IN THE STATE COURT OF DEKALB COUNTY
STATE OF GEORGIA

Stefan Lane Janet Lane, Plaintiffs, — *versus* — Emory Healthcare, Inc. The Emory Clinic, Inc. Principals of the Individual Defendants 1-5 Abrar Chaudhry, MD Ryan A. Marten, MD Bryan Lee Mays, RN Charice Jordan, PA-C Mahmoud Obideen, MD John/Jane Doe 1-5, Defendants	Civil Action File No. 19 A 77517 Jury Trial Demanded HON. ALVIN K. WONG

PLAINTIFFS' SECOND AMENDED COMPLAINT FOR DAMAGES

1. This Second Amended Complaint incorporates all the allegations and requests for relief contained in the preceding complaints (with the modifications made by the First Amended Complaint).

Summary of Amendment

2. This Second Amended Complaint adds a claim for punitive damages for conscious indifference to consequences in the events underlying this case. This amendment also specifies additional grounds for the previously asserted claim for expenses of litigation.

3. Through sworn testimony in this case, Emory physicians have demonstrated that despite marketing itself as a "Primary Stroke Center," Emory Johns Creek Hospital violates consensus standards for identifying the "last known well" of a post-TIA stroke patient.

4. Emory markets their Johns Creek Hospital as a "Primary Stroke Center."

5. But Emory's practices violate generally accepted standards for assessing a stroke patient's "last known well" or "last known normal."

6. Emory's violations put patients at risk of being wrongly denied treatment for a stroke, even when the stroke happens at Emory, under the eyes of Emory physicians.

7. Emory does not comply with the standards required of a "Primary Stroke Center," and their marketing under that phrase is false and misleading.

The "Last Known Well" in Post-TIA Patients

8. One main treatment for stroke is TPA — a "clot-buster" medication.

9. TPA generally must be given within 4-1/2 hours of the patient's "last known well" or "last known normal" — the time before the symptoms of the current stroke.

10. For a blockage of one of the small arteries in the brain, TPA may be the only treatment available, because the artery may be too small for a thrombectomy.

11. However, if you are treated for a stroke more than 4-1/2 hours after the symptoms begin, you generally will not qualify even for TPA.

12. Thus, if you have a small artery blockage and are treated more than 4-1/2 hours after symptoms begin, you are likely doomed. That is, physicians will generally conclude they have no treatment to offer, and your stroke will just have to run its course and kill whatever brain tissue it's going to kill.

13. Proper identification of the last known well is crucial to proper treatment of a stroke.

14. Proper identification of the last known well can make the difference between full recovery and serious, permanent brain damage and disabilities.

15. When you have a stroke at home, the EMS and ER staff generally identify your last known well from your own statements or those of a friend or family member.

16. A transient ischemic attack (TIA) is a mini-stroke. In a TIA, a temporary blockage of blood flow causes temporary symptoms.

17. When you have a TIA that resolves, and at some later time you have symptoms of a new stroke, your last known well is the last known time before the symptoms of the new stroke began.

18. When you have a stroke in the hospital — after a prior TIA has resolved — better identification of the last known well should be possible than when you have a stroke at home.

19. "Primary Stroke Center" certification is based on the readiness of a medical center to swiftly identify, evaluate, and treat with TPA qualified acute stroke patients.

20. The policies and practices of Emory Johns Creek Hospital violate the consensus standards for identifying TPA-qualified stroke patients — including the standards of the Joint Commission and the American Heart Association and American Stroke Association.

21. The consensus standards require stroke treatment providers to identify the last known well from the available evidence — whether it is the patient's own report, a family member's report, a paramedic's report, etc.

22. Emory does not do that. According to the sworn testimony of two Emory physicians, Emory disregards neurological assessments performed by Emory nurses, for purposes of identifying a patient's last known well.

23. Emory's practices mean that some stroke patients who should be given TPA are instead denied TPA — that is, a treatable stroke is not treated. The stroke is left to run its course unabated. The Emory patient is left unprotected, to suffer whatever harm the stroke will inflict.

24. Emory advertises and markets Emory Johns Creek Hospital as a "Primary Stroke Center."

25. On information and belief, Emory has not informed the Joint Commission, the American Heart Association, or the American Stroke Association — the certifying bodies for "Primary Stroke Center" status — that Emory disregards neurological assessments by nurses, for purpose of identifying a patient's last known well.

26. The certification is unearned and erroneous, and the marketing is misleading.

Emory's Treatment of Post-TIA Patients Admitted for Observation

Emory's Practices & Withholding of Stroke Treatment from Stefan Lane

27. In testimony in this case, an Emory physician acknowledged that Emory's practices put post-TIA patients at risk of suffering an untreated stroke.

28. When Emory admits a post-TIA patient to the main floor of their hospitals, Emory will not take the last known well from the patient's own statements, nor from a friend or family member in the room, nor even from formal neurological assessments by Emory's own nurses.

29. For a post-TIA patient in the hospital, Emory will take the last known well only from a physician's — and possibly only from a neurologist's — neurological assessment.

30. But Emory does not perform regular, periodic neurological assessments by physicians.

31. In other words, for a post-TIA patient admitted for observation out of concern for a follow-on stroke, Emory does not perform regular neurological assessments that track or update the patient's last known well.

32. Emory knowingly, intentionally keeps itself ignorant of a potential stroke patient's last known well.

33. Thus, for a post-TIA patient who later suffers a full-blown stroke under the eyes of an Emory physician, even if the patient's last *actual* well was only an hour earlier, the physician may refuse TPA because the last physician-conducted neurological assessment was more than 4-1/2 hours ago.

34. The effect of Emory's practices is that stroke patients who should receive TPA therapy and might fully recover from a stroke are instead denied TPA and left to suffer whatever brain-tissue death the stroke will cause.

35. Such patients would be better off if they were sent home after their mini-stroke resolved and later suffered a full-blown stroke at home rather than at the hospital.

36. If such patients suffered the stroke at home, they would qualify for clot-buster medication based on their own or a family member's identification of the last known well. In Emory's hospital, though, Emory physicians will deny clot-buster medication because they do not consider a neurological assessment by a nurse sufficient to identify the patient's last known well.

37. That's what happened to Stefan Lane:

a. Stefan went to the Emory Johns Creek ER with a mini-stroke that resolved while he was there.

b. Emory admitted Stefan to the main floor, for observation.

c. Over the next day and a half, Emory nurses performed multiple neurological assessments showing that Stefan was neurologically normal.

d. Stefan later had a stroke in the hospital.

e. An Emory neurologist came into Stefan's room while Stefan was having a stroke.

f. At that point, it was less than three hours since a nurse performed a neurological assessment and found Stefan normal.

g. Nonetheless, the Emory neurologist withheld TPA from Stefan, partly because he deemed Stefan outside the window for TPA — because Emory deems a nurse's neurological assessment inadequate to establish a last known well.

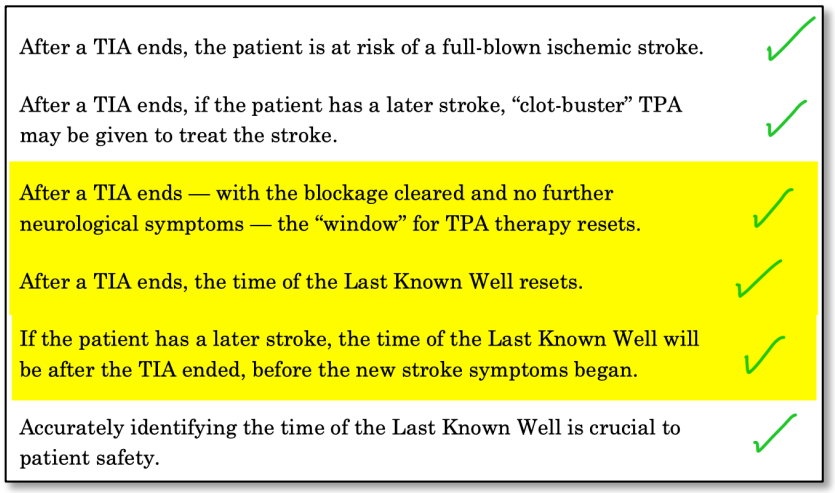
h. Stefan's stroke continued, and went on to kill brain tissue — leaving Stefan with serious, permanent disabilities.

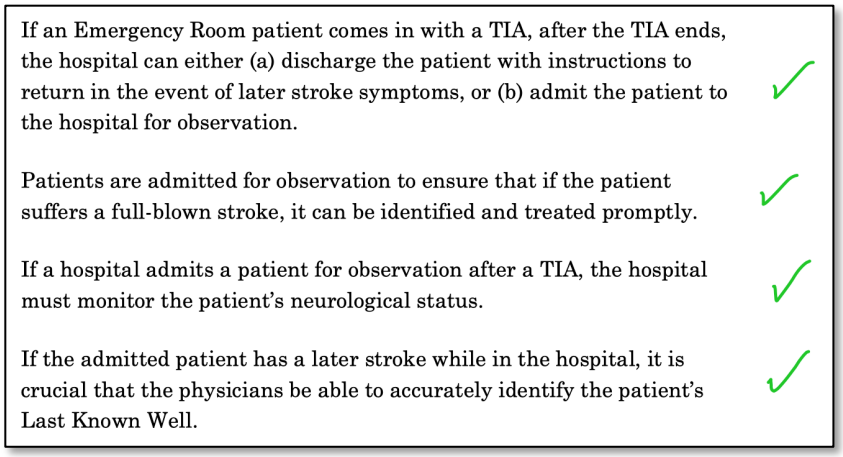
38. Based on Emory's conscious indifference to the risk they imposed on Stefan — while failing to inform Stefan of that risk — Plaintiffs add a claim for punitive damages.

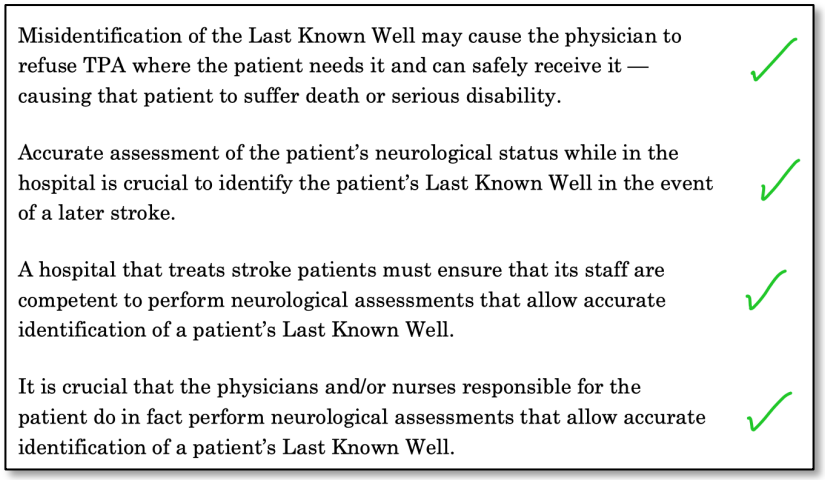
Testimony of Emory Physicians

39. Two Emory physicians — neurologist Mahmoud Obideen and hospitalist Abrar Chaudhry — testified about stroke treatment practices at Emory Johns Creek Hospital.

40. At his deposition, Dr. Chaudhry agreed with the following statements. Each of those statements is true. From Exhibit Chaudhry 4:







41. A schedule of neurological assessments every four hours puts post-TIA patients at risk, because the window for TPA is only 4-1/2 hours — and 3 hours for some patients. As Dr. Abrar Chaudhry testified:

Q. Okay. So in that situation, he looks back to the last known well, which is the time of the first assessment back at 1:00 a.m.; true?
A. Yes. True.
Q. But now the problem is four hours of the tPA window has already been used up; right?
A. Uh-huh (affirmative).
Q. So for a patient with a four-and-a-half-hour window, that window is now going to close in 30 minutes; right?
A. True.
Q. For that patient, this is a risky situation because there's a good chance that the tPA cannot be administered within 30 minutes.

44

A. True.
Q. Okay. And what's worse is that if the patient happens to be someone for whom the tPA window is only three hours, she's just completely out of luck; right?
A. Uh-huh (affirmative).
Q. That's a yes?
A. Yes. True. Yes.
Q. So the four-hour monitoring regimen is bad for the four-and-a-half-hour-window patients, and it's terrible for the three-hour-window patients; agree?
A. True. Yes.

42. Emory is required to have nurses capable of performing neurological assessments adequate to track a patient's last known well. As Dr. Chaudhry testified:

45

Q. And now I'm not -- I'm no longer talking hypothetically. I'm asking about the actual facts at Emory Johns Creek Hospital.

Does Emory ensure that the nurses they hire and assign responsibility to care for stroke patients are competent and diligent to perform a neurological assessment that would allow physicians to accurately identify the time of the last known well?
A. Yes, I believe so.
Q. Just to put a point on it, if Emory is hiring nurses who cannot do that job, then Emory is dooming some number of their stroke patients to death or serious disability.
MR. LADNER: Object to form.
Q. (By Mr. Holloway) Right?
A. If they are not doing that, they would not

46

get approved to be a stroke center.

43. However, at Emory, the neurological assessments performed by nurses — the *only* regularly scheduled assessments — are disregarded by physicians, for purposes of establishing a patient's last known well. As Dr. Chaudhry and Dr. Mahmoud Obideen testified:

Dr. Chaudhry

48

So -- and the nurses that -- the assessments that the nurses do is not to establish the patient's last known normal, which is part of the protocol of the TIA patients that get admitted at Emory, at all Emory facilities.

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57

Q. ... So this is your testimony. In fact, a nurse's neurological assessment at Emory Johns Creek Hospital is not adequate to identify the patient's last known normal.
MR. LADNER: Object to form.
THE WITNESS: True.

MR. LADNER: Go ahead.
THE WITNESS: True.
Q. (By Mr. Holloway) Okay. Before we go farther here, your -- you are firm on this point; is that right?
MR. LADNER: Object to form.
THE WITNESS: Yeah.

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58

Q. Okay. This testimony began a moment ago that, in fact, a nurse's assessment at Emory Johns Creek Hospital is not adequate to identify the patient's last known normal.
First of all, do you want to walk that back or are you solid on that point?
MR. LADNER: Object to form. You can

59

answer it.
THE WITNESS: No, I think I do believe that. The neuro exam that the nurses follow every four hours based off of the order set that we place and request them to do every four hours is not to establish the patient's last known normal.

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76

Q. Right. So what you're telling me -- tell me if I've got this right. What you're telling us is that in -- in the real world where these assessments are actually done by nurses, what's going to happen is by the time a physician gets called at 5:00 a.m. here, the physician is going to consider tPA; right?

77

A. Yes. If there's some concerning, et cetera.
Q. And the physician is going to have to figure out when the last known well was.
A. Yes.
Q. But what you're saying now is if -- if this assessment was done by a nurse, then it's no good for telling you the last known well; right?
A. Yeah, because their assessment will not determine their last known well.

* * *

Dr. Obideen

0158
Q. Do you have any reason to think Nurse Mays is not qualified to perform a detailed neurological assessment as he has recorded here on Page 819 in the record?
A. No, I don't have anything to say he is not qualified, but I know that in general, that the neuro -- the same neuro exam that is done by nurse is not the same as accurate as neuro exam done by stroke specialist. So there is a possibility that the nurse tell me normal and I -- the patient is not normal. In that case, like for TPA is made -- in this example, if the nurse tell me he is normal, I did the exam and he was normal, I respect that but I don't take it only that. I keep asking, keep searching because I know that any exam done by nurse is not as accurate as exam done by stroke and I am giving TPA that can kill the patient.
So I will say no, I don't have anything to say that he is not qualified, but it
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is not enough for me that a neuro check done by a nurse, like just give TPA. In that case you don't need neurologist is like for candidate.

44. For a patient coming into the ER with stroke symptoms, the patient's last known well would be determined from the statements of the patient or a friend or family member. As Dr. Chaudhry testified:

136

Q. (By Mr. Holloway) If Stefan had been discharged from the ER with instructions to come back --
A. Uh-huh (affirmative).
Q. -- let's say six hours later he comes back. They would have asked him when were you last normal; right?
MR. LADNER: Object to form.
THE WITNESS: Yes.
Q. (By Mr. Holloway) And if he said, I was last normal an hour ago, they would rely on that, wouldn't they?
A. Yes.
Q. Doctors will rely on patient reports of last known normal, but on your testimony, doctors at Emory will not rely on a neurological examination performed by a nurse; true?
MR. LADNER: Object to form.
THE WITNESS: True.

45. Dr. Chaudhry revealed that — as an Emory physician — he does not know whether the standard of care requires neurological assessments that allow correct identification of the last known well.

51

Q. (By Mr. Holloway) So I think -- I take your point. I think you have answered the question. What you're saying is you don't know one way or the other whether the standard of care requires neurological assessments that allow correct identification of the last known well.
A. Yeah, I do not know.

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167

Q. (By Mr. Holloway) Yeah. Did the standard of care require you to order a neurological assessment that would be reliable to identify a last known well?
A. So those are nurses neuro assessments which

are ordered every four hours, and that -- they do not establish the last known normal like we discussed before.

Q. Right. So my question is: Knowing that, did the standard of care require you to order neurological assessments that would suffice to

identify a new last known well?

A. I believe whatever is ordered is, to my knowledge, the standard of care.

Q. Well, you -- taking on your view, the neurological assessments you ordered were not adequate to identify a new last known well; correct?

A. Yeah, true. The nurse's assessment, right.

Q. So as a matter of fact, you did not order neurological assessments that would suffice to identify a new last known well.

A. True.

Q. So my question is: Did the standard of care require you to order such assessments?

A. I do not know.

Q. And nobody at Emory has told you that you are expected to make sure neurological assessments are being done for a post-TIA patient that would suffice to establish a new last known well.

A. Yeah, they have told us to use the certain order sets and they have all the standard of care orders in there.

Q. Who created those order sets?

A. I specifically do not know.

Q. Who might know?

MR. LADNER: Object to form.

THE WITNESS: I don't know. Quality control department at Emory.

46. No one at Emory has ever told Dr. Chaudhry that neurological assessments must be adequate to identify the patient's last known well. As Dr. Chaudhry testified:

51

Q. Nobody at Emory has told you that patients need to be assessed adequately to identify the last known well.
A. We just follow the Emory protocols which

52

basically encompasses all of this, and the best way to treat a TIA patient under observation, and we do believe when we place these orders, they are all based off of extensive amount of research and they do follow the standard of care. And whatever is encompassed in that order set is what it is.
MR. HOLLOWAY: Objection, nonresponsive.
Q. (By Mr. Holloway) The question is: Nobody at Emory has told you that it is necessary to assess neurological status adequately to correctly identify last known well.
MR. LADNER: Object to form. You can answer.
THE WITNESS: Same response what I said before.
MR. HOLLOWAY: Well, objection, nonresponsive.
Q. (By Mr. Holloway) Has anybody at Emory told you that you must ensure neurological assessments are being done sufficient to identify last known well?
MR. LADNER: Object to form, asked and answered. You can answer it again.
THE WITNESS: Same thing. I don't have anything new to add. You can continue

53

asking the same thing. I mean...
Q. (By Mr. Holloway) Okay. What has Emory told you about the need or lack of need for

neurological assessments adequate to identify last known well?

A. Whatever is in there, in the medical record, in the orders that I have placed according to the ischemic stroke or TIA order set, that is what they have, you can say, quote/unquote, told me.

47. At the time Stefan Lane came under Emory's care care in 2017, physicians at Emory generally knew that — per Emory's practices — a neurological assessment by a nurse would be disregarded for purposes of determining the last known well of post-TIA patients like Stefan. As Dr. Chaudhry testified:

58

Q. Okay. This testimony began a moment ago that, in fact, a nurse's assessment at Emory Johns Creek Hospital is not adequate to identify the patient's last known normal.

First of all, do you want to walk that back or are you solid on that point?

MR. LADNER: Object to form. You can

59

answer it.

THE WITNESS: No, I think I do believe that. The neuro exam that the nurses follow every four hours based off of the order set that we place and request them to do every four hours is not to establish the patient's last known normal.

Q. (By Mr. Holloway) And did you know that in December 2017 when Stefan Lane came under your care?

A. Based off of the medical records, yeah. Like I said, I don't specifically remember them personally because it has been so long ago. It's been quite some time and...

Q. Okay. So you see the problem that sets up for Stefan Lane and other patients like him; right?

A. Yeah. Yeah, I do. Do you want to go back to your -- what was it called? Chaudhry 1?

Q. I can in a moment, but I've got a couple of follow-ups here.

So based on what you're saying --

A. I think it will really help us all if you did go back to that.
MR. LADNER: Dan -- Dan, let's take a break. Let's take five minutes.
MR. HOLLOWAY: No. No.

60

MR. LADNER: No, you said we can take a break whenever we need to. There's not a question pending. I need a break. It's been almost two hours.
MR. HOLLOWAY: All right.
MR. LADNER: We'll take a break.
MR. HOLLOWAY: We can do that, but the first question when we come back is going to be: Dr. Chaudhry, did you speak to your lawyer about the substance of this deposition during the break?
MR. LADNER: He's not going to answer that question. You can ask him whatever you want. It's been almost two hours. I asked for a break 15 minutes ago. We're taking a break. He's not going to answer that question.
MR. HOLLOWAY: That's fine. I am -- I am asking do not talk about the substance of the deposition during the break. We can go off the record.
(A recess was taken.)
Q. (By Mr. Holloway) Dr. Chaudhry, over the break, did you talk to your lawyer about the substance of this deposition?

61

MR. LADNER: Object to the question. I'll instruct the witness not to answer.
Dan, you really think it's appropriate? In Georgia, we have an attorney-client privilege. You are not allowed to inquire into anything we discussed. Do you think that's an appropriate question?
MR. HOLLOWAY: I'm avoiding colloquies

here.
Q. (By Mr. Holloway) Dr. Chaudhry, you're going to follow your lawyer's instruction not to answer?
A. Yes.
Q. Okay. Before the break, we were talking about -- well, now that we've had the break, do you need to revise any of your -- the testimony you've already given?
A. No.
Q. Okay. So before the break, we were talking about your testimony that a neurological assessment done by nurses is not adequate to identify the patient's last known well. Do you recall that discussion?
A. Yes.

Q. Okay. Your testimony here today that the nurse's assessment is not adequate to identify last known well, did you believe that to be true in December 2017 When Stefan Lane came under your care?
A. Yes.
Q. So your testimony is that you assigned the task of conducting neurological assessments for Stefan Lane to nurses you believed were not capable of doing an assessment that would let you identify Stefan's last known well?
MR. LADNER: Object to form, misstates his testimony.
Q. (By Mr. Holloway) Do I have that right?
MR. HOLLOWAY: No speaking objections, please.
MR. LADNER: Object to form, misstates his testimony.
THE WITNESS: Remember we established that the nurses can do the same exam as neurologists do?
Q. (By Mr. Holloway) Are you saying now that as a matter of fact, nurses can, after all, do neurological assessments adequate to identify last known well?
MR. LADNER: Object to form.

THE WITNESS: Yeah, if they're trained like them and if they do the same exam -- almost the same exam as a neurologist does or a physician does. But their neurological assessment per the protocol does not establish the last known normal.

Q. (By Mr. Holloway) All right. I want to make sure I understand. I think you're saying, yes, in theory a nurse could do a neurological assessment adequate to identify last known well, but in practice, at Emory, they don't.

A. Yes.

Q. That's your testimony.

A. Yes.

Q. So as a practical matter, when nurses operate according to normal protocols and procedures at Emory, their neurological assessments will not let you identify last known well.

A. True.

Q. And you knew that in December 2017 when Stefan Lane came under your care.

A. True.

Q. And if you knew that, surely you're not the only physician at Emory who knew that, were you?

A. Of course.

Q. That was generally known by the physicians treating stroke patients --

A. TIA.

Q. -- at Emory.

Post-TIA patients.

A. Yes.

Q. Okay. Is that phrase "post-TIA," does that make a difference?

A. Yeah.

Q. Okay. So it was generally known at Emory that -- by physicians treating post-TIA patients that the neurological assessments routinely done by nurses were not adequate to allow physicians to identify last known well.

A. True.

Q. For treating post-TIA patients, in this

case, you know that you ordered neurological assessments to be performed by nurses; right?
A. The Q4 hour nurses' assessment, neurological assessment, yes.
Q. When -- when treating a post-TIA patient who has been admitted for observation, is it customary at Emory to assign the job of routine neurological assessments to the nurses?
A. Yes. Per the protocol, the Q4 hour checks.

65

Q. So the routine at Emory in December 2017 -- well, first of all, Stefan, of course, was in the hospital in December 2017. Has the -- the protocol or the customary procedure changed from December 2017 until now?
A. I don't believe so.
Q. So then and now, the practice at one of Emory's primary stroke centers was to assign the task of routine neurological assessments for a post-TIA patient to nurses who would not perform assessments adequate to identify the patient's last known well.
A. Yeah, true. For a post-TIA patient who was being observed in the hospital.

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71

Q. This marketing website by Emory, do you think where it says, "Our teams make sure you get the right care at every stage of treatment," do you take that to be a fantasy description of what might happen in a -- in an ideal world or do you take that to be --
A. All --
Q. Let me finish the question.
A. Okay.
Q. Do you take that to be a statement of fact by Emory about what they do in the real world?
A. Yeah, what we do in the real world.
Q. Okay. So talking about the real world, in the real world, is it crucial that a post-TIA patient admitted for observation at an Emory primary stroke center has somebody doing neuro assessments that let you identify the correct last known normal if they

have a stroke later?
A. Yeah, that would be an excellent thing to have.

72

Q. And in the real world, what happens instead, according to your testimony, is the job of the routine neuro assessments goes to nurses who are not qualified or at least, in fact, do not do assessments that let you identify the last known normal.
MR. LADNER: Object to form. You can answer it.
THE WITNESS: True.
Q. (By Mr. Holloway) And that's not some one-time aberration that just happened to Stefan Lane because he was unlucky. That, on your testimony, is how Emory does it routinely; right?
MR. LADNER: Same objection.
THE WITNESS: For a TIA patient, yes, who could have also been discharged home.

48. At Emory, a patient in Stefan's situation typically would not be informed of the risk of being denied treatment for a stroke as a result of neurological assessments by nurses being disregarded for purposes of establishing the last known well. As Dr. Chaudhry testified:

72

Q. (By Mr. Holloway) Okay. So let's talk about what that means for a patient like Stefan or for any post-TIA patient. By the way, before we do that, when Stefan was admitted for observation, did you have a conversation with him and Janet in which you explained it is vitally important that if you have a stroke in ten hours or 15 hours that we know the last known well; however, we are not going to have qualified people do neurological assessments that would let us find out the last known well?

73

Did you have a conversation like that with

Stefan or Janet?
MR. LADNER: Object to form.
THE WITNESS: I don't remember saying that specifically to them.
Q. (By Mr. Holloway) Do you believe you had that conversation?
MR. LADNER: Same objection.
THE WITNESS: I don't remember.
Q. (By Mr. Holloway) I understand you don't remember. In the ordinary course of things, is that a conversation you would have with a post-TIA patient you're admitting for observation?
MR. LADNER: Same objection. You can answer the question.
THE WITNESS: Yeah, I would tell them about the -- the protocol and the admission -- we would admit them in the hospital. We would observe them. We would also -- basically there are two more things that each patient gets -- gets done when they get admitted in the hospital and they are admitted under observation is that if they have a -- if they had a TIA or a stroke, we try to determine why they had

it. And so we do -- we do several things. And then the second thing, which the reason why they get admitted for observation is also we -- what we can do to initiate the treatment or increase the treatment if they're already on some to prevent the next one from happening. So to initiate that treatment and then monitor them and make sure they don't develop any side effects, et cetera.
So I would explain all of that when they get admitted and do further tests, detailed tests. This takes time to do and then to get the results.
MR. HOLLOWAY: Objection, nonresponsive.
Q. (By Mr. Holloway) The question is: When you admit a post-TIA patient for observation, do you, as a routine matter, tell them it is vitally important

for your health and safety that we know the last known well in the event you develop a stroke later, but we are not going to assign the task of neurological assessment to people qualified to do assessments that would let us figure out the last known well? Is that a conversation you routinely have --

75

A. I cannot say that.
MR. LADNER: Object to form. You can answer. You can answer it.
THE WITNESS: Whatever you just said, I do not say that.
Q. (By Mr. Holloway) Of course not because it would be crazy to say that, wouldn't it?
MR. LADNER: Object to form.
THE WITNESS: I would not say that.
Q. (By Mr. Holloway) Right. You wouldn't say it because it's -- it would be a ridiculous thing to say, wouldn't it?
MR. LADNER: Object to form.
THE WITNESS: Yeah, I don't know -- I don't have an answer to that.
Q. (By Mr. Holloway) Well, do you think it would be a reasonable thing to say?
A. It would not be a reasonable thing to say. Then why are we admitting that? Then we should just send them home.

49. Emory's practices are bad for post-TIA patients. Dr. Chaudhry believes, though, that it is a problem with the requirements for stroke-center certification, which affects all hospitals certified as stroke centers.

Q. Let's just stick with the questions, please.

82

So the reason this patient is out of luck is just because the hospital assigned the task of the regular neuro assessments to somebody who is not competent to do an assessment that would let you figure out the last known well; right?
MR. LADNER: Object to form.
THE WITNESS: Not -- not competent,

but they're not told to do that. There's a difference.

Q. (By Mr. Holloway) And that's the way it was at Emory in December 2017. That's the way it is today in August 2020.

MR. LADNER: Objection, asked and answered multiple times. You can answer it again.

THE WITNESS: Yeah.

Q. (By Mr. Holloway) Are you okay with that?

MR. LADNER: Object to form.

THE WITNESS: I'm sure there are definitely improvements that can happen, but like we discussed about ideal situations and then -- and the tasks that we can do. Like, if this patient was admitted in the ICU and we did Q1 hour neuro checks, that would give enough time

for the nurses to call the provider, whoever is there, to do everything and things could have been done on time. But unfortunately, that is not the standard of care.

Just like a TIA patient who gets admitted -- or actually who comes to the ER and their symptoms get resolved, they also get discharged home to come back if their symptoms recur or they get admitted in CDU, you know. If this patient, if this scenario would have happened in the ICU, we would have caught that TIA or stroke happening right after 1:30, and that was two hours, two hours after the onset or from the last known normal and that patient would have gotten -- if they don't have any contraindication, they would have gotten tPA.

So you have to keep that in mind.

MR. HOLLOWAY: Objection, nonresponsive.

Q. (By Mr. Holloway) The question was: Are you okay with a system in which patients who might be able to receive tPA safely and who need it are

deprived of it because the neuro assessments are given to people who can't do an assessment that lets you figure out the last known well? Are you okay with that, Dr. Chaudhry?

MR. LADNER: Object to form. Object to form, asked and answered.

THE WITNESS: I mean, what can you do? Can you have anything better than standard of care?

Q. (By Mr. Holloway) I think you're saying this is -- this is a lousy situation, but it's what we're stuck with at Emory. Is that --

MR. LADNER: Object -- object to form.

THE WITNESS: No, that's not what I'm saying.

Q. (By Mr. Holloway) Are you saying this is a good situation?

A. No, I'm definitely not saying that.

Q. This is a bad situation, isn't it?

A. I think we -- they have -- they probably have to make improvements in what determines what a stroke center is, et cetera --

Q. Right.

A. -- in all the hospitals. And I think there's one major standard which is applied and which

happens in every facility which calls themselves a stroke center. So it's not -- I don't believe -- I don't know the details, but I don't believe it's a strictly Emory problem.

Q. You're -- you've only ever worked at Emory; right?

A. After my residency.

Q. That's what I mean, after residency.

A. Right. Yeah. I did three years of training there.

Q. Has anybody told you that at other primary stroke centers around the country, routine neurological assessments are given to nurses who are not capable of doing assessments that identify the

last known well?
MR. LADNER: Object to form.
THE WITNESS: No, no one has told me like that.

* * *

87

Q. And in this hypothetical, she is denied tPA because the neuro assessment that was done by the nurse was not adequate to identify Nancy's last known well; right?
A. Yes.
Q. So of the two primary treatments for stroke, thrombectomy is out in this hypothetical because of the nature of the clot, and tPA is also out, leaving her with zero; right?

88

A. Right.
Q. This patient is just doomed to suffer whatever the clot is going to do to her brain, whatever tissue it's going to kill, whatever disability it's going to leave her with, if it's going to kill her, she's just doomed to suffer it.
MR. LADNER: Object to form.
Q. (By Mr. Holloway) Because the neuro assessment was not adequate to identify last known well.
MR. LADNER: Object to form.
Q. (By Mr. Holloway) True?
A. True. In this situation, true.
Q. And part of Emory's position in this lawsuit and part of Dr. Obideen's position in this lawsuit and now part of your position in this lawsuit is that's what happened with Stefan Lane; right?
MR. LADNER: Object to form.
THE WITNESS: Yeah. We can say yes. Yeah.

50. At Emory, Stefan's chance of receiving TPA after symptoms of a new stroke occurred depended on pure dumb luck — on the symptoms coincidentally returning less than about four hours after a *physician* conducted a *non-scheduled* neurological assessment. Dr. Chaudhry further admitted that no one at Emory informed Stefan of this risk. As Dr. Chaudhry testified:

Q. (By Mr. Holloway) If Stefan had been discharged from the ER with instructions to come back --
A. Uh-huh (affirmative).
Q. -- let's say six hours later he comes back. They would have asked him when were you last normal; right?
MR. LADNER: Object to form.
THE WITNESS: Yes.
Q. (By Mr. Holloway) And if he said, I was last normal an hour ago, they would rely on that, wouldn't they?
A. Yes.
Q. Doctors will rely on patient reports of last known normal, but on your testimony, doctors at Emory will not rely on a neurological examination performed by a nurse; true?
MR. LADNER: Object to form.
THE WITNESS: True.
Q. (By Mr. Holloway) So at the time Stefan was admitted for observation, the only chance he had for

137

getting tPA from Emory physicians was if he was just lucky enough that his symptoms returned within two or three hours of a physician examination.
MR. LADNER: Object to form.
Q. (By Mr. Holloway) True?
A. True.
Q. And you were in a position to know that at the time.
A. Yeah.
Q. The other doctors at Emory who treat stroke patients, they were in a position to know that at the time.
A. I believe so, yes.
Q. And nobody breathed a word about that to

Stefan or Janet, did they?
MR. LADNER: Object to form.
THE WITNESS: I believe so.
Q. (By Mr. Holloway) You believe I'm correct that nobody said that?
A. Yes.

* * *

179

Q. Okay. And you did -- we already looked at the point on the timeline where you did your assessment somewhere around midnight, 1:00 a.m.
A. Yeah. Yeah. 12:30 approximately. Yeah.
Q. Now, did the standard of care require you to do another neurological assessment at any time from then until 7:00 a.m. when you hand off the patient?
A. No.
Q. It could be very useful, very good for the patient if you did another neurological exam.
A. Definitely, yes.
Q. But in your -- as you understand it, the standard of care did not require you to do so.
A. Yeah, no. Because I have approximately 125, 120 other patients that are -- that I'm taking care of at that time.
Q. Right. So if you -- if -- in this situation

180

if you and other physicians cannot rely on the neurological assessments by the nurses to update the last known well and the patient's not in the ICU, then Stefan is just out of luck when it comes to having his last known well updated.
MR. LADNER: Object to form.
THE WITNESS: Yeah. You can say yeah because of the number of physicians and nurses in the hospital. During the daytime, we have several teams who take care of patients, but at night, it's just me so...

51. Indeed, on Dr. Obideen's view, even a neurological assessment by an ordinary Emory *physician* would not suffice to identify a patient's last known well. On Dr. Obideen's view, only an assessment by a neurologist could establish the last known well. As Dr. Obideen testified:

0100

Q. This would have been at 1:32 in the morning. So you see H&P, you see Doctor Chaudhry. It says, Mr. Lane is a 68-year-old male, history of coronary disease, in the emergency department, his symptoms self resolved. Do you see that?
A. Yes.

0101

Q. Do you have any reason to dispute that?
A. Sorry. What did you say?
Q. Do you have any reason to dispute that when Mr. --
A. No, I see here, documented self resolved.
Q. So if the symptoms self resolved, then that would reset the TPA clock, would you agree?
A. No. For the same thing, like -- like this is just symptoms. We still -- like I need -- it is not enough. Like most -- like high possibility, I agree with you, but there is still like not enough information to reset. Resetting that clock here, the patient has to be back to baseline, not the symptoms resolved. Has to be completely back to baseline and like as I mentioned to you, there is the exam, there is other, like -- it is not enough to say that for us.
Q. Well, what makes you think that he was not back -- what can you point to that -- to suggest that he was not back to baseline when Doctor --
A. I am not saying he is not back. I am saying it's not enough. Sorry.
Q. Can you point to anything in the medical record to suggest that Mr. Lane was not back to

0102

baseline when the medical record documents, while he was in the emergency department his symptoms self resolved?
A. Yeah. I am not saying like -- like I am not saying he is not back to baseline. I am saying

like there is not enough information for me, like as in stroke specialist to say if he completely back to baseline. I agree with that symptom, that self resolve but Doctor Chaudhry did not do the full neuro exam that I do to say he is back to baseline.

So what I am saying, just information in Doctor Chaudhry's note are not enough for me to say he back to baseline and reset the clock. But I agree, he resolve, the symptoms resolved.

Q. So if the symptoms resolved and just assume, this is my question, and he is back at baseline, then you would agree that the window for TPA would reset?

A. Yes, if he is back to baseline.

Q. Excuse me, beginning at 1:32?

A. Yeah, if he is back to baseline. As I mentioned to you, like for me, like not only symptoms. I ask the patient, he tell me his

0103

symptoms resolve, I take that, this is very important. And there is other things I do, which is the complete neuro exam. And if it is normal, everything is normal then I reset the clock. But just if you tell me it is just -- I had numbness, the numbness is gone without complete neuro exam, it is not enough for me. I agree with you, most likely, but it is not enough.

Q. Okay. Does Doctor -- do you regard Doctor Chaudhry as a competent physician?

A. Yeah, he is very smart.

Q. And do you trust your patients with his care? Or would you trust --

A. Yeah, he is medicine doctor. He is medicine doctor. Yeah, I -- like he is very smart.

Q. You have high confidence in his abilities?

A. Yes.

Q. And if Doctor Chaudhry testified that based on his records, that Mr. Lane's symptoms had self resolved and he was, quote, back to baseline, if you accept that to be true, then you would agree with me that that would reset the four and a half hour clock for TPA?

A. So what I am trying to say is --

Q. Answer the question. I will give you a

0104

chance to explain.
A. No, I don't reset it because -- I agree with him, I trust him when he say the symptoms resolve. As I mentioned to you, we have symptoms, subjective, and we have our own exam, neuro exam. We need both of them to say is normal to reset the clock.

Doctor Chaudhry took the symptoms, he was asking Mr. Lane and he told him his symptoms resolve, so I will take that from symptoms. But Doctor Chaudhry does not do what the criteria we need to do that, to reset the clock. So that is why I am not like not trusting Doctor Chaudhry. I trust what he say, but he didn't like give me the entire criteria to say he is back to baseline. He only say that, speaking about the symptoms. Like I had weakness on the left side, the weakness is gone. Like I agree with him, symptoms resolve, I trust him, but for me as neurologist, he didn't do the complete neuro exam we do to say 100 percent he is back to baseline.

Like if you look at his neuro exam, he doesn't ask the patient, for example, to -- he didn't do the complete neuro exam. So it is not

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enough, like most likely but not -- I cannot say 100 percent he is back to baseline. This is what I am saying.
Q. Well, he evaluated him neurologically and this is on Page 100 of his history and physical. He says down here, neurologic, cranial nerves 2 through 12 were grossly intact, no focal deficits. So how can you testify that he didn't evaluate him neurologically when he documented that he did?

MR. LADNER: Hang on. Object to form. You can answer.

THE WITNESS: Yep. So I am not saying he didn't do exam. He did his own exam and he is medicine doctor, not neurologist or specialist, he did this exam but like the neuro exam is not only this three words. Neuro exam is complete neuro exam. Like -- so I trust him that the cranial nerves were intact, I agree with him, but this is

not enough for me. What I am saying like -- like for us as neurologist, to reset the clock -- like, for example, when we -- when I check, for example,

the gait, for medicine they just say gait normal, steady, unsteady. In neurology we don't use this word, steady, unsteady at all. We check like tandem gait, walking on heels, walking on toes. So we have our -- to reset the clock and decide he is back to baseline, we have our own exam. But to check for strength, for them they only ask the patient do like this, push me, pull me. For us we don't depend on that. This is not sensitive test.

We ask, for example, ask the patient play piano like this. If he play piano, we notice he is weaker on the left side. I am just giving you examples why in neurology this is not enough. I agree with him, I trust what he is saying but it is not enough for me to say he is back to baseline 100. Most likely, but not for me 100 percent.

52. Dr. Chaudhry admitted that Emory's practices — disregarding nurses' neurological assessments for purposes of identifying the last known well — doomed Stefan to go without TPA when Stefan had a stroke in the hospital right in front of an Emory neurologist. As Dr. Chaudhry testified:

192

Q. So if Stefan -- excuse me.
If Stefan is having an ischemic stroke in here, this is really maybe contrary to what it seems like at first glance. This CTA result is really bad news for him because it means his -- his stroke cannot be fixed with a thrombectomy; right?
MR. LADNER: Object to form.
THE WITNESS: Yeah.
Q. (By Mr. Holloway) And it's even worse news because on your view at least he's automatically

disqualified from tPA because there has been no neurological assessment at any time since -- since shortly -- you know, whenever you did yours shortly after midnight of the 14th. There hasn't been a single neurological assessment to reset his last known well, so tPA is out as an option; right?
A. Yes. True.
Q. So in this situation, essentially Stefan is just doomed.
MR. LADNER: Object to form.
THE WITNESS: Yeah. That's very

193

unfortunate.
Q. (By Mr. Holloway) I mean, if -- if only this neurological assessment had been done by somebody capable of doing an assessment that resets the last known well, that would have made a big difference.
MR. LADNER: Object to form.
THE WITNESS: Yeah.

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203

Q. (By Mr. Holloway) Just to finish up here. The -- the care that Stefan got or did not get while at Emory worked out badly for Stefan and Janet, didn't it?
A. Yes.
Q. And the thing about that is that the outcome was entirely predictable from the very beginning if, on your view, there is no way to update a patient's last known well by having nurses do neurological assessments.
MR. LADNER: Object to form.
Q. (By Mr. Holloway) Am I right?
A. Right.
Q. I mean, as you tell it, everybody involved except Stefan and Janet knew there was no way Stefan was going to get tPA if he had another stroke.
MR. LADNER: Object to form.
THE WITNESS: True. If he didn't meet the criteria.

Q. (By Mr. Holloway) Right. Unless -- unless he just got lucky and by pure dumb luck a later stroke just happened to be not long after a physician did a neurological assessment, if he got lucky in that respect, then maybe he would be eligible for tPA, but otherwise, he might as well have had a stroke in an

204

alley behind a supermarket for all the good it would do him if he wanted acute treatment for a stroke.
MR. LADNER: Object to form.
THE WITNESS: Yeah.
Q. (By Mr. Holloway) Do you think Stefan and Janet had a right to know what they were getting into when they went with the decision to have Stefan admitted for observation at Emory?
MR. LADNER: Object to form.
THE WITNESS: Yeah.

53. Dr. Chaudhry admitted that Emory markets its services as a stroke center despite knowing that their practices put post-TIA patients at risk. As Dr. Chaudhry testified:

88

Q. (By Mr. Holloway) And Emory is going out advertising itself as a stroke center; right?
A. Yes, Johns Creek.
Q. I'm sorry. I don't mean to interrupt.
And Emory is telling the ambulance services,

89

We are stroke -- we're a stroke center. Bring your stroke patients to us; right?
MR. LADNER: Object to form.
THE WITNESS: Right.
Q. (By Mr. Holloway) And they're doing that knowing that post-TIA patients like Stefan are going to -- in at least a lot of cases they're going to be doomed to have tPA refused because the neurological assessments are not adequate to identify last known

well.
MR. LADNER: Object to form.
THE WITNESS: Yeah.

54. Stefan Lane needed neurological checks more frequently than every four hours, but Emory would provide them only in the ICU, and Emory would not admit Stefan to the ICU to get the neurological checks he needed. As Dr. Chaudhry testified:

170

Q. I don't want to get off on a whole big thing about this, but Emory had admitted Stefan in part to -- presumably to prevent -- to identify and treat a stroke if he was so unfortunate as to have one; right?
A. Right.
Q. I mean, this state of affairs where if he has a stroke, he just is ineligible for the first-line treatment, doesn't that strike you as perverse?
MR. LADNER: Object to form.
THE WITNESS: It would have been ideal if he was admitted in the ICU --
Q. (By Mr. Holloway) Should he have been --
A. -- where we can do Q1 hour or Q2 hour neuro checks.
Q. Should he have been admitted to ICU?
A. No, because that's not the standard of care.
Q. What's -- what determines whether you get admitted to the ICU or not in a situation like this?

171

A. If there's more frequent neuro checks required, that would be one of them. Or if a blood pressure is out of control that requires drips. If they're not protecting their airway which requires advanced airway support.
Q. So -- I'm sorry.
A. Also, there's -- per nurse -- there's less patients per nurse so they can give more time more frequently to the patients. So all of that matters.
Q. So Stefan is now living with -- for the rest

of his life, he's going to be living with the disability he has now, and there's an -- in your mind, there's at least a reasonable chance that he could have been spared that if his last known well had been tracked at adequate time intervals so that he could have gotten tPA when he did have a stroke.

MR. LADNER: Object to form.

THE WITNESS: Yeah. Yeah. In an ideal situation, yes.

Q. (By Mr. Holloway) So I want to go back to -- well, you said a moment ago one reason to admit someone to the ICU would be if they need more frequent neurological exams; right?

A. Yes.

Q. Stefan did need more frequent neurological

exams, didn't he?

A. Looking back at things, maybe. But at that time, if I would have called an ICU team to see, evaluate that patient, I can certainly tell you they would say no, he doesn't mean the -- he doesn't meet the criteria to be admitted in the hospital and they would have said no.

Q. What --

A. Like I said, right now he would barely meet -- if -- if he can -- at that moment, if he could have walked to the bathroom by himself or with -- with some assistance and he had these symptoms before, he would not even get admitted on the medical floor. He would go to CDU, the observation unit, get the MRI and neurology consult in the morning and -- yeah, so definitely he did not meet the criteria for the ICU admission.

Q. What were -- who sets the criteria for ICU admission?

A. So again, that would be something for quality department to determine, critical care department.

Q. So the -- let me make sure I'm putting this together right in my head. You -- it sounds like you agree with me that -- that what Stefan really needed

was frequent neurological assessments that would be capable of updating his last known well.

MR. LADNER: Object to form.

Q. (By Mr. Holloway) We agree so far?

A. Yes.

Q. But the place at Emory Johns Creek, the unit that could provide those continuous updates, the assessments to do those updates is the ICU.

A. If you want to do it more than four hours or more frequent than four hours, then yes.

Q. And the problem, though, is that he couldn't get into the ICU because of the criteria for ICU admission.

A. Yes.

Q. And that's -- that was out of your hands.

A. Yeah.

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178

Q. (By Mr. Holloway) Okay. Dr. Chaudhry, let's -- let me go back to the timeline we were looking at. One second while I put it up. Okay.

So I think when -- right before we left, we were talking about admission to the ICU versus non-ICU and we went through risks of each. Going back to the criteria that -- the fact of the matter is just that under the criteria that Emory imposes for ICU admission, Stefan -- there was nothing you could do to get Stefan into the ICU?

A. Yeah, that's true. He would not meet the criteria to be in the ICU.

Q. Okay. So he had to stay on the medical floor, and on the medical floor you have a standard order set for -- for TIA patients or post-TIA patients.

A. Yes.

179

Q. And that standard order set provides for neurological assessments by the nurses every four

hours.
A. Yes.

55. It would not be difficult for nurses to do a neurological assessment that could be relied on — by whatever standards Emory adopts — to identify the last known well. As Dr. Chaudhry testified:

121

Q. Okay. First of all, is there anything on here that is beyond the intellectual or physical capacity of the nurses at Emory?
MR. LADNER: Object to form.
THE WITNESS: I don't think so.
Q. (By Mr. Holloway) Okay. So if the nurses are failing to do any part of this, it's because they have not been trained or instructed to do it.
A. I guess, yeah.
Q. Is there -- to your knowledge, having worked as a physician at one of Emory's primary stroke centers for about five years, has Emory trained the nurses to perform this neurological assessment that you're describing?
MR. LADNER: Object to form.
THE WITNESS: I do not know.
Q. (By Mr. Holloway) It would be good for

122

Emory's stroke patients if the nurses did know how to do this; right?
MR. LADNER: Object to form.
THE WITNESS: True. Or if not know, but if they -- if a complete neuro exam is done that frequently or more frequently.

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126

Q. Is there anything on the list -- to make it

go a little faster, is there anything on here that you've talked about that you just think is really complicated and it would take just a lot of time for the nurses to understand and become able to do it?
A. To the point where I am comfortable enough that that establishes patient's last known normal?
Q. Yeah.
A. No.
Q. That is -- just to make sure I've understood the no. So what you're saying is everything on this list --
A. Uh-huh (affirmative).
Q. -- the nurses could -- could learn without a

127

great deal of difficulty and implement without a great deal of difficulty; true?
A. Say that again.
Q. Everything -- so we've made this list of things that go into a neurological assessment to identify a last known normal, and am I right that everything on this list, the nurses could learn without much difficulty and could implement without much difficulty?
A. Yeah, but this is done to establish last known normal, but we should also understand that we are trying to establish that to determine the treatment; correct?

56. Nonetheless, Dr. Chaudhry testified that he personally would never rely on a nurse's neurological evaluation to identify a patient's last known well.

129

Q. Okay. I want to go over some -- a number of things you said there. Give me just a second here. Okay. So first of all, I think you just told me that regardless of how extensive a neurological evaluation the nurse does, you would never rely on the nurse's evaluation to establish the patient's last known normal.
A. Personally, I wouldn't.

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130

Q. I hear all that. I'm -- I'm -- that goes well beyond the question I asked. I just want to make sure I'm hearing you right. You're saying that regardless of how extensive or good a neurological assessment a nurse does may be, you would never rely on the nurse's assessment to establish the last known well.
A. True.
Q. Okay.
A. And that's what I have said from the beginning.

57. It is Emory's policy — not merely an idiosyncratic practice of Dr. Chaudhry and Dr. Obideen — to disregard neurological assessments by nurses, for purposes of identifying a patient's last known well. As Dr. Chaudhry testified:

206

Q. So what you're saying is at least for you, Dr. Abrar Chaudhry, no nurse in the world could do a neurological examination that you would rely on for updating the last known well because they're a nurse, not a doctor.
A. Not enough for me to personally prescribe tPA. I'm sorry, no.
Q. Right. If you're -- no matter how highly trained, no matter how careful, no matter how diligent, no matter how qualified, no nurse examination is good enough for you to reset the last known well even if taking that position means the patient is disqualified from tPA and doomed to just suffer whatever effect a stroke causes.
MR. LADNER: Object to form.
Q. (By Mr. Holloway) Have I --
A. Not to -- not to reset the tPA clock, no. I

207

would not -- I would not trust that because the consequence is much higher. Consequence is death. So

I do not want to risk that.
MR. HOLLOWAY: Objection, nonresponsive.
Q. (By Mr. Holloway) Did I correctly state your position?
MR. LADNER: Object to form, asked and answered.
THE WITNESS: True.
Q. (By Mr. Holloway) And you are telling us that that position you're taking, that is the way it -- that's not just you. That's the way it happens at Emory.
MR. LADNER: Object to form, calls for speculation.
THE WITNESS: I believe so, yes.
Q. (By Mr. Holloway) Let me ask you this: If Emory -- if Emory decided that as a matter of policy they wanted to -- to set out a policy that neurological assessments performed by properly trained nurses would be treated as resetting the last known well, if they did that, would you follow that policy?
MR. LADNER: Object to form.
THE WITNESS: If it's backed by

standard of care and if it's done more frequently, but I don't know. I would still have to think about it, whether it would be enough for me to prescribe tPA myself.
Q. (By Mr. Holloway) Okay. You might have --
A. The risk.
Q. You might or might not follow that policy?
A. If they develop it, then they would do it if it's standard of care, backed by research, et cetera, et cetera. So I just cannot answer a hypothetical question like that.
Q. You don't know if you would -- okay. So you don't know whether or not you would follow that policy.
MR. LADNER: Object to form.
THE WITNESS: If it's backed by research, we would get informed about it by the department, et cetera, by the quality department, neurology department, emergency

department. And if it happens like that, formally, all throughout the system, Emory system, then, yeah, then I would -- then I would -- then I would follow it. I would have to look at the detailed exam that they

209

do. I would -- I would also see whether -- how the nurses are being trained, et cetera.

Q. (By Mr. Holloway) So maybe you would follow that policy, but it's all a hypothetical because Emory has no such policy.

A. Of what, for the nurses to do their neurological exam to set the last known normal, no.

Q. And as far as you understand it, Emory is 100 percent behind the approach you believe in, which is no nurse can do a neurological exam reliable to reset the last known well.

MR. LADNER: Object to form.

THE WITNESS: True.

Q. (By Mr. Holloway) It was that -- it's that way back in December of 2017. It's that way today in August 2020.

MR. LADNER: Object to form.

THE WITNESS: True, they don't determine the last known normal.

Q. (By Mr. Holloway) And you don't have any -- you see no indication that Emory has any intention of changing that going forward for future post-TIA patients.

MR. LADNER: Object to form.

210

THE WITNESS: I have not heard about that.

58. Dr. Chaudhry did not perjure himself in his deposition, with respect to his description of policies and practices at Emory as to identification of the last known well for a post-TIA patient admitted to the main floor for observation.

59. Dr. Obideen did not perjure himself in his deposition, with respect to his description of policies and practices at Emory as to identification of the last known well for a post-TIA patient admitted to the main floor for observation.

60. Dr. Chaudhry testified truthfully about practices at Emory concerning identification of a patient's last known well.

61. Dr. Chaudhry testified truthfully that Emory physicians disregard neurological assessments by nurses, for purposes of identifying a patient's last known well.

62. As a general matter, Emory physicians disregard neurological assessments by nurses for purposes of identifying a patient's last known well.

Emory's Stubbornly Litigious Behavior

63. To narrow the issues in dispute in this lawsuit, Plaintiffs served requests for admission (RFAs) pursuant to OCGA 9-11-36.

64. The RFAs asked the Defendants to admit some of the general medical principles that apply to this case.

65. The RFAs also asked the Defendant to admit some of the case-specific facts concerning Emory's treatment of Stefan Lane — facts drawn from Emory's own medical records.

66. The law requires a party responding to RFAs to make a reasonable inquiry, before claiming ignorance.

67. The law requires a party responding to an RFA to admit as much as can be admitted, where the party cannot admit the RFA completely.

68. The Defendants made false claims of ignorance.

69. For example, Emory Healthcare, Inc. claimed ignorance as to the most basic medical principles concerning stroke.

70. In its marketing, Emory Healthcare, Inc. holds itself out as a healthcare provider.

71. For example, Emory advertises itself as "your one-stop shop for all of your health care needs, both in sickness and in health."[1]

72. Under the law, the knowledge of the officers of Emory Healthcare, Inc. is knowledge of Emory Healthcare, Inc., and Emory Healthcare, Inc. is bound thereby.[2]

73. The Chief Executive Officer of Emory Healthcare, Inc. is Jonathan Lewin, MD.

74. Dr. Lewin is currently the Executive Vice President for Health Affairs, Emory University; Executive Director, Woodruff Health Sciences Center; and CEO and Chairman of the Board, Emory Healthcare.

75. Dr. Lewin also serves as Professor of Radiology and Imaging Sciences and Professor of Biomedical Engineering in the Emory School of Medicine and Professor of Health Policy and Management in the Rollins School of Public Health.

76. Emory holds Dr. Lewin out as a national leader in academic medicine strategy and integrated health care delivery and an international scientific leader in interventional and intraoperative MRI.

77. The Chief Academic Officer of Emory Healthcare, Inc. is Vikas P. Sukhatme, MD, ScD.

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[1] *See* https://www.emoryhealthcare.org/.

[2] *See, e.g., Miller v. Lomax,* 266 Ga App 93 (2004) ("Knowledge of officers of a corporation is knowledge to that corporation and the corporation is bound thereby.").

78. Dr. Sukhatme is Dean of Emory University School of Medicine. He also serves as Chief Academic Officer of Emory Healthcare and as Woodruff Professor.

79. Prior to coming to Emory, Dr. Sukhatme was Chief Academic Officer and Harvard Faculty Dean for Academic Programs at Beth Israel Deaconess Medical Center in Boston and the Victor J. Aresty Professor of Medicine at Harvard Medical School.

80. On information and belief, Dr. Lewin knows, for example, what a stroke is.

81. On information and belief, so does Dr. Sukhatme.

82. Nonetheless, Emory Healthcare, Inc. claimed ignorance as to the most basic medical principles — for example, what a stroke is.

DEFENDANT EMORY HEALTHCARE, INC.'S
RESPONSES TO PLAINTIFFS'
INITIAL REQUESTS FOR ADMISSION TO ALL DEFENDANTS

COMES NOW, EMORY HEALTHCARE, INC., a Defendant in the above-captioned matter, by and through his undersigned counsel, and pursuant to O.C.G.A. § 9-11-36 files this, its Responses to Plaintiffs' Initial Requests for Admission showing this Honorable Court as follows:

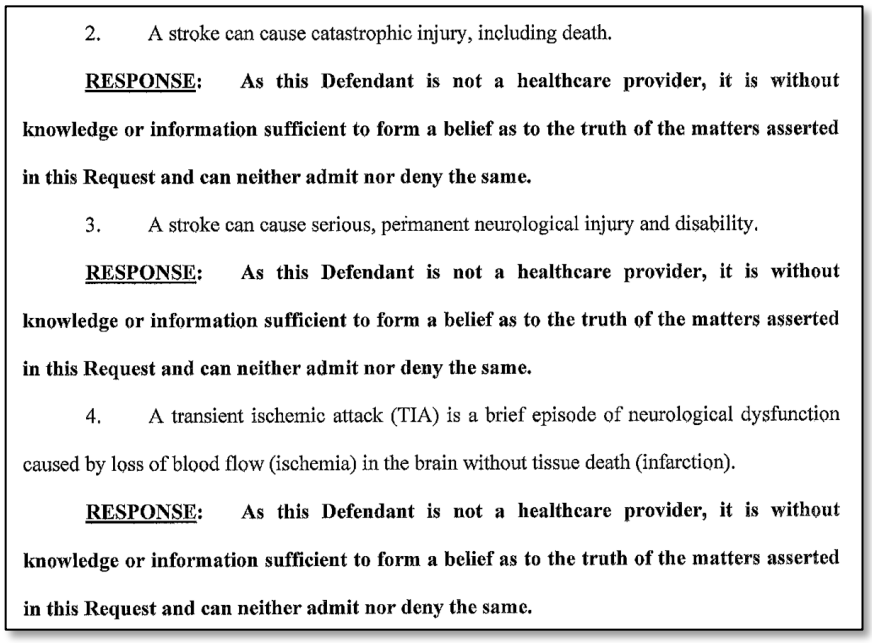
1. A stroke can be caused by interruption of the blood supply to part of the brain or nervous system.

RESPONSE: As this Defendant is not a healthcare provider, it is without knowledge or information sufficient to form a belief as to the truth of the matters asserted in this Request and can neither admit nor deny the same.

83. Emory Healthcare, Inc. claimed that it is not a healthcare provider. The answer is false and frivolous.

84. Emory Healthcare, Inc. claimed that it — and thus its officers, including Dr. Jonathan Lewin and Dr. Vikas Sukhatme — are ignorant of what a stroke is. The answer is false and frivolous.

85. Emory Healthcare, Inc. made repeated, voluminous false and frivolous claims of ignorance. For example:



2. A stroke can cause catastrophic injury, including death.

RESPONSE: As this Defendant is not a healthcare provider, it is without knowledge or information sufficient to form a belief as to the truth of the matters asserted in this Request and can neither admit nor deny the same.

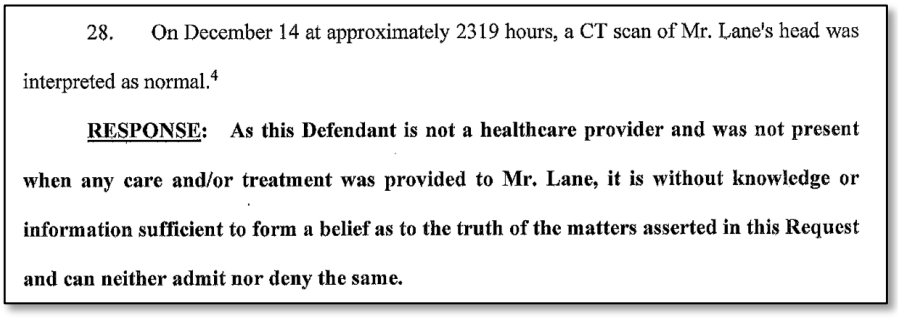
3. A stroke can cause serious, permanent neurological injury and disability.

RESPONSE: As this Defendant is not a healthcare provider, it is without knowledge or information sufficient to form a belief as to the truth of the matters asserted in this Request and can neither admit nor deny the same.

4. A transient ischemic attack (TIA) is a brief episode of neurological dysfunction caused by loss of blood flow (ischemia) in the brain without tissue death (infarction).

RESPONSE: As this Defendant is not a healthcare provider, it is without knowledge or information sufficient to form a belief as to the truth of the matters asserted in this Request and can neither admit nor deny the same.

86. Similarly, Emory Healthcare, Inc. repeatedly made false and frivolous claims of ignorance as to facts documented in Emory's own medical records. For example:



28. On December 14 at approximately 2319 hours, a CT scan of Mr. Lane's head was interpreted as normal.[4]

RESPONSE: As this Defendant is not a healthcare provider and was not present when any care and/or treatment was provided to Mr. Lane, it is without knowledge or information sufficient to form a belief as to the truth of the matters asserted in this Request and can neither admit nor deny the same.

87. Each of the other Defendants (except The Emory Clinic, Inc., which has not responded to RFAs), has similarly made voluminous false and frivolous RFA answers.

Count 6 – Punitive Damages, against Emory Healthcare, Inc., The Emory Clinic, Inc., Dr. Marten, Dr. Chaudhry, and Dr. Obideen

88. Plaintiffs incorporate by reference, as if fully set forth herein, all the allegations of the original Complaint, the First Amended Complaint, and all the preceding paragraphs of this Second Amended Complaint.

89. Plaintiffs assert a claim for punitive damages against Emory Healthcare, Inc., The Emory Clinic, Inc., Dr. Marten, Dr. Chaudhry, and Dr. Obideen.

90. Emory Healthcare, Inc. and The Emory Clinic, Inc. acted fraudulently by marketing Emory Johns Creek Hospital as a "Primary Stroke Center," despite knowing that — in violation of consensus standards — Emory would disregard neurological assessments by nurses, for purposes of identifying a post-TIA stroke patient's last known well.

91. Emory Healthcare, Inc., The Emory Clinic, Inc., Dr. Marten, and Dr. Chaudhry acted with conscious indifference to consequences by admitting Stefan Lane for observation (or failing to discharge him), despite knowing that by keeping Stefan on the main floor of the hospital (and acting pursuant to Emory's practices), they were depriving Stefan of the chance for TPA therapy in the event Stefan suffered a post-TIA stroke in the hospital.

92. Dr. Obideen acted with conscious indifference to consequences by acting pursuant to Emory's practice of disregarding neurological assessments by nurses, for purposes of identifying a stroke patient's last known well.

93. The presumptive cap of $250,000 on punitive damages does not apply to Defendants Emory Healthcare, Inc., The Emory Clinic, Inc., Ryan Marten, MD, and Abrar Chaudhry, MD.

94. These Defendants knew that by admitting Stefan for observation (or failing to discharge him), they dramatically reduced Stefan's chances of receiving TPA therapy in the event Stefan suffered a stroke in the hospital.

95. These Defendants knew that by admitting Stefan for observation (or failing to discharge him), they put Stefan at risk of serious, permanent disability in the event Stefan suffered a stroke in the hospital.

96. Nonetheless, these Defendants intentionally admitted (or failed to discharge) Stefan knowing that their actions would impose this harm on Stefan.

97. In admitting Stefan for observation (or failing to discharge him), these Defendants acted, or failed to act, with the specific intent to cause harm.

Damages

98. Plaintiffs incorporate by reference, as if fully set forth herein, all preceding paragraphs of this Complaint.

99. As a direct and proximate result of the Defendants' individual and collective conduct, Plaintiffs are entitled to recover from Defendants reasonable compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury for all damages Plaintiffs suffered, including physical, emotional, and economic injuries.

100. WHEREFORE, Plaintiffs demand a trial by jury and judgment against the Defendants as follows:

a. Compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury;

b. The expenses of litigation, including attorney fees;

c. All costs of this action;

d. Punitive Damages; and

e. Such other and further relief as the Court deems just and proper.

December 22, 2020

Respectfully submitted,

/s/ Lloyd N. Bell
Lloyd N. Bell
Georgia Bar No. 048800
Daniel E. Holloway
Georgia Bar No. 658026

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Attorneys for Plaintiffs

IN THE STATE COURT OF DEKALB COUNTY
STATE OF GEORGIA

Stefan Lane Janet Lane, Plaintiffs, — *Versus* — Emory Healthcare, Inc. The Emory Clinic, Inc. Principals of the Individual Defendants Abrar Chaudhry, MD Ryan A. Marten, MD Bryan Lee Mays, RN Charice Jordan, PA-C Mahmoud Obideen, MD John/Jane Doe 1-5, Defendants	)	CIVIL ACTION FILE NO. 19A77517 Jury Trial Demanded

CERTIFICATE OF SERVICE

I hereby certify that I have served a copy of the within and foregoing **Plaintiffs' Second Amended Complaint for Damages** upon all parties to this proceeding by electronically filing the same with the Clerk of Court using Odyssey eFileGA which will send electronic notification to counsel of record as follows:

David Ladner, Esq.
Bendin Sumrall & Ladner, LLC
One Midtown Plaza, Suite 800
1360 Peachtree Street NE
Atlanta, GA 30309

December 22, 2020.

BELL LAW FIRM

/s/ Lloyd N. Bell
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