I think he asked for an extra dose of Ativan as well. But other than that, no.
Q. Despite those requests by him, he didn't experience any concerning signs or symptoms that you saw documented in the medical chart, right?
A. No. I think that was just a onetime thing where he got the extra doses, yeah.
Q. Okay. You will testify that Mr. Jewett needed a psych consult or addiction medicine consult due to his history of anxiety, depression and alcohol abuse; is that correct?
A. So I think everything has to be taken in context. I think people can cope with addiction and not abuse substances even if they have a history of that, but I think this patient's acute presentation, being anxious and saying he had pain out of proportion to physical exam findings, imaging findings, and exhibiting some signs, it

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appears, of pain medication-seeking behavior, puts him as someone who likely had opiate use disorder, which is a mental illness, and that history does, I think, factor into his current care at the time.
Q. And so when I asked you that first question, I was just reading from the designation. So just to clarify, it's your opinion that the standard of care required Dr. Amatya to order either a psych consult or an addiction medicine consult?
A. Yeah. I think anyone who is exhibiting pain medication-seeking behavior and it appears that their anxiety is feeding into their request for high doses of pain medication should be seen by either a psychiatrist or an addiction medicine specialist.
Oftentimes many psychiatrists have additional training in addiction medicine; not all of them do, but several of them do. So a psychiatrist that could have addressed his anxiety may have made him a little less anxious, maybe less prone to request such high doses of narcotics.

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Q. Can we agree that the act of not ordering such consults did not cause Mr. Jewett's death in this case?
A. That's kind of speculation. I mean, as I said, if you could have gotten a psychiatrist or an addiction medicine specialist to find a way to address his anxiety and his pain medication-seeking behavior in ways other than just increasing pain medication, then it might have led to him being discharged on lower doses of pain medication and maybe some alternative benzodiazepine, and that actually might have prolonged his life.
Q. Do you have an opinion to a reasonable degree of medical probability that the act of not ordering these consults caused Mr. Jewett's death in this case?
A. It's up to, you know, a pathologist or a forensic examiner to determine the cause of death, so I can't speak to their profession. I'm not a psychiatrist, but I have a great degree of respect for their ability to improve the mental functioning of the patients that are in acute mental crisis.

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Q. And, again, I think this is from your designation that you will testify that these diagnoses, which you referred to earlier as anxiety, depression, and alcohol abuse, increased Mr. Jewett's risk for overdose on narcotics; is that your opinion?

A. Yes.

Q. What's the basis for that opinion?

A. Experience and going to medical conferences. And they've done studies to show that a history of those things increase risks of opiate overdose.

You know, it's a pretty prevalent problem, opiate overdose. That's why you can now get Naloxone without a prescription to help reverse someone who overdosed on opiates. So it's deemed to be an epidemic, the opiate crisis. So, yeah.

Q. How long did Mr. Jewett have his diagnoses of anxiety and depression, if you know?

A. I'm not quite sure. I believe several years. I think he was admitted for suicidal ideation at least twice in the past, and I think it

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went back at least three years prior to his admission, the first hospitalization.

Q. And is that information that you saw when you were reviewing the INOVA Fairfax medical chart?

A. Correct.

Q. And prior to this admission, going years back, Mr. Jewett had been receiving pain medication prescriptions from numerous other providers; is that fair?

A. That's what it appears to be, yes.

Q. Again, from your designation, you will testify that a history of prior rehab stays should have been factored into Dr. Amatya's prescribing of narcotics; is that your opinion?

A. Yes.

Q. What's the basis for that opinion?

A. Again, someone has a history of substance abuse disorder is at risk in the future of repeating those behaviors. So I'm not saying it should prohibit them from ever receiving something that can be addictive such as a narcotic or a benzodiazepine ever again, but it certainly should

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make him question whether a person is relapsing in some of those behavior habits.

Q. Again, also from your designation, you will testify that there was no readily apparent reason for Mr. Jewett's acute increase in pain; is that your opinion?

A. From what I can read from the chart, yes, he was seen by a neurosurgeon, Dr., I think, McHugh, who didn't think he had any kind of surgical acute indication, and he was seen by a pain specialist who, I believe, admitted that his pain complaints didn't match up with the imaging findings. That's also my opinion.

Q. And when you say in that opinion "no apparent reason for his acute increase," increase from when?

A. From his chronic pain complaints. So from compared to when his primary care provider prescribed him pain medication back in May of that year, it didn't appear he had any surgeries in that time frame; he didn't have any traumatic physical trauma in that time frame that would cause an

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increase in his pain level.

Q. Did you review any medical records that discussed Mr. Jewett's chronic pain complaints?

A. In the history and physical, it mentioned that he had pain medication-seeking behavior, and it mentioned he's had multiple previous surgeries. He had an amputation of his left leg; that obviously is painful. And the drug prescribing monitoring program showed that he had gotten narcotics for several years so -- they're used solely for the treatment of pain, so he obviously had chronic pain.

Q. So other than what you just mentioned looking at the H&P, which was in the INOVA records, and then looking at the prescription monitoring program document, you did not review any other medical records regarding Mr. Jewett's chronic pain complaints; is that right?

A. Not medical records. Again, there was the police report that mentioned talking to Dr. Holt, I believe his name was, from his primary care office, but other than that, I don't believe so.

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Q. Again, back to your designation, it states that you will testify that Flexeril can cause drowsiness and should not have been taken with Oxycodone; is that right?
A. It shouldn't have been taken with the combination of Oxycodone and the Ativan. So Flexeril is a muscle relaxant. Ativan is also a muscle relaxant. So combining them seems a little odd. But apart from that, just apart from the indications, all three of those can cause drowsiness, and that's, I think, dangerous in someone with sleep apnea.
Q. Do you plan to testify that Dr. Amatya breached the standard of care in prescribing Flexeril?
A. I think if it was Flexeril alone, it wouldn't have breached the standard of care, but in combination with the Oxycodone and the benzodiazepine, I think it was risky. I think the more -- the larger issue was the Oxycodone and the Ativan. I think Flexeril was more of a risky behavior and not necessarily a breach of standard

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of care.
Q. And Dr. Andros had recommended continuing Flexeril for discharge, right?
A. He did.
Q. And that's something that the patient had been on?
A. Previously, yes, I believe he had.
Q. Do you plan to testify that the Flexeril was a cause of Mr. Jewett's death?
A. No.
Q. And we've already gone over this. We've been discussing Dr. Andros, who was the pain management consultant physician, and he recommended pain medications for Mr. Jewett upon discharge, which were the Oxycodone and MS Contin, right?
A. Yes.
Q. And we can agree that Ativan is not a pain medication, right?
A. Correct.
Q. So we can also agree that Dr. Andros did not address Ativan one way or another in his consultation and recommendations, right?

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A. Again, Flexeril and Ativan can both be muscle relaxers, so combining them is not usually needed. But, no, Dr. Andros didn't recommend Ativan. It's not usually used for pain. But certainly Dr. Amatya should have been aware of the risk of combining that with the MS Contin and Oxycodone -- and ultimately the Oxycodone.
Q. So I'm nearing the end of your designation, I promise. I'm on the bottom of 19 going to 20, which is the last page of your designation.
A. Okay.
Q. I should ask you, would you like to take a break, or do you need to get water or anything like that?
A. Luckily, I have my seltzer here. I'm good.
Q. Okay. Good.
A. Thank you.
Q. All right. So you plan to testify that Mr. Jewett had a primary care physician and a pain management doctor who could have dealt with his

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chronic pain, right?
A. Yes. I believe we later found out that his pain management doctor might not have been actively following him, but he did have a primary care doctor that was actively following him.
Q. And when the designation refers to pain management doctor, who are you referring to?
A. So I believe this patient, Mr. Eric Jewett, had followed with a pain clinic in the past, so providers from that clinic. But I think he wasn't still active with that practice.
Q. If I say Dr. Patel, does that mean anything to you regarding the pain management clinic?
A. Yeah, that name was mentioned in Dr. Amatya's deposition, but I guess later found out that maybe he wasn't active with that pain management practice but someone he had seen in the past.
Q. And you never reviewed any medical records from Dr. Patel or the pain management clinic, right?

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A. We couldn't locate -- no. No, I did not.
Q. As you've alluded to, Dr. Patel had actually discharged Mr. Jewett as a patient in 2014 or '15, right?
A. I'm not aware of that.
Q. So at the time of this hospital admission in August of 2016, Mr. Jewett did not have a pain management doctor; is that right?
A. I'm not sure.
Q. Going to the other part of this opinion, which is regarding the primary care doctor, and that's -- in all of this testimony, you've been referring to Dr. Davidson; is that right?
A. Yes. I think he works in the patient's primary care office.
Q. We've also been talking about the prescription monitoring program document that you reviewed, which I think you mentioned covers about two years of time; is that right?
A. Uh-hum. I believe so, yes.
Q. At the time of Mr. Jewett's admission to INOVA Fairfax in August of 2016, Mr. Jewett was not

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regularly or consistently seeing one primary care provider, right?
A. I'm not sure how the primary care office, you know, rotates providers and how they see patients. I think that Dr. Holt was the one who most recently saw the patient.
Q. In terms of Dr. Davidson, are you aware that prior to August of 2016, Dr. Davidson had only seen Mr. Jewett two times?
A. I was not aware of that. I just knew that he was following with the same practice.
Q. Okay. Are you aware that Dr. Davidson, from the two times that he saw Mr. Jewett, was not prescribing him any narcotic pain medications?
A. I was not aware of that, but everyone in that office, including the ones that were prescribing him pain medication, should have access to the chart, the outpatient chart.
Q. Are you aware that Dr. Holt is not in practice with Dr. Davidson?
A. I was not aware.
Q. Are you aware that Dr. Holt practices as a

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provider in UVA or in the adjacent UVA offices?
A. I was not aware of that.
Q. Are you aware that it was earlier that year that Mr. Jewett attempted to establish care with Dr. Holt at UVA?
A. I was not aware of that.
Q. Are you aware that the relationship between Mr. Jewett and Dr. Holt was not a long-standing one because Dr. Holt refused to continue prescribing opiates to Mr. Jewett as he was requesting?
A. I was aware he prescribed opiates several times that year. Again, I didn't review charts from the primary care doctor's office.
Q. Okay. So I take it you're not aware that Dr. Holt was not Mr. Jewett's primary care provider as of August of 2016?
MR. BLAZER: Objection. That may mischaracterize the evidence.
MS. NIKOLIC: You can answer, Doctor.
A. Can you repeat the question?
BY MS. NIKOLIC:

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Q. Sure. Are you aware -- I'll rephrase it for you.
Are you aware whether or not Dr. Holt was Mr. Jewett's primary care provider in August of 2016 when he was at INOVA Fairfax Hospital?
A. I'm aware that the patient had a listed primary care provider in the INOVA Fairfax chart that was documented as his primary care provider. So if they misrepresented his primary care provider, then that's what happened.
Q. That documentation in the chart was not Dr. Holt, right?
A. It was not. That was in the police report. I try to piece things together as I can.
Q. In terms of your testimony regarding Mr. Jewett had a primary care provider and pain management who he should have -- could have followed up with for his chronic care following the admission, we can agree that Dr. Amatya told Mr. Jewett to follow up with a pain management team as soon as possible, right?
A. I believe he did document that. And I

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think he also scheduled an appointment with his primary care doctor a week out by the social worker in the hospital.

Q. And that would be Dr. Davidson?

A. It was documented that a social worker made an appointment with a primary care provider. I can't recall which one.

Q. And Dr. Davidson was sent a copy of Mr. Jewett's discharge summary that same day, right?

A. I'm not sure how the hospital handles forwarding discharge summaries to primary care practices.

Q. If that was something that was documented in the medical chart, would you have any reason to dispute it?

A. No.

Q. So I want to talk a little bit just about the last part of your opinions which touches on the causation portions of this.

You state in the last paragraph of your designation that the management and discharge

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medication instructions described above, in the rest of the designation, represented breaches of the applicable standard of care and more likely than not caused the death of Mr. Jewett.

That's your opinion, right?

A. Yes.

Q. What is your opinion as to what specifically caused Mr. Jewett's death here?

A. So, again, the coroner determines the cause of death, but it appears that he was given Ativan on his day of discharge, at least two times, and he was prescribed large doses of Oxycodone, which was found in his bloodstream at a high level, a dangerously high level, and so I think the combination of those two things, getting dosed Ativan on his day of discharge multiple times as well as being given a prescription for high-dose narcotics, contributed or ultimately caused him to expire.

Q. We can agree that the toxicology report in this case did not show Ativan in Mr. Jewett's femoral blood at death, right?

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MR. BLAZER: Objection --

A. Right.

MR. BLAZER: -- mischaracterizes the evidence.

Go on, Doctor, you can answer the question.

THE WITNESS: Okay.

A. So I believe Dr. Schneider commented on this, Kevin Schneider, that while they couldn't detect the Ativan, it still could be in his system in a therapeutic level.

There is something in pharmacology called half-life of a medication. It's similar to, like, carbon-dating on fossils. They kind of determine how old something is by how it decays.

So for medications, the half-life is how long it takes for half of the substance to break down in the bloodstream. So for Ativan, it's roughly 12 hours. It usually takes about four to five half-lives for the medication to be gone from your system.

So if he was dosed with Ativan on his day

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of discharge, it would have been in his system for at least 48 hours after his day of discharge. He expired the very following morning. So by that dosing, it was documented it was administered in hospital, the Ativan should have still been in his bloodstream even if they couldn't find detectable levels on the toxicology report.

Q. So is it your opinion that Ativan was still in his bloodstream even though they did not find it in detectable levels --

A. I think that's fair.

Q. -- in the tox report?

A. I think that's very likely.

Q. Do you hold that opinion to a reasonable degree of medical probability?

A. Again, I'm not an expert on toxicology -- I'm not a pathologist -- but based on the timing of his doses of Ativan and then knowing the half-life of that medication, he should have had that still in his system. I'm fairly certain of that.

Q. Is a nondetectable level of Ativan sufficient to contribute and cause death here?

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A. I think with the high dose of narcotic that he was on, it likely contributed to him passing away, yes.
Q. So your testimony is that the nondetectable level of Ativan contributed to his death because of the Oxycodone that he was on?
A. To clarify, I think if you were on Ativan alone, it would not have increased his risk of passing away, but him being on the Ativan, I think it would take probably smaller than therapeutic levels to cause adverse effects along with the Oxycodone.
Q. Okay. And do you hold that opinion to a reasonable degree of medical probability?
A. I think his levels were high enough to be therapeutic or just below, that it would be dangerous with the high level of Oxycodone in his system.
Q. And did you hold that opinion to a reasonable degree of medical probability?
MR. BLAZER: Asked and answered.
MS. NIKOLIC: Go ahead, Doctor.

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A. Yes.
BY MS. NIKOLIC:
Q. What is the basis that forms that opinion for you?
MR. BLAZER: Asked and answered.
A. The pharmacology I just mentioned and the fact that he was dosed with the medication less than 24 hours from his expiration date in the hospital. He wouldn't have had to take any extra doses at home for that to be dangerous.
BY MS. NIKOLIC:
Q. And when you say that the pharmacology you mentioned, that that's -- you're referring to when you were discussing the half-life?
A. Yes.
Q. That pharmacological information, is that something that you have in your daily knowledge and experience as a hospitalist?
A. Yes. So drug companies need to figure out how often to recommend the prescribers for the medications, and the FDA has to evaluate those drug companies' data to see how safe it is to take a

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medication. That's why some medications are dosed daily, some are dosed twice a day, because some of them the body breaks down faster than others.
Q. You don't have any specialized training in pharmacology; is that right?
A. I received pharmacology training in medical school, and then when you're dosing medications, it's important to understand the pharmacology so you don't dose something inappropriately.
Q. And when you say that information, is that what you mentioned, information from drug companies?
A. So doctors use different databases on some medications they don't prescribe that often to see how often something should be prescribed.
So UpToDate is a medical database you can look to see what something's half-life is, or if you want to see if it's broken down more by the kidneys or the liver.
Something called Medscape is a database that has an app you can put on your phone that can

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give you something's half-life and how it's metabolized in the body.
These things all play in -- if someone has renal disease or liver disease, we'll provide a medication that's broken down predominately by those organs, and if you want to know how often to dose something, you might want to look at its half-life.
Q. And thank you for that, and I understand your testimony with reference to the dosing that you've just been testifying about.
A little bit different of a question for you: Is it within your area of expertise as a hospitalist to know the amount of nondetectable level of Ativan that is required to cause death in combination with Oxycodone?
A. I'm required to know which medications are dangerous to be given in combination with each other. I'm not required to be an expert on toxicology or pathology.
Q. And is that something that you would defer to a toxicologist or a pathologist or a forensic

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pathologist or something like that?
A. They would be more familiar with those things than I would. I have an understanding of them, but I'm not an expert.
Q. So is it fair to say you would defer to a toxicologist or a pathologist in terms of the specifics of cause of death?
MR. BLAZER: Objection. Asked and answered.
MS. NIKOLIC: Go ahead, Doctor.
A. Yes.
BY MS. NIKOLIC:
Q. Did you review the deposition transcript of the medical examiner in this case?
A. Yes, the initial one and then the revised one.
Q. Oh. Okay.
A. Are you saying the death certificate?
Q. Let me just rephrase. Yeah. So I asked you about the deposition transcript, but I think you're referring to the report, like the cause of death report that the medical examiner authored.

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A. I was referring to the death certificate, yes. You're referring to what again?
Q. To a deposition transcript, which is like what you would have read for Dr. Amatya.
A. I reviewed the one from Kevin Schneider that was done. I reviewed that, and I reviewed the list of expert witnesses that was sent to me, yes.
Q. Okay. But if I tell you that the medical examiner in this case, Dr. Kessler, was deposed like you're being deposed right now and that there was a transcript of that deposition, do you believe that you reviewed that?
MR. BLAZER: I'll stipulate that I did not send it to him.
A. Yeah, I didn't see that.
BY MS. NIKOLIC:
Q. Okay. And I just wanted to confirm that, Doctor. It wasn't a trick question. I just wanted to confirm, because when you answered my initial question, you were -- I think you believed you were referring to the death certificate, and then later you did see that there was an amended one that she

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had authored; is that right?
A. Yes, but -- yeah, I didn't see Dr. Kessler's deposition.
Q. Okay. You're aware that Dr. Kessler -- that that's the name of the medical examiner, right?
A. You reminded me of that name, yes, but I've seen it before.
Q. And you're aware that her amended report, which had really an amended cause of death, that that was mixed-drug intoxication. Are we on the same page when we refer to "amended," that that's what you reviewed?
A. Yes.
Q. Okay. Just making sure.
In terms of Dr. Kessler's amended report for cause of death for mixed-drug intoxication, we can agree that under her cause of death for mixed-drug intoxication, Ativan was not one of those drugs, right?
A. Yes.
Q. In reviewing this case, did you rule out

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any other causes of death?
MR. BLAZER: Objection. He's already told you he's not a coroner or medical examiner.
Go ahead, Doctor.
MS. NIKOLIC: Go ahead, Doctor. You can answer.
A. Yeah, I'm not a coroner or a medical examiner. I'm not ultimately responsible to determine the cause of death in cases like this.
BY MS. NIKOLIC:
Q. So you would defer to someone else?
A. Correct.
Q. In your practice as a hospitalist, are you regularly called upon to determine a cause of death of a patient at the hospital?
A. Yes. If someone passes away in the hospital on our service and it's during the daytime, because I usually work days, then we come and pronounce them, and then we do an electronic death certificate and fill out the cause of death. Because I'm a hospitalist, I don't fill out those for someone who dies at home.

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Q. I'm sorry. Could you repeat that? I just didn't hear you.
A. As I'm a hospitalist, I don't fill out those kind of things for someone that passes away at home.
Q. Okay. I understood. So, in other words, it would be just a patient of yours at the hospital, right?
A. Correct.
Q. I want to go back to something that you said earlier when we were talking about -- initially when we started talking about cause of death. I think you said something to the effect of that he had been prescribed Oxycodone at a high level, and I believe you were referring to the toxicology report.
Do you recall that testimony a few minutes ago?
A. I said he was prescribed a high dose of Oxycodone and that the level was high in his blood stream on the toxicology report, yes.
Q. Do you recall what that level was?

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A. I have it here. It was .41 milligrams per liter.
Q. Do you have, in your experience as a hospitalist, experience in determining lethal amounts of narcotics such as Oxycodone?
A. I can determine someone having adverse effects when I'm rounding on them if they become, you know, obtunded; but, no, I don't have responsibility determining a lethal level of the substance on a toxicology report.
Q. In terms of your testimony that the Oxycodone reported in the bloodstream was at a high level, what is the basis for that opinion that that's a high level?
A. I am deferring to the pathologist who said it was a lethal level.
Q. And that's the pathologist who authored the tox report in this case?
A. I believe so.
Q. I should also add and the medical examiner who ultimately authored the death certificate and that cause of death report?

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A. Yes.
MR. BLAZER: Objection to the form of the question. You're mixing two separate individuals. Could you make clear who you're talking about?
MS. NIKOLIC: Yeah.
BY MS. NIKOLIC:
Q. Are you relying on Dr. Schneider or on Dr. Kessler; I'll ask it that way, Doctor?
A. Dr. Kessler, I believe, put down that it was a lethal level of Oxycodone. I think Dr. -- Dr. Schneider put it was a lethal level. I think Dr. Kessler also stated that Oxycodone was part of the cause of death, though.
MS. NIKOLIC: Okay, Doctor, I think I'm almost done. Let's just take a brief break. Since this is our first break of the morning, let's just take a 10-minute break, and that way people can go to the restroom, grab coffee, whatever, and so we'll be back in about 10 minutes. Okay?
THE WITNESS: Sure. Okay.
MR. BLAZER: Thank you.
MS. NIKOLIC: Thanks, Donna. We'll go off

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the record.
(Whereupon, a recess was taken at 11:41 a.m. until 11:53 a.m. and then the proceedings continued as follows:)
BY MS. NIKOLIC:
Q. Doctor, I just have a few more questions for you, and then I promise I will let you get out of here.
So I just wanted to go back to something you testified to earlier. Do you recall my questioning and your testimony regarding your opinion regarding the need for a psych consult due to Mr. Jewett's anxiety, depression, alcohol abuse? Do you recall that testimony?
A. Yes.
Q. Okay. And then I think you had testified that that type of history -- the reason a psych consult is needed is because of that type of history and that that type of history can cause an increased risk of overdose.
Was that a fair summary? I know that was about an hour ago.

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A. I believe so, yeah.
Q. Okay. Do you have an opinion as to whether Mr. Jewett committed suicide?
A. There was mention in the chart that he did not appear to be suicidal and he had a normal affect. There was no mention of him appearing to be suicidal in the chart so...
Q. So then is that a yes or a no?
A. He didn't appear to be suicidal.
Q. Okay. Do you have any other opinions in this case that we haven't already covered today?
A. I think you touched base on all of them.
Q. Okay. Just a couple of very, very general questions.
Do you know or have a relationship with any of the INOVA Fairfax providers?
A. No. I don't know any of them.
Q. And that would include Dr. Amatya, right?
A. Correct, yeah.
Q. Do you know or have any relationship with the other standard of care expert who has been designated in this case, Dr. John Dombrowski?

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A. I don't know him, no.
Q. And I take it you do not know or have a relationship with Dr. Schneider or Dr. Kessler, the other two providers we've been discussing?
A. They're strangers. No, I don't know them.
MS. NIKOLIC: Okay, Doctor, I think those are all the questions I have for you.
I will just say for the record I will attach your CV as Exhibit 1 and the expert designation as Exhibit 2.
Donna, I apologize, I did not get those to you earlier, but I will just send them to you after this, but those will be Exhibits 1 and 2.
And I thank you very much for your time today, Doctor.
Mr. Blazer might have some questions for you, but I'm done, so thank you.
MR. BLAZER: Mark, I have no questions.
You have the right to read the transcript and to confirm that your testimony has been accurately transcribed. I am going to ask that you take advantage of that opportunity.

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So, Madam Court Reporter, we will read, and so send me a mini transcript and an errata sheet, and I'll get that back to you as soon as possible.
(Caryl MD Exhibits 1 and 2 were reserved to be marked for identification.)
(Whereupon, signature not having been waived by counsel, the deposition of the witness herein, Mark R. Caryl, D.O., concluded at 11:57 a.m.)
* * * * *

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I, Mark R. Caryl, D.O., do hereby certify that I have read the foregoing typewritten pages 1 to 92, and corrections, if any, were noted by me; and same is now a true and correct transcript of my testimony.

PAGE	LINE	CHANGE OR CORRECTION	REASON THEREFOR
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DATE MARK R. CARYL, D.O.

VIRGINIA:
IN THE CIRCUIT COURT OF FAIRFAX COUNTY

DENNIS MARK JEWETT, Personal Representative of the Estate of ERIC JUSTIN JEWETT, deceased,
Plaintiff,
Case No. 2020-0002561
v.
INOVA HEALTHCARE SERVICES, INC., d/b/a INOVA FAIRFAX HOSPITAL, et al.,

Defendants.

I, MARK R. CARYL, D.O., do hereby acknowledge that I have read and examined the foregoing pages of testimony, and the same is a true, correct and complete transcription of the testimony given by me, and any changes and/or corrections appear on the attached errata sheet signed by me under penalties of perjury.

_____ _____
(Date) (Signature)

_____ _____
(Notary) (Commission Expires)

CERTIFICATE OF STENOTYPE REPORTER - NOTARY PUBLIC

I, DONNA L. LINTON, RDR-CCR-CLR, and a Notary Public in and for the Commonwealth of Virginia, before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in Shorthand at the time and place mentioned in the caption hereof and thereafter transcribed by me; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

DONNA L. LINTON, RDR-CCR-CLR
Notary Public in and for
COMMONWEALTH OF VIRGINIA

My commission expires: March 31, 2026
My notary registration number: 118816

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SENT VIA EMAIL
Monday, November 21, 2022
Mark R. Caryl, D.O.
c/o The Law Office of John A. Blazer
John A. Blazer, Esq.
JohnBlazerLaw@gmail.com

IN RE: DEPOSITION OF MARK R. CARYL, D.O.
Dennis Mark Jewett v. Inova Healthcare Services Inc., et al.

Dear Dr. Caryl:

Enclosed please find the requested copy of the transcript with the original signature page to your deposition taken on Thursday, November 10, 2022.

Please review your deposition testimony, note any changes on the separate errata sheet by reference to page and line number, i.e., "he said" to "she said," and send the errata sheet and executed signature page back to Ms. Nikolic within 21 days of receipt of this letter. Ms. Nikolic will then include the signed signature pages with the original transcript, which is in her possession. To further ensure quality in reporting, please feel free to send a copy of the errata sheet to our office via e-mail.

Very truly yours,

Donna L. Linton, RDR-CCR-CLR
cc: Aneta Nikolic, Esq.